COUNTY OF DARE

PO Box 1000. Manteo. NC 27954

DARE COUNTY BOARD OF COMMISSIONERS
Dare County Administration Building
954 Marshall C. Collins Dr., Manteo, NC

Tuesday, September 07, 2021

"HOW WILL THESE DECISIONS IMPACT OUR CHILDREN AND FAMILIES?"

AGENDA

9:00 AM CONVENE, PRAYER, PLEDGE OF ALLEGIANCE

ITEM 1 Opening Remarks - Chairman's Update

ITEM 2 Presentation of County Service Pins - September 2021

ITEM 3 Employee of the Month

ITEM 4 Public Comments

ITEM 5 2021B IFC Resolution of the Board of Comm. of Dare County, NC, Authorizing the Negotiation of an Installment Financing Contract and Providing for Certain Other Related Matters Thereto

ITEM 6 Public Hearing -- 2021 B Installment Financing Contract

ITEM 7 2021A IFC 2021A IFC Resolution of the Board of Comm. of Dare County, NC, Approving an Installment Financing Contract and Delivery Thereof and Providing for Certain Other Related Matters

ITEM 8 UPS Zoning Text Amendment -- Request to Schedule a Hearing

ITEM 9 Resolution Approving the Memorandum of Agreement Between the State of NC and Local Governments on Proceeds Relating to the Settlement of Opioid Litigation

ITEM 10 Architectural Contract for 2022 EMS Station Projects

ITEM 11 Resolution - Authorize the Use of Electronic Advertisement for Contracts Subject to G.S. 143-129

ITEM 12 One Call Non-Emergency Ambulance Service Agreement

ITEM 13 WellCare Health Plans, Inc. Provider Agreement

ITEM 14 Proclamation - Constitution Week

ITEM 15 Resolution Opposing the United States Fish & Wildlife Service's Proposed Designation of Critical Habitat Unit NC-1 and NC-1A (Outer Banks-Hatteras Island and Shoals) for the Red Knot Rufa

ITEM 16 **Consent Agenda**

1. Approval of Minutes
2. 2021 CRS Annual Report
3. Designated Agent Approval Form – Grants and Waterways Administrator
4. Health and Human Services - Public Health School Health Liaison
5. Public Health Breaking Through Task Force Public Awareness Campaign to Address Community Mental Health Grant
6. Health and Human Services - Public Health Quality Improvement Design Team Stipend
7. Health & Human Services - Johnson Controls, Inc.

ITEM 17 Upcoming Board Appointments

ITEM 18 Commissioners' Business & Manager's/Attorney's Business

ADJOURN UNTIL 5:00 P.M. ON SEPTEMBER 20, 2021

Opening Remarks - Chairman's Update

Description

Dare County Chairman Robert Woodard will make opening remarks.

Board Action Requested

Informational Presentation

Item Presenter

Chairman Robert Woodard, Sr.

Presentation of County Service Pins - September 2021

Description

The following employees are scheduled to receive service pins this month:
Ricki Burrus, Customer Service Representative (occupancy taxes) - 10 year pin
Bonnie Cooper, Comm. Social Service Technician - 10 year pin
John Luke, Metering Services Technician (water) - 10 year pin
Mary Jernigan, Leisure Activity Coordinator and Steve Gwaltney, Auto Body Mechanic - 15 year pins
George Bowman, Community Program Coordinator (Sheriff's Office) - 25 year pin
Brandi Bohanan, Community Center Manager - 25 year pin
Debbie Dutton, Public Health Nursing Director - 30 year pin

Board Action Requested

None - presentation

Item Presenter

Robert Outten, County Manager

Employee of the Month

Description

The Employee of the Month Certification will be presented.

Board Action Requested

None

Item Presenter

To Be Determined

Public Comments

Description

The Board of Commissioners encourages citizen participation and provides time on the agenda at every regularly scheduled meeting for Public Comments. This is an opportunity for anyone to speak directly to the entire Board of Commissioners for up to five minutes on any topic or item of concern. Masks and social distancing required.

Comments can be made at the Commissioners Meeting Room in Manteo (Administration Bldg., 954 Marshall Collins Drive, Manteo) or through an interactive video link at the Fessenden Center Annex (47013 Buxton Back Road, Buxton).

Board Action Requested

Hear Public Comments

Item Presenter

Robert Outten, County Manager

RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AUTHORIZING THE NEGOTIATION OF AN INSTALLMENT FINANCING CONTRACT AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS THERETO

Description

Please see the attached Item Summary

Board Action Requested

Adopt the Initial Resolution

Item Presenter

David Clawson, Finance Director

Item Summary: **RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AUTHORIZING THE NEGOTIATION OF AN INSTALLMENT FINANCING CONTRACT AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS THERETO**

This agenda item begins the process to issue debt with a five-year term to finance the County's share of the Towns' 2022 beach nourishment project and certain improvements to the Justice Center.

The Justice Center budget was established by the Board on 8/16. Beach nourishment bids will be opened on 8/31 and the project budget and contract will be presented to the Board on 9/20.

The schedule for the financing is:

7/28 Letter sent to the NC General Assembly JL Committee on Local Government
8/22 Notice of Public Hearing published
8/30 Term Sheet for financing bids due to Piper Scott (placement agent)
8/31 Beach nourishment project bid opening
9/7 BOC adopts Initial Resolution and calls for a public hearing
9/7 BOC holds Public Hearing
By 9/7 Local Government Commission (LGC) application due
9/20 BOC adopts Approving Resolution
BOC establishes beach nourishment project budget
BOC approves beach nourishment construction contract
10/5 LGC meeting and approval
10/13 Debt closing

Attachments after this Item Summary are:

- Initial Resolution
- Notice of Public Hearing
- Financing Term Sheet

The Initial Resolution states:

- It is in the best interest of the County to enter into an installment financing contract to finance the Projects, and that the Justice Center will be pledged under the deed of trust;
- The Projects are essential to the County, and the County can finance them at favorable interest rates;
- The financed amount will not exceed $13,000,000;
- The use of an installment financing contract for the financing vehicle is preferred;
- There is no property tax increase necessary to finance the Projects;
- The County's taxing power is not pledged for the financing;
- The County is not in default under any of its debt service obligations;
- The County's budget process is in compliance with the Local Government Budget and Fiscal Control Act;
- Per past audit reports, the County has been in compliance with the law and has not been censured by the LGC; and
- A public hearing will be held on the financing on September 7, 2021.

The Initial Resolution authorizes:

- The County Manager & the Finance Director to proceed with the Contract for a principal amount of not to exceed $13,000,000 under NCGS 160A-20;
- The Finance Director is directed to file an application with the LGC;
- The Finance Director is authorized and directed to retain Parker Poe Adams & Bernstein as bond counsel, DEC & Associates as Financial Advisor, and Piper Scott & Co. as Placement Agent; and
- Sets a Public Hearing on September 7, 2021 on the contract, the deed of trust, and the projects.

The Board is requested to:

1. Adopt the Initial Resolution.

RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AUTHORIZING THE NEGOTIATION OF AN INSTALLMENT FINANCING CONTRACT AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS THERETO

WHEREAS, the County of Dare, North Carolina (the "*County*") is a validly existing political subdivision of the State of North Carolina, existing as such under and by virtue of the Constitution, statutes and laws of the State of North Carolina (the "*State*");

WHEREAS, the County has the power, pursuant to the General Statutes of North Carolina to (1) enter into installment contracts in order to purchase, or finance or refinance the purchase of, real or personal property and to finance or refinance the construction or repair of fixtures or improvements on real property and (2) create a security interest in some or all of the property financed or refinanced to secure repayment of the purchase price;

WHEREAS, the Board of Commissioners of the County (the "*Board*") hereby determines that it is in the best interest of the County to enter into (1) an Installment Financing Contract (the "*Contract*") with [Bank][a financial institution to be determined] (the "*Bank*") in order to finance beach nourishment projects in Duck, Kill Devil Hills, Kitty Hawk and Southern Shores and improvements to the County's Justice Center (the "*Projects*"), and (2) a deed of trust, security agreement and fixture filing (the "*Deed of Trust*") related to the County's fee simple interest in the real property on which the County's Justice Center is located (the "*Mortgaged Property*") that will provide security for the County's obligations under the Contract;

WHEREAS, the County hereby determines that the Projects are essential to the County's proper, efficient and economic operation and to the general health and welfare of its inhabitants; that the Projects will provide an essential use and will permit the County to carry out public functions that it is authorized by law to perform; and that entering into the Contract and Deed of Trust is necessary and expedient for the County by virtue of the findings presented herein;

WHEREAS, the County hereby determines that the Contract allows the County to finance the Projects at a favorable interest rate currently available in the financial marketplace and on terms advantageous to the County;

WHEREAS, the County hereby determines that the estimated cost of financing the Projects is an amount not to exceed $13,000,000 and that such cost of financing the Projects exceeds the amount that can be prudently raised from currently available appropriations, unappropriated fund balances and non-voted bonds that could be issued by the County in the current fiscal year pursuant to Article V, Section 4 of the Constitution of the State;

WHEREAS, although the cost of financing the Projects pursuant to the Contract is expected to exceed the cost of financing the Projects pursuant to a bond financing for the same undertaking, the County hereby determines that the cost of financing the Projects pursuant to the Contract and the Deed of Trust and the obligations of the County thereunder are preferable to a general obligation bond financing or revenue bond financing for several reasons, including but not limited to the following: (1) the cost of a special election necessary to approve a general obligation bond financing, as required by the laws of the State, would result in the expenditure of significant funds; (2) the time required for a general obligation bond election would cause an unnecessary delay which would thereby decrease the financial benefits of financing the Projects; and (3) no revenues are produced by the Projects so as to permit a revenue bond financing;

WHEREAS, the County has determined and hereby determines that the estimated cost of financing the Projects pursuant to the Contract reasonably compares with an estimate of similar costs under a bond financing for the same undertaking as a result of the findings delineated in the above preambles;

WHEREAS, the increase in taxes, if any, necessary to meet the sums to fall due under the Contract will not be excessive;

WHEREAS, no deficiency judgment may be rendered against the County in any action for its breach of the Contract, and the taxing power of the County is not and may not be pledged in any way directly or indirectly or contingently to secure any money due under the Contract;

WHEREAS, the County is not in default under any of its debt service obligations;

WHEREAS, the County's budget process and Annual Budget Ordinance are in compliance with the Local Government Budget and Fiscal Control Act, and external auditors have determined that the County has conformed with generally accepted accounting principles as applied to governmental units in preparing its Annual Budget ordinance;

WHEREAS, past audit reports of the County indicate that its debt management and contract obligation payment policies have been carried out in strict compliance with the law, and the County has not been censured by the North Carolina Local Government Commission (the *"LGC"*), external auditors or any other regulatory agencies in connection with such debt management and contract obligation payment policies; and

WHEREAS, a public hearing on the Contract after publication of a notice with respect to such public hearing was held on the date of the adoption of this Resolution and approval of the LGC with respect to entering the Contract must be received; and

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AS FOLLOWS:

Section 1. ***Authorization to Negotiate the Contract; Ratification***. That the County Manager and the Deputy County Manager/Finance Director, individually and collectively, with advice from the County's financial advisor, are hereby authorized and directed to proceed and negotiate on behalf of the County to finance the Projects for a principal amount not to exceed $13,000,000 under the Contract to be entered into in accordance with the provisions of Section 160A-20 of the General Statutes of North Carolina and to provide in connection with the Contract, as security for the County's obligations thereunder, the Deed of Trust conveying a lien and interest in the Mortgaged Property, including the improvements thereon, as may be required by the Bank providing the funds to the County under the Contract. All actions of the County Manager and the Deputy County Manager/Finance Director, individually and collectively, or their designees, in furtherance of financing the Projects, whether previously or hereinafter taken, are hereby ratified and authorized.

Section 2. ***Application to LGC.*** That the Deputy County Manager/Finance Director or his designee is hereby directed to file with the LGC an application for its approval of the Contract and all relevant transactions contemplated thereby on a form prescribed by the LGC and to state in such application such facts and to attach thereto such exhibits regarding the County and its financial condition as may be required by the LGC.

Section 3. ***Direction to Retain Special Counsel and Financial Advisor.*** That the selection by the Deputy County Manager/Finance Director to retain the assistance of Parker Poe Adams & Bernstein

LLP, as special counsel, DEC Associates, Inc., as financial advisor, and Piper Sandler & Co., as placement agent, is hereby authorized and ratified.

Section 4. ***Ratification.*** All actions of the County and its officials, whether previously or hereafter taken in effectuating the proposed financing as described herein, are hereby ratified, authorized and approved.

Section 5. ***Repealer.*** That all motions, orders, resolutions and parts thereof in conflict herewith are hereby repealed.

Section 6. ***Effective Date.*** That this Resolution is effective on the date of its adoption.

Adopted this the 7th day of September, 2021.

_____
Robert Woodard, Chairman

Attest:

_____
Cheryl C. Anby, Clerk to the Board

STATE OF NORTH CAROLINA)
) SS:
COUNTY OF DARE)

I, *Cheryl C. Anby*, Clerk to the Board of Commissioners of the County of Dare, North Carolina, ***DO HEREBY CERTIFY*** that the foregoing is a true and exact copy of a resolution entitled **"RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AUTHORIZING THE NEGOTIATION OF AN INSTALLMENT FINANCING CONTRACT AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS THERETO"** duly adopted by the Board of Commissioners of the County of Dare, North Carolina at a meeting held on the 7th day of September, 2021.

WITNESS my hand and the corporate seal of the County of Dare, North Carolina, this the ___ day of September, 2021.

_____

(SEAL)

Cheryl C. Anby
Clerk to the Board of Commissioners
County of Dare, North Carolina

NOTICE OF PUBLIC HEARING

The Board of Commissioners (the "Board") of the County of Dare, North Carolina (the "County") is considering entering into an installment financing contract (the "Contract"), in a principal amount not to exceed $13,000,000, under which the County will make certain installment payments, in order to (a) pay the costs of beach nourishment projects in Duck, Kill Devil Hills, Kitty Hawk and Southern Shores and improvements to the County's Justice Center (the "Projects") and (b) pay the costs associated with entering into the Contract. In connection with the Contract, the County will grant a security interest in the site of the County's Justice Center located at 962 Marshall C. Collins Drive, Manteo, North Carolina 27954 and improvements thereon for the benefit of the entity providing the funds to the County under the Contract.

NOTICE IS HEREBY GIVEN, pursuant to Sections 160A-20 of the General Statutes of North Carolina, that on September 7, 2021 at 9:00 a.m., or as soon thereafter as practicable, in the County Board of Commissioners' Meeting Room, Administration Building, 954 Marshall C. Collins Drive, Manteo, North Carolina 27954, the Board will conduct a public hearing concerning the approval of the execution and delivery of the Contract, the financing of the Projects and the granting of a security interest described above. All interested parties are invited to present comments at the public hearing on the Contract. Any person wishing to comment in writing should do so by submitting comments to the Board of County Commissioners, P.O. Box 1000, Manteo, NC 27954, Attention: Clerk to the Board, or cheryl.anby@darenc.com. Written comments must be submitted between the date of publication of this notice and 24 hours before the public hearing.

/s/ Cheryl C. Anby
Clerk to the Board of Commissioners
County of Dare, North Carolina

Dare County, North Carolina
Installment Financing Contract

TERM SHEET

The Contract (as defined herein) is offered solely pursuant to this Term Sheet to a limited number of "Qualified Institutional Buyers" or "Institutional Accredited Investors" within the meaning of the Securities Act of 1933, as amended. No dealer, broker, salesperson or other person has been authorized by the County (as defined herein) or Piper Sandler & Co., as Placement Agent, to give any information or to make any representations other than those contained in this Term Sheet, and if given or made, such other information or representations must not be relied upon as having been authorized by any of the foregoing. By execution and delivery of an investment letter in the form attached as Appendix A to this term sheet and the execution and delivery of the Contract, any such lender therefor shall be deemed to have had access to such financial and other information concerning the County and the Contract as such lender deemed necessary to make an independent investment decision to execute the Contract, including the opportunity, at a reasonable time prior to such execution, to ask questions of and receive answers concerning the County and the terms and conditions of the Contract and the security therefor.

This Term Sheet is being sent to you as a prospective lender in connection with a private placement identified by Piper Sandler & Co. Piper Sandler & Co. has not independently verified the information contained herein or otherwise made any further investigation of the financing, the credit of the issuer, the collateral or the terms. Neither Piper Sandler & Co. nor any of its affiliates, partners, officers, agents, employees or representatives makes any representation or warranty, express or implied, as to the accuracy or completeness of such information. See the last page of this Term Sheet for additional disclaimers. Lenders will be expected to complete their own due diligence if selected.

Issuer:	County of Dare, North Carolina (the "County").
Issue:	Installment Financing Contract pursuant to NCGS 160A-20 (the "Contract")
Purpose:	Proceeds of the Contract will be used for 1) $325,000 of improvements to the Dare County Justice Center for roof replacement and improvements, carpet replacement and improvements to the entire Clerk of Court area, and sound panel replacement and improvements to Courtrooms A, B and D, 2) fund the County's share ($12,315,869) of the Towns of Duck, Southern Shores, Kitty Hawk and Kill Devil Hills approximate $43,284,737 beach nourishment project, and 3) pay the issuance costs for the Contract. The County will pledge the Justice Center as collateral for the Contract (the "Justice Center").
Par Amount*:	Approximately $12,775,000. Assume the $13,000,000 million par amount for purposes of this bid and the amount will be adjusted at award.
Dated/Closing Date*:	October 13, 2021 (or January 19, 2023 if forward financing – See "Bidder Rate Quote" below)
Bids Due to Piper:	**We look forward to your response by 4:00pm North Carolina time on Wednesday, August 31, 2021.** Proposals should be emailed to: matt.morrell@psc.com

*Preliminary, subject to change.

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TERM SHEET

Principal Payment Dates: June 1st, beginning 6/1/23 with a final maturity of 6/1/27 (for both October 13, 2021 and January 19, 2023 closings – See "Bidder Rate Quote" below).

Interest Payment Dates: December 1st and June 1st, beginning June 1, 2022 (if close October 13, 2021) and June 1, 2023 (if a forward closing in January 19, 2023). See "Bidder Rate Quote" below.

Rating: The Issuer will not seek a rating. The County's current limited obligation bond ratings are AA/Aa2/AA-.

Tax Status: Interest will be tax exempt.

Current Amortization: *

	Series 2021B
6/1/2023	2,600,000
6/1/2024	2,600,000
6/1/2025	2,600,000
6/1/2026	2,600,000
6/1/2027	2,600,000
Total	13,000,000

Bidder Rate Quote: Bidders are requested to provide ***fixed interest rate*** for either or both of the following:

1) ***Current Interest Rate:*** a single interest rate for the Contract assuming a closing on October 13, 2021, or
2) ***Forward Interest Rate:*** a single interest rate for the Contract assuming a forward drawing/closing on January 19, 2023.

Average Life (from closing)*:

2021 Closing	**2023 Closing**
3.633 Years	2.656 Years

*Preliminary, subject to change.

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TERM SHEET

Prepayment Provision:	Piper Sandler will entertain any prepayment provisions, but all offers should include at least a 1-year par call option and a non-call option.
Security:	The Contract will be secured under a Deed of Trust on the Justice Center. The County's obligation to pay the debt service will be subject to annual appropriation by the Board of County Commissioners. The taxing power of the County will not be pledged to secure repayment.
Collateral:	The Justice Center will be pledged as collateral for the Bonds. The current insured value for the facility is $19,196,000.
Description of Dare County:	Please see attached the most recent S&P, Moody's and Fitch credit reports for Dare County NC. Current financials for the past 5 years can be found at the following link: https://www.darenc.com/departments/finance/annual-financial-reports
Special Counsel and Bond Counsel:	Parker Poe Adams & Bernstein LLP serves as bond counsel to the County, will draft all bond documents, and will provide a validity opinion and an opinion as to the treatment of the interest component of installment payments under the Contract under State and federal tax law. The proposer should indicate if it is the proposer's preference to draft the financing documents. By submitting a proposal, the successful proposer waives any conflict of interest that Parker Poe Adams & Bernstein LLP's involvement in connection with the financing presents to such successful proposer.
Financial Advisor:	DEC Associates, Inc. serves as the County's financial advisor.
Acceptance of Proposals:	The County reserves the right to select the proposal that best meets the needs of the County, but the selection will be made primarily on the lowest interest cost to the County. The County reserves the right to reject all proposals. Selection of any proposal is subject to approval thereof and approval of documentation by the Board of County Commissioners which is expected to occur on October 4,

2021, and the North Carolina Local Government Commission which is expected to occur on October 5, 2021. The successful bidder will be expected to honor its bid quote through closing.

Investment Letter:

A form of investor letter is attached as **Appendix A** to this Term Sheet. Unless Piper Sandler obtains a written representation in the following form as part of the investor letter or otherwise, Piper Sandler will be required under its regulatory authority to obtain a CUSIP.

The Lender is a bank[1]*, any entity directly or indirectly controlled by a bank, or under common control with a bank (other than a dealer registered under the Exchange Act), or a consortium of such entities [or the Lender is a municipal entity purchasing the securities with funds that are, at least in part, proceeds of, or fully or partially secure or pay, the lending entity's issue of municipal obligations (e.g. state revolving fund or bond bank)], and the Lender is entering into the Contract solely for its own account for investment purposes only, with a present intent to retain its interest in the Contract until maturity or early redemption (subject to the understanding that disposition of the Lender's property will remain at all times within its control).*

The Contract will contain language restricting the transfer of the Lender's interest in the Contract consistent with policies of the North Carolina Local Government Commission.

Transfer Restriction:

The Bonds will be non-transferable, except to a bank, insurance company or similar financial institution or any other entity approved by the Local Government Commission of North Carolina.

[1] The term "bank" means a banking institution organized under the laws of the United States or a Federal savings association, as defined in section 2(5) of the Home Owners' Loan Act [12 USCS § 1462(5)], (B) a member bank of the Federal Reserve System, (C) any other banking institution or savings association, as defined in section 2(4) of the Home Owners' Loan Act [12 USCS § 1462(4)], whether incorporated or not, doing business under the laws of any State or of the United States, a substantial portion of the business of which consists of receiving deposits or exercising fiduciary powers similar to those permitted to national banks under the authority of the Comptroller of the Currency pursuant to the first section of Public Law 87-722 (12 U.S.C. 92a), and which is supervised and examined by State or Federal authority having supervision over banks or savings associations, and which is not operated for the purpose of evading the provisions of this title, and (D) a receiver, conservator, or other liquidating agent of any institution or firm included in clauses (A), (B), or (C) of this paragraph." 15 U.S.C.S. § 78c.(a)(6).

TERM SHEET

REGARDING THE USE OF THIS TERM SHEET

THE INFORMATION AND EXPRESSIONS OF OPINION HEREIN ARE SUBJECT TO CHANGE WITHOUT NOTICE, AND NEITHER THE DELIVERY OF THIS TERM SHEET NOR ANY SALE MADE HEREUNDER SHALL, UNDER ANY CIRCUMSTANCES, CREATE ANY IMPLICATION THAT THERE HAS BEEN NO CHANGE IN THE AFFAIRS OF THE COUNTY SINCE THE DATE HEREOF.

THE CONTRACT HAS NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED.

IN MAKING AN INVESTMENT DECISION, INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE COUNTY AND THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

Additional Information Respecting Documentation

The attached document is being sent to you as a prospective purchaser or lender in connection with a private placement or loan opportunity identified by Piper Sandler & Co. or its affiliate. Piper Sandler & Co. and its affiliates have not independently verified the information contained herein or otherwise made any further investigation of the loan, the credit of the borrower and any obligor, the collateral or the loan terms. Neither Piper Sandler & Co. nor any of its affiliates, partners, officers, agents, employees or representatives makes any representation or warranty, express or implied, as to the accuracy or completeness of such information. All references to financial information of the borrower, any obligor or the collateral shall not be considered as applicable for any period after the date they are referenced, unless expressly stated otherwise.

In addition to this Term Sheet, you as prospective lender will be provided with or granted access to all of the available financial and other information requested and deemed by you to be necessary to enable you to make an independent and informed judgment with respect to the collateral, the borrower and any obligor and their credit and the desirability of participating in the prospective financing. You as prospective lender agree to make a complete examination of all loan documents and approve of the form and content of the same prior to your funding, and you agree that Piper Sandler & Co. and its affiliates shall have no responsibility to perform and have not independently performed an examination of or approved the loan documents or any specific loan terms and shall not have any duty to inspect the collateral or the books and records of borrower or any obligor.

By accepting this package and considering becoming a prospective lender, you hereby represent that you have the sophistication and knowledge required to evaluate the loan, the credit of the borrower and any obligor, the collateral and the loan terms and that you will make your own independent credit analysis and decision with respect to the loan based upon your own independent examination and evaluation of the transaction and the information you have deemed appropriate, without reliance on Piper Sandler & Co. or its affiliates, its directors, officers, employees, attorneys or agents.

TERM SHEET

Piper Sandler & Co., its affiliates, directors, officers, employees, attorneys or agents make no representations or warranties, express or implied as to the business wisdom or propriety of entering into the loan, compliance with any lending or regulatory requirements, the credit worthiness of the borrowers or any obligor and the value and security of the collateral or with respect to the solvency, condition (financial or other) or future condition (financial or other) of borrower, any obligor, or the collateral securing any loan or for the due execution, legality, validity, enforceability, genuineness, sufficiency or collectability of the collateral or any loan document relative thereto. Piper Sandler & Co. and its affiliates shall not be responsible for the performance or observance of any of the terms, covenants or conditions of the loan documents.

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Form of Investor Acknowledgement Letter

[Date]

[Issuer Name]
Piper Sandler & Co., as Placement Agent
800 Nicollet Mall
Minneapolis, MN

Re: Dare County, North Carolina Installment Financing Contract dated as of _____, 2021

Ladies and Gentlemen:

The undersigned, [name of lender] (the "Lender") hereby represents and warrants to you as follows:

1. The Lender has on the date hereof entered into the Installment Financing Contract dated as of _____, 2021 (the "Loan Obligation") between the Lender and the County of Dare, North Carolina (the "County").

2. DELETE PARAGRAPH AND FOOTNOTE IF THE LENDER IS A NON-BANK ENTITY: The Lender is a bank[2], any entity directly or indirectly controlled by the bank or under common control with the bank, other than a broker, dealer or municipal securities dealer registered under the Securities Exchange Act of 1934, or a consortium of such entities; or a municipal entity with funds that are, at least in part, proceeds of, or fully or partially secure or pay, the Lender's issue of municipal obligations (*e.g.,* state revolving fund or bond bank).

3. The Lender has sufficient knowledge and experience in business and financial matters in general, and investments such as the Loan Obligation in particular, to enable the Lender to evaluate the Loan Obligation, the credit of the borrower, the collateral and the bond terms and that the Lender will make its own independent credit analysis and decision to enter into the Loan Obligation based on independent examination and evaluation of the transaction and the information deemed appropriate, without reliance on Piper Sandler & Co. or its affiliates, its directors, officers, employees, attorneys or agents.

4. The Lender acknowledges that no credit rating has been sought or obtained with respect to the Loan Obligation.

5. The Lender acknowledges that no official statement has been prepared for the Loan Obligation, and that the County will not be entering into a continuing disclosure agreement to provide ongoing disclosure respecting the Loan Obligation. The Lender has been offered copies of or full access to all documents relating to the Loan Obligation and all records, reports, financial statements and other information concerning the County and pertinent to the source of payment for the Loan Obligation as deemed material by the Lender, which the Lender as a reasonable investor, has requested and to which

[2] A) a banking institution organized under the laws of the United States or a Federal savings association, as defined in section 2(5) of the Home Owners' Loan Act [12 USCS § 1462(5)], (B) a member bank of the Federal Reserve System, (C) any other banking institution or savings association, as defined in section 2(4) of the Home Owners' Loan Act [12 USCS § 1462(4)], whether incorporated or not, doing business under the laws of any State or of the United States, a substantial portion of the business of which consists of receiving deposits or exercising fiduciary powers similar to those permitted to national banks under the authority of the Comptroller of the Currency pursuant to the first section of Public Law 87-722 (12 U.S.C. 92a), and which is supervised and examined by State or Federal authority having supervision over banks or savings associations, and which is not operated for the purpose of evading the provisions of this title, and (D) a receiver, conservator, or other liquidating agent of any institution or firm included in clauses (A), (B), or (C) of this paragraph." 15 U.S.C.S. § 78c(a)(6).

the Lender, as a reasonable investor, would attach significance in making an investment decision.

6. The Lender confirms that its entering into the Contract constitutes an investment that is suitable for and consistent with its investment program and that the Lender is able to bear the economic risk of the Contract, including a complete loss of such investment.

7. The Lender states that: (a) it is a bank, savings and loan association, insurance company, or registered investment company; or an investment adviser registered either with the Securities and Exchange Commission under Section 203 of the Investment Advisers Act of 1940 or with a state securities commission (or any agency or office performing like functions); or any other entity (whether a natural person, corporation, partnership, trust, or otherwise) with total assets of at least $50 million; and (b) it is (i) an "accredited investor" within the meaning of Rule 501(a)(1) of Regulation D under the Securities Act of 1933, as amended (the 1933 Act") or (ii) a "Qualified Institutional Buyer" as defined in Rule 144A under the 1933 Act; and (c) it is capable of evaluating investment risks and market value independently, both in general and with regard to transactions and investment strategies in municipal securities; and (d) it is exercising independent judgment in evaluating: (i) the recommendation of the Placement Agent, if any, or its associated persons; and (ii) the quality of execution of the Lender's transactions by the Placement Agent; and (e) the Lender has timely access to material information that is available publicly through established industry sources as defined in Municipal Securities Rulemaking Board (MSRB) Rule G-47;[3]

8. The Lender is entering into the Contract solely for its own account for investment purposes only, with a present intent to remain in the Contract until maturity, early redemption or mandatory tender, and not with a view to, or in connection with, any distribution, resale, pledging, fractionalization, subdivision or other disposition thereof (subject to the understanding that disposition of Lender's property will remain at all times within its control).

9. The Lender understands that the Loan Obligation (i) has not been registered under the Securities Act of 1933, as amended (the "Act"), and (ii) has not been registered or qualified under any state securities or "Blue Sky" laws, and that the Contract has not been qualified under the Trust Indenture Act of 1939, as amended.

10. The Lender acknowledges that in connection with the Lender entering into the Contract: (i) Piper Sandler & Co. as Placement Agent has acted at arm's length, is not an agent or financial advisor of, and owes no fiduciary duties to the Lender or any other person irrespective of whether the Placement Agent has advised or is advising the Lender on other matters, and (ii) the Lender represents it has had the opportunity to consult with its own legal counsel and to negotiate this Certificate prior to execution. The Lender waives to the fullest extent permitted by law any claims it may have against the Placement Agent arising from an alleged breach of fiduciary duty in connection with the Contract.

11. The Lender understands that the County and Piper Sandler & Co., and their respective counsel and Bond Counsel will rely upon the accuracy and truthfulness of the representations and warranties contained herein and hereby consents to such reliance.

12. The signatory of this Certificate is a duly authorized officer of the Lender with the authority to sign this Certificate on behalf of the Lender, and this Certificate has been duly authorized, executed and delivered.

Very truly yours,

_____

[3] Pursuant to MSRB Rule G-47 established industry sources shall include the MSRB's Electronic Municipal Market Access("EMMA"®) system, rating agency reports, and other sources of information relating to municipal securities transactions generally used by brokers, dealers, and municipal securities dealers that effect transactions in the type of municipal securities at issue.

By:_____
Name:_____
Title:_____

Public Hearing -- 2021 B Installment Financing Contract

Description

A public hearing is scheduled for 9:00 a.m., or as soon thereafter as practicable, regarding the Board's approved resolution at their regular meeting on August 16, 2021, to finance the County share of the Towns' beach nourishment project and to finance improvements at the Justice Center.

Board Action Requested

Conduct public hearing.

Item Presenter

Robert Outten, County Manager

NOTICE OF PUBLIC HEARING

The Board of Commissioners (the "Board") of the County of Dare, North Carolina (the "County") is considering entering into an installment financing contract (the "Contract"), in a principal amount not to exceed $13,000,000, under which the County will make certain installment payments, in order to (a) pay the costs of beach nourishment projects in Duck, Kill Devil Hills, Kitty Hawk and Southern Shores and improvements to the County's Justice Center (the "Projects") and (b) pay the costs associated with entering into the Contract. In connection with the Contract, the County will grant a security interest in the site of the County's Justice Center located at 962 Marshall C. Collins Drive, Manteo, North Carolina 27954 and improvements thereon for the benefit of the entity providing the funds to the County under the Contract.

NOTICE IS HEREBY GIVEN, pursuant to Sections 160A-20 of the General Statutes of North Carolina, that on September 7, 2021 at 9:00 a.m., or as soon thereafter as practicable, in the County Board of Commissioners' Meeting Room, Administration Building, 954 Marshall C. Collins Drive, Manteo, North Carolina 27954, the Board will conduct a public hearing concerning the approval of the execution and delivery of the Contract, the financing of the Projects and the granting of a security interest described above. All interested parties are invited to present comments at the public hearing on the Contract. Any person wishing to comment in writing should do so by submitting comments to the Board of County Commissioners, P.O. Box 1000, Manteo, NC 27954, Attention: Clerk to the Board, or cheryl.anby@darenc.com. Written comments must be submitted between the date of publication of this notice and 24 hours before the public hearing.

/s/ Cheryl C. Anby
Clerk to the Board of Commissioners
County of Dare, North Carolina

RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, APPROVING AN INSTALLMENT FINANCING CONTRACT AND DELIVERY THEREOF AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS

Description

Please see the following Item Summary

Board Action Requested

Adopt Resolution

Item Presenter

David Clawson, Finance Director

Item Summary: **RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, APPROVING AN INSTALLMENT FINANCING CONTRACT AND DELIVERY THEREOF AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS**

The following Resolution is the final, approving resolution for the 2021A Installment Financing Contract to finance the purchase of property in Kill Devil Hills (Mako Mikes) and in Manteo (Masonic Lodge).

The second attachment is the summary of financing bids, taken on 8/10. Seven bids were received for the 10-year debt, ranging from a high of 1.90% to a low of 1.48% from First Bank. The interest rate is less than one half of the rate used for the approved 2022 CIF Model. The final attachment is the debt numbers run for the low bid.

The Local Government Commission meeting for approval is September 14, and the debt closing will be September 16.

The Resolution makes several findings and statements of fact, including:

- It is in the best interests of the County to enter into the Installment Financing Contract with First Bank and into the Deed of Trust pledging the Manteo property;
- The Board held a public hearing on August 2, 2021; and
- Copies of the documents have been made available to the Board and the Board approves the Contract and the Deed of Trust.

The Resolution resolves:

1. That the projects, the financing of $3,000,000 at an interest rate of 1.48%, and the "Instruments" (documents) are approved and that the County Manager, the Deputy County Manager/Finance Director, and the Clerk, or their designees ("Authorized Officers") are authorized and directed to execute and deliver the Instruments with any changes which shall to them seem necessary;
2. That the Authorized Officers are authorized to do all such acts and things necessary to comply with the provisions of the Instruments; and
3. That the Authorized Officers are designated as the County's Representatives to act on behalf of the County with the transactions; that the County Attorney is authorized to provide an opinion; and that the Authorized Officers are authorized to supply all information and perform all acts and to execute other documents which they deem necessary and appropriate to complete the transaction.

Board Action: Adopt the Resolution.

RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, APPROVING AN INSTALLMENT FINANCING CONTRACT AND DELIVERY THEREOF AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS

WHEREAS, the County of Dare, North Carolina (the *"County"*) is a validly existing political subdivision of the State of North Carolina, existing as such under and by virtue of the Constitution, statutes and laws of the State of North Carolina (the *"State"*);

WHEREAS, the County has the power, pursuant to the General Statutes of North Carolina to (1) enter into installment contracts in order to purchase, or finance or refinance the purchase of, real or personal property and to finance or refinance the construction or repair of fixtures or improvements on real property and (2) create a security interest in some or all of the property financed or refinanced to secure repayment of the purchase price;

WHEREAS, the Board of Commissioners of the County (the *"Board of Commissioners"*) has determined that it is in the best interest of the County to receive an advance of funds in an aggregate principal amount of not more than $3,000,000 by entering into an installment financing contract (the *"Contract"*) with First Bank (the *"Bank"*) in order to finance the capital costs of the acquisition of land and an existing building for future use by the County to replace the County's Kill Devil Hills EMS Station and the acquisition of property in Manteo (the *"Manteo Property"*) and renovation of the existing building to be used as a youth center (the "*Projects*"), and (2) pay the costs related to execution and delivery of the Contract;

WHEREAS, the obligation of the County to make Installment Payments under the Contract is a limited obligation of the County payable solely from currently budgeted appropriations of the County and does not constitute a pledge of the faith and credit of the County within the meaning of any constitutional debt limitation;

WHEREAS, in order to provide security for the County's obligations under the Contract, the County will grant to the Bank a security interest under a deed of trust, assignment of rents and leases security agreement and financing statement (the *"Deed of Trust"*) in the County's fee simple interest in the site of the Manteo Property, together all improvements and fixtures located thereon (collectively, the "*Mortgaged Property*");

WHEREAS, a public hearing on the Contract after publication of a notice with respect to such public hearing must be held and the Board of Commissioners conducted such public hearing at its August 2, 2021 meeting;

WHEREAS, there has been made available to the Board of Commissioners the form of the Contract and the Deed of Trust and other related agreements which the County proposes to approve, enter into and deliver, as applicable, to effectuate the proposed financing; and

WHEREAS, it appears that each of the Contract and the Deed of Trust (collectively, the "*Instruments*") is in appropriate form and is an appropriate instrument for the purposes intended;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, AS FOLLOWS:

Section 1. ***Approval, Authorization and Execution of Instruments.*** The Board of Commissioners hereby approves the financing of the Projects in accordance with the terms of the Instruments, which will be valid, legal and binding obligations of the County in accordance with their

respective terms. The Board of Commissioners hereby approves the amount to be advanced by the Bank to the County pursuant to the Contract in an aggregate principal amount not to exceed $3,000,000 at an interest rate of 1.48% per annum, such amount to be repaid by the County to the Bank as provided in the Contract. The form, terms and content of the Instruments are in all respects authorized, approved and confirmed, and each of the County Manager, the Deputy County Manager/Finance Director and the Clerk to the Board of Commissioners, or their respective designees (the *"Authorized Officers"*), are authorized, empowered and directed to execute and deliver the Instruments for and on behalf of the County, including necessary counterparts, in substantially the forms presented to the Board of Commissioners, but with such changes, modifications, additions or deletions therein as shall to them seem necessary, desirable or appropriate, their execution thereof to constitute conclusive evidence of their approval of any and all such changes, modifications, additions or deletions, and that from and after the execution and delivery of the Instruments, each of the Authorized Officers are hereby authorized, empowered and directed to do all such acts and things and to execute all such documents as may be necessary to carry out and comply with the provisions of the Instruments as executed.

Section 2. ***Further Actions.*** Each of the Authorized Officers are hereby designated as the County's representatives to act on behalf of the County in connection with the transactions contemplated by the Instruments, and each of the Authorized Officers are authorized and directed to proceed with the financing of the Projects in accordance with the terms of the Instruments and to seek opinions on matters of law from the County Attorney, which the County Attorney is authorized to furnish on behalf of the County, and opinions of law from such other attorneys for all documents contemplated hereby as required by law. Each of the Authorized Officers are hereby authorized to designate one or more employees of the County to take all actions which each of the Authorized Officers are authorized to perform under this Resolution, and each of the Authorized Officers, including their designees, are in all respects authorized on behalf of the County to supply all information pertaining to the transactions contemplated by the Instruments. Each of the Authorized Officers are authorized to execute and deliver for and on behalf of the County any and all additional certificates, documents, opinions or other papers and perform all other acts as may be required by the Instruments or as they may deem necessary or appropriate in order to implement and carry out the intent and purposes of this Resolution. Any and all acts of the Authorized Officers may be done individually or collectively.

Section 3. ***Related Actions***. All acts and doings of officers, employees and agents of the County, whether taken prior to, on, or after the date of this Resolution, that are in conformity with and in furtherance of the purposes and intents of this Resolution as described above shall be, and the same hereby are, in all respects ratified, approved and confirmed.

Section 4. ***Repealer.*** All motions, orders, resolutions, ordinances and parts thereof, in conflict herewith are hereby repealed.

Section 5. ***Severability.*** If any section, phrase or provision of this Resolution is for any reason declared to be invalid, such declaration will not affect the validity of the remainder of the sections, phrases or provisions of this Resolution.

Section 6. ***Effective Date***. This Resolution is effective on the date of its adoption.

Adopted this the 7th day of September, 2021.

_____

Robert Woodard, Chairman

Attest:

Cheryl C. Anby, Clerk to the Board

STATE OF NORTH CAROLINA)
) SS:
COUNTY OF DARE)

I, *Cheryl C. Anby*, Clerk to the Board of Commissioners of the County of Dare, North Carolina, ***DO HEREBY CERTIFY*** that the foregoing is a true and exact copy of a resolution entitled **"RESOLUTION OF THE BOARD OF COMMISSIONERS OF THE COUNTY OF DARE, NORTH CAROLINA, APPROVING AN INSTALLMENT FINANCING CONTRACT AND DELIVERY THEREOF AND PROVIDING FOR CERTAIN OTHER RELATED MATTERS"** duly adopted by the Board of Commissioners of the County of Dare, North Carolina at a meeting held on the 7th day of September, 2021.

WITNESS my hand and the corporate seal of the County of Dare, North Carolina, this the ___ day of September, 2021.

_____

(SEAL)

Cheryl C. Anby
Clerk to the Board of Commissioners
County of Dare, North Carolina

Bank	Rate	Closing Date	Prepayment	Final Maturity	Bank Closing Fees	Continuing Disclosure	Notes:
First Bank *(Proposal dated June 1st; confirmed that rate is still current)*	1.480%		Prepayable in whole anytime @ 100	120 months (10 years)	No loan fee will be charged; appraisal, legal, environmental, inspection, etc to be paid by borrower at closing		
CapitalOne	1.580%	*Email did not include full proposal; just the rate*					
Signature Bank	1.645%	9/9/2021	Any payment date @ 101 following 30 days' prior written notice	12/1/2030	$2,500 Documentation & Review fee, which will be applied to Lessor's legal costs		
PNC	1.680%	9/16/2021	Make-Whole Call		$10,000 NTE	Annual Audits FYE + 180	
Truist Bank	1.690%	10/8/2021	Prepayable in whole anytime @ 100	12/1/2030	$5,900	Annual Audits FYE + 270	
JPMC	1.720%	9/23/2021	No redemption @ 1.72% rate; alternative 1.85% rate calable @ par beginning 12/1/2023	12/1/2030	$5,750 bank counsel fees	Annual Audits FYE + 270	Rate could change if not accepted today (08/09/2021)
Sterling National Bank	1.900%	*Email did not include full proposal; just the rate*					

TABLE OF CONTENTS

Dare County, NC
IFC Firstbank

SOURCES AND USES OF FUNDS

Dare County, NC
IFC Firstbank

Dated Date	09/22/2021
Delivery Date	09/22/2021

Sources:	
Bond Proceeds:	
Par Amount	3,000,000.00
	3,000,000.00

Uses:	
Project Fund Deposits:	
KDH Property	1,961,700.00
Manteo Property	767,700.00
Manteo Improvements	200,000.00
	2,929,400.00
Cost of Issuance:	
Other Cost of Issuance	70,600.00
	3,000,000.00

BOND PRICING

Dare County, NC
IFC Firstbank

Bond Component	Maturity Date	Amount	Rate	Yield	Price
Serial Bond:					
	12/01/2021	300,000	1.480%	1.480%	100.000
	12/01/2022	300,000	1.480%	1.480%	100.000
	12/01/2023	300,000	1.480%	1.480%	100.000
	12/01/2024	300,000	1.480%	1.480%	100.000
	12/01/2025	300,000	1.480%	1.480%	100.000
	12/01/2026	300,000	1.480%	1.480%	100.000
	12/01/2027	300,000	1.480%	1.480%	100.000
	12/01/2028	300,000	1.480%	1.480%	100.000
	12/01/2029	300,000	1.480%	1.480%	100.000
	12/01/2030	300,000	1.480%	1.480%	100.000
		3,000,000			

Dated Date	09/22/2021	
Delivery Date	09/22/2021	
First Coupon	12/01/2021	
Par Amount	3,000,000.00	
Original Issue Discount		
Production	3,000,000.00	100.000000%
Underwriter's Discount		
Purchase Price	3,000,000.00	100.000000%
Accrued Interest		
Net Proceeds	3,000,000.00	

BOND MATURITY TABLE

Dare County, NC
IFC Firstbank

Maturity Date	Serial Bond
12/01/2021	300,000
12/01/2022	300,000
12/01/2023	300,000
12/01/2024	300,000
12/01/2025	300,000
12/01/2026	300,000
12/01/2027	300,000
12/01/2028	300,000
12/01/2029	300,000
12/01/2030	300,000
	3,000,000

BOND DEBT SERVICE

Dare County, NC
IFC Firstbank

Period Ending	Principal	Coupon	Interest	Debt Service	Annual Debt Service
12/01/2021	300,000	1.480%	8,510	308,510	
06/01/2022			19,980	19,980	
06/30/2022					328,490
12/01/2022	300,000	1.480%	19,980	319,980	
06/01/2023			17,760	17,760	
06/30/2023					337,740
12/01/2023	300,000	1.480%	17,760	317,760	
06/01/2024			15,540	15,540	
06/30/2024					333,300
12/01/2024	300,000	1.480%	15,540	315,540	
06/01/2025			13,320	13,320	
06/30/2025					328,860
12/01/2025	300,000	1.480%	13,320	313,320	
06/01/2026			11,100	11,100	
06/30/2026					324,420
12/01/2026	300,000	1.480%	11,100	311,100	
06/01/2027			8,880	8,880	
06/30/2027					319,980
12/01/2027	300,000	1.480%	8,880	308,880	
06/01/2028			6,660	6,660	
06/30/2028					315,540
12/01/2028	300,000	1.480%	6,660	306,660	
06/01/2029			4,440	4,440	
06/30/2029					311,100
12/01/2029	300,000	1.480%	4,440	304,440	
06/01/2030			2,220	2,220	
06/30/2030					306,660
12/01/2030	300,000	1.480%	2,220	302,220	
06/30/2031					302,220
	3,000,000		208,310	3,208,310	3,208,310

BOND SUMMARY STATISTICS

Dare County, NC
IFC Firstbank

Dated Date	09/22/2021
Delivery Date	09/22/2021
Last Maturity	12/01/2030
Arbitrage Yield	1.480144%
True Interest Cost (TIC)	1.480144%
Net Interest Cost (NIC)	1.480000%
All-In TIC	2.017483%
Average Coupon	1.480000%
Average Life (years)	4.692
Duration of Issue (years)	4.492
Par Amount	3,000,000.00
Bond Proceeds	3,000,000.00
Total Interest	208,310.00
Net Interest	208,310.00
Total Debt Service	3,208,310.00
Maximum Annual Debt Service	337,740.00
Average Annual Debt Service	349,045.51
Underwriter's Fees (per $1000)	
Average Takedown	
Other Fee	
Total Underwriter's Discount	
Bid Price	100.000000

Bond Component	Par Value	Price	Average Coupon	Average Life	PV of 1 bp change
Serial Bond	3,000,000.00	100.000	1.480%	4.692	1,344.00
	3,000,000.00			4.692	1,344.00

	TIC	All-In TIC	Arbitrage Yield
Par Value	3,000,000.00	3,000,000.00	3,000,000.00
+ Accrued Interest			
+ Premium (Discount)			
- Underwriter's Discount			
- Cost of Issuance Expense		-70,600.00	
- Other Amounts			
Target Value	3,000,000.00	2,929,400.00	3,000,000.00
Target Date	09/22/2021	09/22/2021	09/22/2021
Yield	1.480144%	2.017483%	1.480144%

BUSINESS PROMOTIONAL MATERIALS DISCLAIMER

Dare County, NC
IFC Firstbank

Piper Sandler is providing the information contained herein for discussion purposes only in anticipation of being engaged to serve as underwriter or placement agent on a future transaction and not as a financial advisor or municipal advisor. In providing the information contained herein, Piper Sandler is not recommending an action to you and the information provided herein is not intended to be and should not be construed as a ' recommendation' or 'advice' within the meaning of Section 15B of the Securities Exchange Act of 1934. Piper Sandler is not acting as an advisor to you and does not owe a fiduciary duty pursuant to Section 15B of the Exchange Act or under any state law to you with respect to the information and material contained in this communication. As an underwriter or placement agent, Piper Sandler's primary role is to purchase or arrange for the placement of securities with a view to distribution in an arm's-length commercial transaction, is acting for its own interests and has financial and other interests that differ from your interests. You should discuss any information and material contained in this communication with any and all internal or external advisors and experts that you deem appropriate before acting on this information or material. Piper Sandler Companies (NYSE: PIPR) is a leading investment bank and institutional securities firm driven to help clients Realize the Power of Partnership®. Securities brokerage and investment banking services are offered in the U.S. through Piper Sandler & Co., member SIPC and FINRA; in Europe through Piper Sandler Ltd., authorized and regulated by the U.K. Financial Conduct Authority; and in Hong Kong through Piper Sandler Hong Kong Ltd., authorized and regulated by the Securities and Futures Commission. Asset management products and services are offered through separate investment advisory affiliates.

The information contained herein may include hypothetical interest rates or interest rate savings for a potential refunding. Interest rates used herein take into consideration conditions in today's market and other factual information such as credit rating, geographic location and market sector. Interest rates described herein should not be viewed as rates that Piper Sandler expects to achieve for you should we be selected to act as your underwriter or placement agent. Information about interest rates and terms for SLGs is based on current publically available information and treasury or agency rates for open-market escrows are based on current market interest rates for these types of credits and should not be seen as costs or rates that Piper Sandler could achieve for you should we be selected to act as your underwriter or placement agent. More particularized information and analysis may be provided after you have engaged Piper Sandler as an underwriter or placement agent or under certain other exceptions as describe in the Section 15B of the Exchange Act.

UPS Zoning Text Amendment -- Request to Schedule a Hearing

Description

Prime Engineering on behalf of United Parcel Service (UPS) has filed a zoning text amendment request. A staff report is attached with additional details of the request.

Board Action Requested

Schedule a hearing -- "I move that a hearing on the UPS zoning text amendment be scheduled for September 20, 2021 at 5:00 p.m."

Item Presenter

Donna Creef, Planning Director

STAFF REPORT SEPTEMBER 7, 2021 BOARD OF COMMISSIONERS MEETING

FROM: DONNA CREEF, PLANNING DIRECTOR

RE: REQUEST TO AMEND C-3 ZONING DISTRICT

Prime Engineering on behalf of United Parcel Service (UPS) has submitted a zoning text amendment request to amend zoning regulations in conjunction with a proposed expansion of their facility on Etheridge Road on Roanoke Island. The UPS site is zoned I-1, industrial. In addition to a list of permitted uses specific to the I-1 district, the I-1 district also allows all uses permitted in the C-3 commercial district according to the dimensional requirements of the C-3 district. The c-3 district includes a 60% lot coverage limitation. For other permitted uses in the I-1 district, the lot coverage is limited to 35% or impervious coverage. UPS corporate guidelines require paved parking and service areas. In order to complete their expansion plans, an increase in lot coverage is needed in excess of the 35% allowed by the I-1 industrial district .

The Planning Board reviewed the request on August 9, 2021 and discussed two options. One option was to increase the lot coverage of all of the I-1 district to 60%. The second option was to amend the C-3 list of permitted uses to add “package distribution and delivery services”. The second option of amending the C-3 district to add the use of package distribution and delivery services was preferred by the Planning Board. Increasing the I-1 lot coverage would have applied an increased lot coverage to the entire list of permitted uses of the I-1 district. The I-1 district was included as part of the original zoning ordinance adopted in 1975. It is assumed the 35% lot coverage for I-1 uses was designed to mitigate impacts from high intensity land uses typically associated with an industrial zoning classification. The addition of package distribution and delivery services is consistent with the other permitted uses of the C-3 district, which includes cabinet and woodworking shops, automobile sales and service, bus terminals, building contractor offices and all uses permitted in the C-2 commercial district. The Planning Board voted unanimously to recommend favorable action on the C-3 text amendment

Before the Board can act on the proposed C-3 amendment, a public hearing must be held. The first available date is September 20, 2021. The requested action is to schedule a hearing to add package distribution and delivery services to the C-3 list of permitted uses.

Motion: “I move a public hearing be scheduled on the UPS zoning text amendment request for September 20, 2021 at 5:00 p.m.”

Cc: Prime Engineering

PRIME ENGINEERING INCORPORATED®

Request for Text Amendment

FOR: Donna Creef, Planning Director
Phone:252.475.5873
Fax:252.475.5640
Email: donnac@darenc.comn
Administration Building 954 Marshall C Collins Dr,
Manteo 27954

FROM: Prime Engineering, Inc.
3715 Northside Parkway NW
Building 300, Suite 200
Atlanta, GA 30327

DATE: July 23, 2021

Mrs. Creef,

United Parcel Service has contracted with our firm, Prime Engineering, for design services for a new facility expansion at the UPS distribution facility located at 221 Etheridge Road. This project will include a new parcel distribution building, multiple Modular Distribution Centers (MDC's), and increased site parking, and trailer staging.

This facility, as designed, will require long-life paved areas for trucks and customer vehicles with little available use for pervious pavement systems. Our most efficient layout will require an increase from the 35% pervious paving limitation set forth in the zoning I-3 requirements, to a 60% pervious paving limit as provided in the C-3 zoning requirements.

On behalf of our client, United Parcel Service, Prime Engineering formally requests a text amendment to convert the site's I-3 pervious limitations to a C-3 pervious limitation to adequately accommodate UPS' business function.

Sincerely,

Craig M. Dupuis, RA, NCARB
Prime Engineering, Inc.

cc: File
File: C:\Users\cdupuis\Desktop\2021-07-22 UPS Manteo Text Amendment Request.docx

1888 Emery Street, NW ▪ Suite 300 ▪ Atlanta, GA 30318
main: 404-425-7100 ▪ fax: 404-425-7101 ▪ www.prime-eng.com

SECTION 22-26 - C-3 COMMERCIAL DISTRICT

The following regulations shall apply to the C-3 commercial district:

(a) Intent. The C-3 district is established to provide for the development of commercial facilities to furnish a broad range of services and commodities to serve the entire community.

(b) Permitted uses. The following uses shall be permitted by right:

(1) All permitted uses allowed within the C-2 general commercial district. Single- family dwellings, multi-family dwellings and duplexes according to the dimensional requirements of the R-3 residential district. The maximum dwelling density for multi-family structures shall not exceed ten units per acre. (Amended 10-15-2018)

(2) Automobile sales and service.

(3) Indoor recreation activities.

(4) Building supply and equipment sales.

(5) Plumbing supply and equipment sales.

(6) Cabinet and woodworking shops.

(7) Bus terminals.

(8) Building contractors offices and storage areas.

(9) Farm machinery supplies, sales and repairs.

(10) Mobile home or recreational vehicle display and sales.

(11) Boat display and sales.

(12) County owned or leased facilities.

(13) Boat engine repair and boat maintenance. (Adopted 5-2-2011)

(14) Workforce housing - administrative review for one WHU subject to provisions of Section 22-58.7.

(15) Commercial storage yards as defined in Section 22-2 provided the following conditions are met:

a. Storage areas shall be enclosed with fencing for security purposes. Such fencing shall be at least 6 feet in height but shall not exceed 10 feet in height. The security fencing shall be maintained as needed by the property owner.

b. A vegetative buffer in addition to the security fencing shall be installed and perpetually maintained where the storage yard abuts a residential zone or a residential use to the side or the rear of the site. The vegetative buffer shall be of a sufficient size and height to effectively buffer the site from the abutting residential zone or residential use. A plan detailing the type, size, and species of vegetation proposed for use as a buffer shall be provided to the Zoning Administrator for review and approval. Existing on-site vegetation may be used if deemed to be sufficient by the Zoning Administrator.

c. There shall be no storage of inoperable or junked vehicles and equipment; unoccupied mobile (manufactured) homes; unattached flatbed trailers or container-type trailers designed for connection to tractor-trailer trucks; or large pieces of equipment used in dredging operations, road

construction, and other industrial uses. Any vehicle or trailer stored on the site shall have a valid license plate and/or valid owner registration.

d. No recreational vehicles, travel trailers, or campers stored on the site shall be occupied or used for habitation while stored at the site.

e. All vehicles and equipment stored on the site shall be locked, enclosed or otherwise fashioned to such an extent that it is impossible for a child to obtain access or be entrapped in such vehicle or equipment.

f. There shall be no bulk storage of fuel, paint, or other combustible or hazardous materials at the site. (Adopted 10-21- 2019)

(16) Travel trailer parks and campgrounds. (Adopted 10-19-2020)

(c) Special Uses. The following special uses shall be permitted, subject to the requirements of this district and additional regulations and requirements imposed by the Board of Commissioners as provided in Article IX of this chapter or Chapter 152 of this code:

(1) Automobile service stations; provided that no principal or accessory building shall be located within fifty feet of a residential use or district, that there shall be not storage of wrecked or abandoned cars and that no portion of a service station building, equipment or gas pumps shall be nearer than twenty-five feet to any right-of-way.

(2) Public and private utility facilities.

(3) Seafood market.

(4) Outdoor recreation activities. Outdoor recreation activities, including amusement parks, rides and other similar activities, may be permitted subject to other requirements of this chapter and provided the following conditions are met:

a. The site shall not be located closer than 500 feet to any land suitable for development and zoned residential.

b. Paved parking shall be provided at the rate of one parking space per 200 square feet of principal use ground area plus one for each two employees.

c. Holding lanes shall be provided on the site for automobiles entering and leaving the site to minimize traffic congestion on public roads.

d. Lighting shall be arranged and shielded so that light and glare is directed away from surrounding property.

e. Loudspeakers or sound amplification devices which are audible over 100 hundred feet from the site shall not be permitted.

The entire site shall be buffered by dense vegetative planting or natural vegetation not less than eight feet in height and ten feet in width. Suitable plant types for a site not containing natural vegetation shall be those recommended for the coastal area by the U.S. Department of Agriculture, such as Japanese Pine, Bayberry, Wax Myrtle or other types, which will reach a matured growth of eight to ten feet within three years.

(5) Biodiesel fuel production, subject to the following conditions and additional regulations and requirements imposed by the Dare County Board of Commissioners as provided in Article IX of this chapter or Chapter 152 of this code:

a. A structure, of suitable size to house all production equipment shall be approved by the Dare County Health Department, Building Inspector and Fire Marshal;

b. All production facilities including structures, storage tanks, equipment and other appurtenances shall conform with setbacks established for primary use structures;

c. Verification from the U.S. Environmental Protection Agency, and all other applicable agencies, shall be submitted to indicate that all environmental requirements have been met;

d. The facility shall be registered with the North Carolina Department of Revenue;

e. The developer shall verify that production waste will be disposed of with a suitable disposal service or facility;

f. Reactor size shall not exceed a 700 gallon capacity. Assurance of reactor size shall be provided by the manufacturer and/or registered engineer;

g. Fuel production shall not exceed 500 gallons per week;

h. A 5 foot wide vegetative buffer is required along those property boundaries adjacent to a residential use or district; and

i. A 15 foot wide, improved access shall be provided to the site. (Adopted 12-1-2008)

(6) Vehicle storage impoundment facility provided the following conditions are met:

a. Vehicles shall only be stored on a short-term basis which is defined as 60 consecutive days for the purpose of this regulation.

b. A vehicle storage impoundment facility shall be located on a site no greater than 40,000 square feet in area.

c. Storage areas shall be enclosed with fencing for security purposes. Such fencing shall be 8 feet in height. If chain link fencing is approved for use by Dare County, then such fencing shall include slatting within the fence openings in the same color as the fence material. The security fencing shall be maintained as needed by the property owner. Solid fencing may be required by Dare County as determined during conditional use review of the site based on the existing land uses adjacent to the proposed vehicle storage impoundment facility.

d. A vegetative buffer in addition to the security fencing shall be installed and perpetually maintained where the storage yard abuts a residential zone or a residential use to the side or rear of the site. The vegetative buffer shall be of a sufficient size and height to effectively buffer the site from the abutting residential zone or residential use. Existing vegetation may be used if of sufficient size to effectively buffer the site. If existing vegetation cannot be used, then a plan detailing the type, size and species of vegetation proposed for use as a buffer shall be provided to the Zoning Administrator for review and approval. The vegetative buffer shall be maintained as needed by the property owner. Solid fencing of wood or other solid materials may be required by Dare County.

e. All vehicle storage areas and buffers shall be located a minimum distance of 100 feet from the front property line of any property that abuts US Highway 64 on Roanoke Island or abuts NC 12 Highway on Hatteras Island shall be established. All other sites that do not abut these highways shall be subject to the front yard setback of 15 feet as established for the C-3 district.

f. All vehicles stored on the site shall be locked, enclosed or otherwise secured to such an extent that it is impossible for a child to obtain access or be entrapped in a vehicle.

g. The location of all proposed light fixtures shall be depicted on a site plan. Lighting fixtures shall be located on the site and designed, shielded, or oriented in such a manner as to minimize light spill across property lines. No light fixture shall exceed 18 feet in height and the maximum allowable footcandle from any light fixture shall not exceed a maximum of 8 footcandles. Documentation certifying the footcandle rating of any proposed light fixtures shall be submitted with the site plan. It

shall be the responsibility of the property owner to ensure that all light fixtures are maintained to ensure compliance with the footcandle rating. (Adopted 1- 22-2013)

(7) Workforce housing units - special use review if two or more WHU units subject to provisions of Section 22-58.7.

(8) Educational housing projects subject to the provisions of Section 22-58.8.

(9) Special use subdivisions subject to the provisions of Section 22-58.9.

(d) Dimensional requirements:

(1) Minimum lot size: Commercial lots shall be of sufficient size to meet requirements of the County Health Department, to provide adequate siting for structures and to provide parking, loading and maneuvering space for vehicles as required by Article VII of this chapter. In addition, a visual buffer is required where a commercial use or zone abuts a residential use or zone.

(2) Minimum front yard: 15-feet.

(3) Minimum side yard: 10-feet; no side yards required if commercial building constructed with a common wall. An additional 5-foot yard adjacent to the street is required for a corner lot.

(4) Minimum rear yard: 20-feet.

(5) Maximum allowable lot coverage by principal use and all accessory structures: 60%.

(6) Height limitation: 35 feet. (11-20-75, art. 7, 7.11, 2-6-78, 2, 3, 6.)

(7) Maximum gross building size: 20,000 square feet excluding decks, porches and similar non-heated space. Non-heated space including decks and porches shall not be used as retail space for the display of goods, or other commercial activities.

Group developments with a maximum area of 20,000 square feet per individual building, excluding decks and porches.

This gross building size limitation shall not apply to hotels and/or motels. (Adopted by the Dare County Board of Commissioners on May 6, 2002)

(8) In the event a natural disaster or accidental occurrence leads to extensive damage (in excess of 50% value) of a structure or group development project in existence prior to May 6, 2002, such structure or group development may be repaired, replaced or reconstructed to 100% of its status prior to damage or destruction but no greater unless otherwise authorized by the Dare County Board of Commissioners. (Adopted 2-19-07)

(Am. Ord. passed 9-16-2019; Am. Ord. passed 6-21-2021)

SECTION 22-27 - I-1 INDUSTRIAL DISTRICT

The following regulations shall apply to the I-1 industrial district:

(a) Intent. The industrial district is established to provide for the development of commercial and industrial facilities to better furnish a broad range of services and commodities to serve the entire community including, but not limited to, such facilities as commercial laundry, food and beverage ware-housing and procession, building supply facilities, construction equipment storage and servicing, manufacture, production and marketing of concrete and concrete products and other similar uses.

(b) Permitted uses. The following uses shall be permitted by right:

(1) All uses permitted in a C-3 commercial district. Single-family dwellings, multi-family dwellings and duplexes according to the dimensional requirements of the R-3 residential district. The maximum dwelling density for multi- family structures shall not exceed ten units per acre. (Amended 10-15-2018)

(2) Builders' and contractors' supplies and storage areas.

(3) Construction materials processing and storage.

(4) Commercial dry cleaning and laundries.

(5) Food and beverage processing and storage.

(6) Industrial equipment sales and repair.

(7) Public and private utility facilities.

(8) Plumbing, heating, and mechanical contractor's supplies, sales and fabrication.

(9) Sheet metal fabrication.

(10) Truck terminals.

(11) Wholesale warehouse operations.

(12) Manufacture, production and marketing of concrete and concrete products.

(13) County owned or leased facilities.

(14) Mobile homes, as provided for under the R-2 medium-density residential district.

(15) Any size child care operation as defined in Section 22-2, only as an accessory use of an existing or proposed permitted or conditional use in this district, and for the exclusive use of on-site employees of the existing or proposed permitted or conditional use. (Adopted 11-5-90)

(16) Dog agility training facility provided any outdoor training areas are entirely fenced by solid fencing no less than 8 feet in height and subject to the parking requirements of Section 22-56. (Adopted 1-22-2013)

(17) Workforce housing - administrative review for one WHU subject to provisions of Section 22-58.7.

(c) Special uses. The following shall be special uses:

(1) Other uses generally intended for this district but not itemized above as allowed by the Board of Commissioners as provided in Article IX of this chapter or Chapter 152 of this code.

(2) Workforce housing units - special use review if two or more WHU units subject to provisions of Section 22-58.7.

(3) Educational housing projects subject to the provisions of Section 22-58.8.

(4) Special use subdivisions subject to the provisions of Section 22-58.9.

(d) Dimensional and development requirements.

(1) All uses within an I-1 district which are permitted uses in a C-3 commercial district shall conform to the dimensional requirements set out for the C-3 commercial district.

(2) Except as set out above, permitted uses within an I-1 district shall be required to meet the following standards:

a. No portion of a building or open storage or processing area shall be closer than 75 feet to a residential district boundary.

b. Individual lot sizes for a permitted industrial district use shall not be less than one acre.

c. Any unstabilized soil exposed during construction shall be stabilized with vegetative cover to prevent erosion by wind or surface water.

d. No use shall be permitted in an I-1 district which has noxious, harmful or deleterious effect on other development.

e. No more than 35% of an individual lot may be covered with buildings, parking areas or other surfaces impervious to water.

f. The off-street parking requirements of Article VII of this chapter shall apply; except, that no off-street parking or loading space shall be located closer than 50 feet to a residential district boundary or use. (11-20-75, art. 7, 7.12)

(3) Maximum gross building size: 20,000 square feet excluding decks, porches, and similar non-heated space. Non-heated space including decks and porches shall not be used as retail space, for the display of goods, or other commercial activities.

Group developments with a maximum area of 20,000 square feet per individual building, excluding decks and porches.

This gross building size limitation shall not apply to hotels and/or motels. (Adopted by the Dare County Board of Commissioners on May 6, 2002)

(4) In the event a natural disaster or accidental occurrence leads to extensive damage (in excess of 50% value) of a structure or group development project in existence prior to May 6, 2002, such structure or group development may be repaired, replaced or reconstructed to 100% of its status prior to damage or destruction but no greater unless otherwise authorized by the Dare County Board of Commissioners. (Adopted 2-19-07)

(Am. Ord. passed 9-16-2019; Am. Ord. passed 6-21-2021)

Resolution Approving the Memorandum of Agreement Between the State of North Carolina and Local Governments on Proceeds Relating to the Settlement of Opioid Litigation

Description

Representatives of local North Carolina governments, the NC Association of County Commissioners and the NC Department of Justice have negotiated and prepared a Memorandum of Agreement (MOA) to provide for the equitable distribution of any proceeds from a settlement of national opioid litigation to the State of North Carolina and to individual local governments.

Board Action Requested

Adopt Resolution to approve MOA and authorize the County Manager to take such measures as necessary to comply with the terms and receive any settlement funds, including executing any documents.

Item Presenter

Robert Outten, County Manager

A RESOLUTION BY THE COUNTY OF DARE
APPROVING THE MEMORANDUM OF AGREEMENT (MOA) BETWEEN THE STATE OF NORTH CAROLINA AND LOCAL GOVERNMENTS ON PROCEEDS RELATING TO THE SETTLEMENT OF OPIOID LITIGATION

WHEREAS, as of 2019, the opioid epidemic had taken the lives of more than 16,500 North Carolinians, torn families apart, and ravaged communities from the mountains to the coast; and

WHEREAS, the COVID-19 pandemic has compounded the opioid crisis, increasing levels of drug misuse, addiction, and overdose death; and

WHEREAS, the Centers for Disease Control and Prevention estimates the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement; and

WHEREAS, the opioid epidemic has had significant negative impacts upon the citizens of Dare County; and

WHEREAS, certain counties and municipalities in North Carolina joined with thousands of local governments across the country to file lawsuit against opioid manufacturers and pharmaceutical distribution companies and hold those companies accountable for their misconduct; and

WHEREAS, representatives of local North Carolina governments, the North Carolina Association of County Commissioners, and the North Carolina Department of Justice have negotiated and prepared a Memorandum of Agreement (MOA) to provide for the equitable distribution of any proceeds from a settlement of national opioid litigation to the State of North Carolina and to individual local governments; and

WHEREAS, an agreement in the national opioid litigation has been announced that could potentially bring millions in opioid treatment funds to Local Governments and the State of North Carolina; and

WHEREAS, by signing onto the MOA, the state and local governments maximize North Carolina’s share of opioid settlement funds to ensure the needed resources reach communities as quickly, effectively, and directly as possible; and

WHEREAS, it is advantageous to all North Carolinians for local governments, including Dare County and its citizens, to sign onto the MOA and demonstrate solidarity in response to the opioid epidemic, and to maximize the share of opioid settlement funds received both in the state and this county to help abate the harm; and

WHEREAS, the MOA directs substantial resources over multiple years to local governments on the front lines of the opioid epidemic while ensuring that these resources are used in an effective way to address the crisis.

NOW, THEREFORE BE IT RESOLVED, Dare County hereby approves the Memorandum of Agreement Between the State of North Carolina and Local Governments on Proceeds Relating to the Settlement of Opioid Litigation, and any subsequent settlement funds that may come into North Carolina as a result of the opioid crisis. Furthermore, Dare County authorizes the County Manager (or County Attorney) take such measures as necessary to comply with the terms of the MOA and receive any settlement funds, including executing any documents related to the allocation of opioid settlement funds and settlement of lawsuits related to this matter. Be it further resolved copies of this resolution and the signed MOA be sent to opioiddocs@ncdoj.gov as well as forwarded to the North Carolina Association of County Commissioners at communications@ncacc.org.

Adopted this the 7th day of September, 2021.

_____

Robert Woodard, Sr., Chairman
Dare County Board of Commissioners

ATTEST:

_____

Cheryl C. Anby, Clerk to the Board

(SEAL)

North Carolina Association of County Commissioners

Opioid Litigation Settlement Overview

Executive Summary

North Carolina Association of County Commissioners

Issue and Litigation Background

Counties are on the frontlines of the opioid epidemic, which has imposed significant and ongoing devastation throughout North Carolina. More than 16,000 lives have been lost and local governments have spent an untold amount of money on opioid-related costs for healthcare, criminal justice, and social services.

Given the far-reaching impact of the opioid crisis, 76 counties and eight municipalities have filed lawsuits in federal court to hold accountable several companies involved in manufacturing, marketing, promoting, and distributing prescription opioid drugs. The federal cases, which include roughly 3,000 lawsuits from nearly every state have been consolidated into Multi-District Litigation (MDL).

Local governments and the state are hopeful that a National Settlement Agreement with some of the companies involved in the MDL may be forthcoming, along with additional potential proceeds from a bankruptcy resolution involving opioid manufacturer Purdue Pharma. Under the national settlement and bankruptcy resolution (taken together), up to $850 million could be allocated to North Carolina to address the opioid epidemic.

Settlement Fund Allocation Model

The potential settlement money would be allocated among states based on population and the local impact of the opioid crisis, as determined by public health statistics related to opioid misuse. The potential payments would occur over an 18-year period. The allocation formula also includes an incentive that increases the payment amounts as more North Carolina counties and municipalities join the settlement.

In anticipation of potential opioid settlement funds, the North Carolina Association of County Commissioners (NCACC) and the North Carolina Department of Justice (DOJ) have been working closely together over the past 18 months on a plan to maximize North Carolina's share to ensure that resources reach communities as quickly, effectively, and directly as possible.

Executive Summary

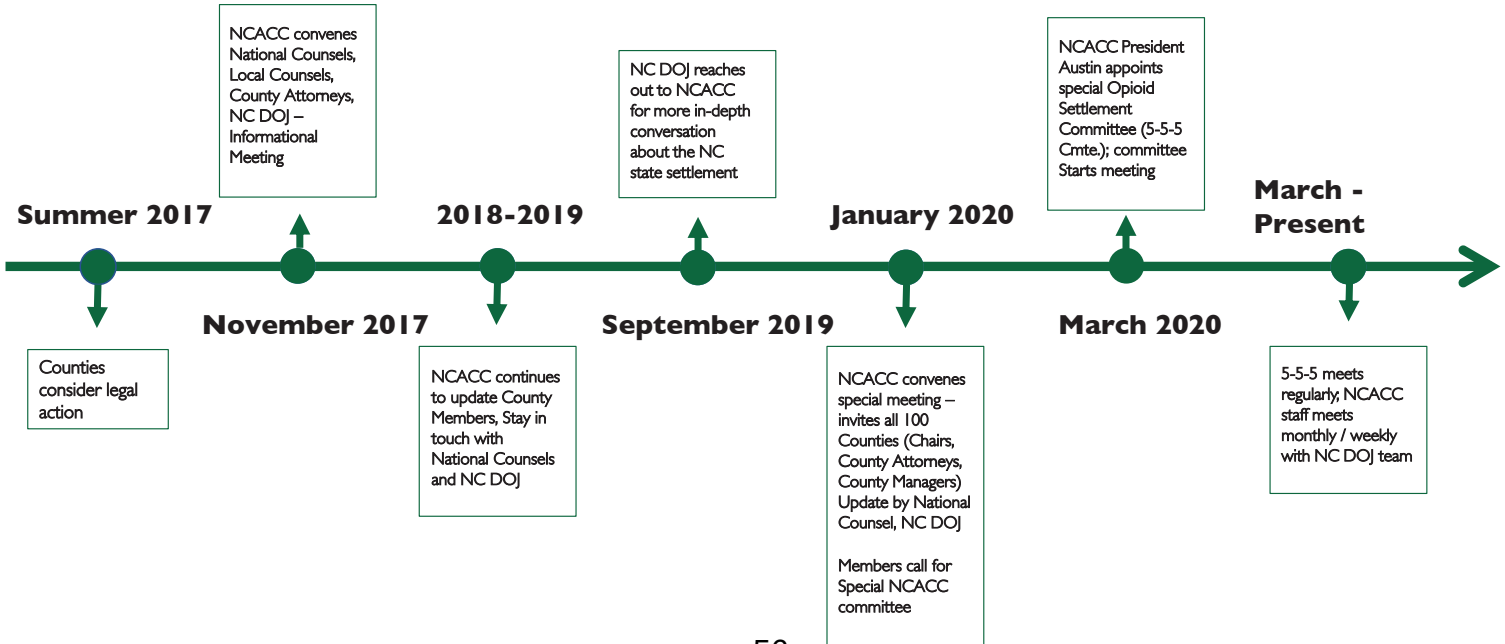
North Carolina Association of County Commissioners

Memorandum of Agreement

NCACC formed a Working Group comprised of five county commissioners, five county managers, five county attorneys and NCACC staff to collaborate with DOJ on a model to distribute potential settlement funds to all 100 counties to use on programs, services, and strategies to address the epidemic. The culmination of this collaborative work is the North Carolina Memorandum of Agreement (NC MOA), which governs how North Carolina would use its share of opioid settlement funds. Under the NC MOA, all opioid settlement funds would be directed as follows:

- 15% to the state (which the General Assembly would have authority to appropriate on a wide range of strategies to address the epidemic)
- 80% to local governments, including all 100 counties plus 17 municipalities, allocated among those counties and municipalities through a formula developed by attorneys representing local governments in national litigation
- An additional 5% percent into an incentive fund for any county (and any municipality in that county slated to receive settlement funds) in which the county itself and every municipality with at least 30,000 residents (based on 2019 population totals) in the county signs the NC MOA

The NC MOA also includes transparency and accountability measures for the use of opioid settlement funds by local governments, including special revenue funds subject to audit, annual financial and impact reports, and a public dashboard showing how they are using settlement funds to address the epidemic.



NCACC and NCDOJ Partnership

North Carolina Association of County Commissioners

Counties are on the front lines of the opioid epidemic

The opioid epidemic has taken the lives of more than 16,000 North Carolinians, torn families apart, and ravaged communities from the mountains to the coast. Just as we began to make progress in combatting the epidemic, the COVID-19 pandemic caused a new wave of isolation, despair, drug misuse and overdose death. Individuals, families, and entire communities continue to suffer.

Counties are on the front lines of the opioid crisis, which has imposed significant and continuing costs on our healthcare, criminal justice, and social service systems. To respond to opioid related public health and safety needs, North Carolina counties and the State have had to draw mostly on taxpayer funds.

76 counties are part of national litigation to hold opioid drug companies accountable

Given the far-reaching impact of the opioid crisis, the State along with 76 counties and 8 municipalities in North Carolina have filed lawsuits in federal court and launched investigations to hold accountable several companies involved in manufacturing, marketing, promoting, and distributing prescription opioid drugs. The federal cases have been consolidated for pretrial proceedings into a Multi-District Litigation (MDL) in Cleveland, Ohio. The opioid MDL consolidated roughly 3,000 lawsuits from nearly every state.

The lawsuits allege that opioid manufacturers "grossly misrepresented the risks of long-term use of those drugs for persons with chronic pain," and that pharmaceutical distribution companies "failed to properly monitor suspicious orders of those prescription drugs — all of which contributed to the current opioid epidemic." Four companies, Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson, have announced their willingness to enter into a global settlement of the cases filed against them for a combined $26 billion.

In preparation for a National Settlement Agreement, NCACC and DOJ joined forces to maximize funds to North Carolina

Local governments and the State are hopeful that a National Settlement Agreement with these four companies may be forthcoming, with potentially more to follow. Importantly, the terms of the National Settlement Agreement will require, among other things, that most settlement funds received by the State and Local Governments be devoted to opioid remediation activities to the maximum extent possible.

Additionally, local governments and the State anticipate that the ongoing bankruptcy proceedings of opioid manufacturer Purdue Pharma may be resolved before the end of the year with a settlement providing $4-5 billion from Purdue and the Sackler family to state and local governments nationwide. The bankruptcy court is expected to

NCACC and NCDOJ Partnership

North Carolina Association of County Commissioners

order these funds be used for opioid remediation activities.

Under the national settlement and bankruptcy resolution (taken together), up to $850 million could be allocated to North Carolina for opioid remediation. The money will be allocated among states based on population and the local impact of the opioid crisis, based on several public health statistics related to opioid misuse. The precise amount will depend not only on the final terms of the National Settlement Agreement and bankruptcy resolutions, but also on whether North Carolina qualifies for incentive structures that increase the payment amounts as more counties and municipalities join the settlement.

The expected settlements and bankruptcy resolution would involve this money being paid out over an 18-year period. The settlement payments would be front-loaded, so that more money is available sooner to local governments to remedy the opioid problems in their communities. As a result, payments in the first three years would be higher than the average annual payment.

In anticipation of a National Settlement Agreement and Purdue bankruptcy resolution, the North Carolina Association of County Commissioners (NCACC) and the North Carolina Department of Justice (DOJ) have been working closely together over the past 18 months on a plan to maximize North Carolina's share of settlement funds to ensure the resources reach communities as quickly, effectively, and directly as possible.

North Carolina Department of Justice Representatives:

- Swain Wood, First Assistant Attorney General and General Counsel
- Kevin Anderson, Senior Deputy Attorney General and Director, Consumer Protection Division
- Daniel Mosteller, Special Deputy Attorney General
- Blake Thomas, Deputy General Counsel
- Steve Mange, Senior Policy Counsel

North Carolina Association of County Commissioners Representatives:

- Kevin Leonard, Executive Director
  - kevin.leonard@ncacc.org
  - (919) 715-4369
- Amy Bason, Deputy Director and General Counsel
  - amy.bason@ncacc.org
  - (919) 715-1430
- Paige Worsham, Associate General Counsel
  - paige.worsham@ncacc.org
  - (919) 715-6245

To assist with this effort, NCACC formed a Working Group to collaborate with DOJ on an allocation model to distribute settlement funds to all 100 counties. NCACC Past President and Yadkin County Commissioner Kevin Austin appointed a special NCACC Opioid Settlement Committee to help craft settlement options in conjunction with NCACC staff. That committee, also known as the 5-5-5 Committee, consists of five County Commissioners, five County Managers, and five County Attorneys.

5-5-5 Committee and North Carolina MOA

North Carolina Association of County Commissioners

County Commissioner Members

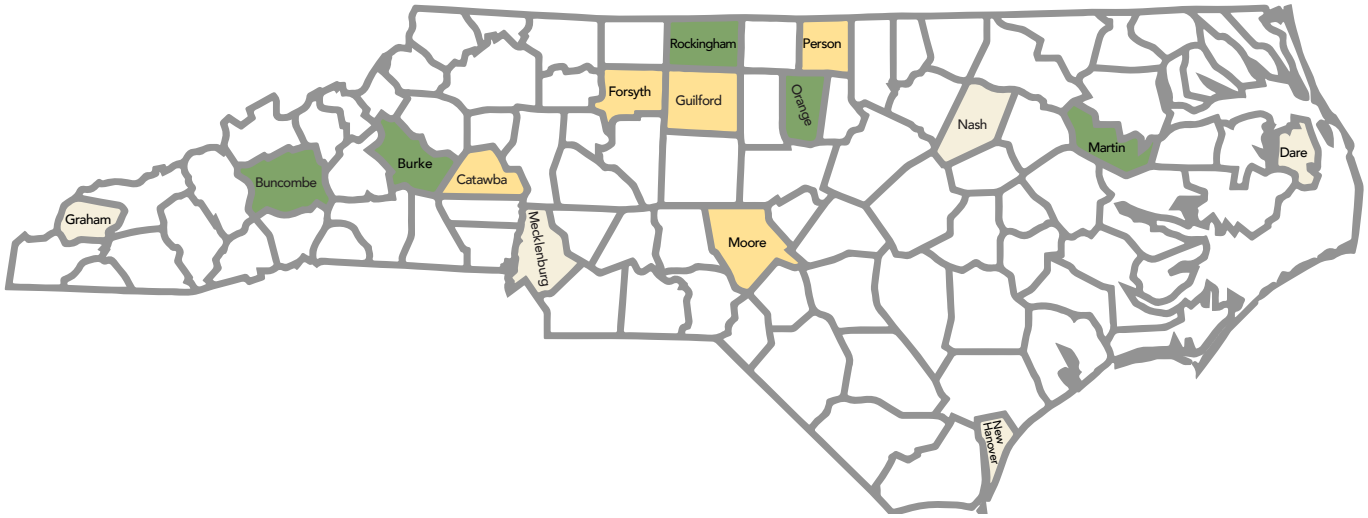
- Jasmine Beach-Ferrara, Buncombe County Commissioner
- Johnnie Carswell, Burke County Commissioner
- Sally Greene, Orange County Commissioner
- Reece Pyrtle, Rockingham County Commissioner
- Ronnie Smith, Martin County Commissioner

County Attorney Members

- Ron Aycock, Special Counsel - Person County
- Debra Bechtel, Catawba County Attorney
- Misty Leland, Moore County Attorney
- Mark Payne, Guilford County Attorney
- Gordon Watkins, Forsyth County Attorney

County Manager Members

- Chris Coudriet, New Hanover County Manager
- Dena Diorio, Mecklenburg County Manager
- Becky Garland, Graham County Manager
- Zee Lamb, Nash County Manager
- Bobby Outten, Dare County Manager



NCACC, 5-5-5 Committee, and DOJ devised a pathbreaking MOA to bring opioid settlement funds directly to communities

Working closely together, NCACC staff, the 5-5-5 Committee and representatives from DOJ developed the Memorandum of Agreement (MOA), which all counties and municipalities are urged to sign.

This pathbreaking agreement recognizes the critical role of North Carolina counties in delivering human and social services to county residents. It directs substantial resources to local governments on the front lines of the opioid epidemic while ensuring that these resources are used in an effective way to address the epidemic.

Opioid settlement funds will be distributed among local governments according to the National MDL Opioid Allocation Class Model, which is a formula developed by local governments' attorneys that allocates funds in proportion to

where the opioid crisis is the most severe. The model accounts for the number of pills dispensed, number of opioid overdose deaths, and number of people suffering from opioid use disorder. A county's allocation percentage will not change over the term of the MOA.

Opioid settlement funds received in North Carolina from the national settlement will be allocated as follows:

- 80% will go to Local Governments listed in the MOA to address the opioid epidemic,
- 15% will go to the State of North Carolina,
- and the remaining 5% will be used for a County Incentive Fund for any county (and any municipality in that county slated to receive settlement funds) in which the county itself and every municipality of a certain size signs the NC MOA.

As explained in more detail below, all of these funds must be used only on opioid remediation activities.

The North Carolina MOA requires collaboration among localities and stakeholder engagement to maximize community impact

The MOA prescribes collaborative strategic planning and stakeholder involvement required for certain activities. Counties are required to hold annual meetings with municipalities within their borders to encourage collaboration and plan for permissible expenditures in the upcoming year. Local governments are also encouraged to engage in a strategic planning process to access additional expenditure options.

The MOA also establishes a Coordination Group composed of local government representatives, state government representatives, and others with relevant expertise will meet periodically to help coordinate and guide Local Governments with their work under the MOA. The Coordination Group includes twelve total representatives as follows:

- **Five Local Government Representatives**

  Four appointed by the North Carolina Association of County Commissioners including:

  - One county commissioner
  - One county manager
  - One county attorney
  - One county local health director or consolidated human services director

  One municipal manager appointed by the North Carolina League of Municipalities
- **Four Experts Appointed by the Department of Health and Human Services**
  - Four appointed by the Secretary of the Department of Health and Human Services
- **One Expert Appointed by the Attorney General**
  - One appointed by the Attorney General of North Carolina from the North Carolina Department of

Justice or another state agency

- **Two Experts Appointed by Legislative Leaders**
  - One representative from the University of North Carolina School of Government with relevant expertise appointed by the Speaker of the North Carolina House of Representatives
  - One representative from the board or staff of the North Carolina Institute of Medicine with relevant expertise appointed by the President Pro Tem of the North Carolina Senate

The North Carolina MOA helps ensure opioid-related strategies are effective and consistent with the National Settlement Agreement

Under the MOA, local governments are required to deposit opioid settlement funds received in a special restricted revenue fund to account separately for the monies. The local government must include in its budget or pass a resolution authorizing the expenditure of opioid settlement funds, indicating the specific strategy it chose from the options outlined in the MOA.

Local governments may expend funds only on opioid remediation activities, as consistent with strategies outlined in the National Settlement Agreement.

The NC MOA offers local governments two options:

- Under Option A, a local government may fund one or more strategies from a shorter list of evidence-based, high-impact strategies to address the epidemic, including many strategies already deployed at the county level. The Option A strategies include:
  - evidence-based addiction treatment
  - recovery support services
  - recovery housing
  - employment-related services
  - early intervention programs
  - naloxone distribution
  - post-overdose response teams
  - syringe service programs
  - criminal justice diversion programs
  - addiction treatment for incarcerated persons
  - reentry programs

- Under Option B, a local government may fund one or more strategies from a longer list of strategies after engaging in a collaborative strategic planning process involving a diverse array of stakeholders at the local level (as detailed in Exhibit C to the MOA). The longer list of Option B strategies – the full range of strategies that will be allowed under a national settlement or bankruptcy resolution – involve multiple strategies falling into these broad categories:
    - Provide treatment for Opioid Use Disorder (OUD)
    - Support people in treatment and recovery and provide connections to care
    - Address the needs of criminal-justice-involved persons with OUD
    - Address the needs of pregnant or parenting women and their families
    - Prevent over-prescribing of opioids and misuse of opioids
    - Prevent overdose deaths and other harms (harm reduction)

The North Carolina MOA includes measures to ensure transparency and track performance

Local governments have annual financial and impact reporting and audit requirements under the MOA to ensure opioid settlement funds are spent consistent with permissible purposes:

- Certain reports and resolutions from the local government's governing body will be available for public access on a statewide opioid settlement dashboard.
- For every fiscal year in which a local government receives, holds, or spends opioid settlement funds, the county or municipality must submit annual financial and impact reports specifying the activities and amounts it has funded.
- The local government must maintain records of opioid settlement Fund expenditures and related documents for at least five years.
- The State Auditor and Department of Justice shall have access to persons and records related to the MOA and expenditures of Opioid Settlement Fund to verify accounts and data affecting fees for performance.
- The Local Government manager/administrator is the point of contact for questions that arise under the MOA.

Please Act by Signing MOA

In order to maximize North Carolina's share of the national settlement and ensure that the funding continues, all counties and all municipalities above 10,000 in population need to sign the MOA between the State of North Carolina and Local Governments on proceeds relating to the Settlement of Opioid Litigation, as well as the eventual National Settlement Agreement.

All North Carolina counties that sign on will receive a portion of opioid settlement funds, regardless of whether they

5-5-5 Committee and North Carolina MOA

North Carolina Association of County Commissioners

are litigants in the national opioid litigation or filed a proof of claim in Purdue Pharma's bankruptcy. Municipalities above 75,000 in population, and municipalities that previously filed litigation, will also receive funds directly. Smaller municipalities will benefit from the maximum possible level of funds being directed into their counties, and their counties are required by the agreement to work closely with all of their municipalities in making decisions about where to direct the funds.

The national settlement agreement is expected to provide the highest benefits to state and local governments that have 100% participation in signing on to their state agreements and the National Settlement Agreement. Therefore, it is important that all counties and referenced municipalities sign on to this proposed agreement.

It is advantageous to all North Carolinians for all local governments to sign onto the MOA and demonstrate solidarity in response to the opioid epidemic, and to maximize the share of opioid settlement funds received in the state to help abate the harm.

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Corporate Accountability: Fighting the Opioid Epidemic in North Carolina

WHAT IT IS

The NC Memorandum of Agreement (NC MOA) governs how North Carolina would use the proceeds of any future national settlement or bankruptcy resolution with drug distributors Cardinal, McKesson, and AmerisourceBergen and opioid manufacturers Johnson & Johnson and Purdue Pharma. These potential settlements and resolutions could bring as much as $850 million to North Carolina over an 18-year period to support state and local efforts to address the epidemic.

WHAT IT DOES

Dedicates all funds to addressing the opioid epidemic.

Enables North Carolina to maximize resources to abating the crisis. For North Carolina to receive the maximum payout under national settlements and bankruptcy resolutions, all relevant parties – including the state itself, all 100 counties, and all large- and medium-sized municipalities – must sign on to the NC MOA and the national settlement agreements. To maximize resources flowing to communities on the front lines of the epidemic, the NC MOA would direct settlement funds as follows:

- 15 percent to the state, which the General Assembly would appropriate to address the epidemic.
- 80 percent to local governments, including all 100 counties and 17 municipalities.
- An additional five percent to an incentive fund to encourage counties and municipalities to sign on to the agreement.

Ensures high levels of transparency and accountability. The agreement offers a high level of transparency into how local governments use the funds, including special revenue funds subject to audit, annual financial and impact reports, and a public dashboard showing how they are using settlement funds to address the epidemic.

WHY IT MATTERS

Personal Cost. The opioid epidemic has taken the lives of more than 16,000 North Carolinians, torn families apart, and ravaged communities from the mountains to the coast. Just as we began to make progress in combatting the epidemic, the COVID-19 pandemic caused a new wave of isolation, despair, drug misuse, and overdose death. Individuals, families, and entire communities continue to suffer and struggle.

Accountability. The opioid epidemic was created and fueled by irresponsible marketing and inadequate monitoring on the part of opioid makers and distributors. Settlements with the big three drug distributors and Johnson & Johnson, and a resolution of the Purdue Pharma bankruptcy proceedings, have the potential to bring as much as $850 million to North Carolina over an 18-year period to support state and local efforts to address the epidemic.

United Front to Heal North Carolina. The NC MOA is an important step forward in our collective effort to hold these companies accountable for their behavior and to secure and direct much-needed resources to communities across the state as they work to address the epidemic and its aftermath.

Click here to access an FAQ on this topic.
Click here to access the memorandum of agreement.

HOW NORTH CAROLINA WOULD USE OPIOID SETTLEMENT FUNDS:
FREQUENTLY ASKED QUESTIONS ON THE MEMORANDUM OF AGREEMENT
BETWEEN STATE AND LOCAL GOVERNMENTS IN NORTH CAROLINA

[UPDATED MAY 20, 2021]

GENERAL QUESTIONS

1. What is the North Carolina Memorandum of Agreement (NC MOA)?

   The NC MOA governs how North Carolina would use the proceeds of any future national settlement or bankruptcy resolution with five companies over their role in fueling the opioid epidemic. The five companies are the "big three" drug distributors (Cardinal, McKesson, and AmerisourceBergen), the opioid manufacturer Johnson & Johnson, and the opioid manufacturer Purdue Pharma (now in bankruptcy proceedings). Throughout this FAQ, the term "opioid settlement funds" refers to the proceeds of any future national settlement or bankruptcy resolution with any of these five companies.

2. Why is the NC MOA important?

   The opioid epidemic has taken the lives of more than 16,000 North Carolinians, torn families apart, and ravaged communities from the mountains to the coast. Just as we began to make progress in combatting the epidemic, the COVID-19 pandemic caused a new wave of isolation, despair, drug misuse and overdose death. Individuals, families, and entire communities continue to suffer and struggle.

   The opioid epidemic was fueled by irresponsible marketing and inadequate monitoring on the part of opioid makers and distributors. Settlements with the big three drug distributors and Johnson & Johnson, and a resolution of the Purdue Pharma bankruptcy proceedings, have the potential to bring as much as $850 million to North Carolina over an 18-year period to support state and local efforts to address the epidemic.

   The NC MOA is an important step forward in our collective effort to hold these companies accountable for their behavior and to direct much-needed resources to communities across the state as they work to address the epidemic and its aftermath.

3. What are the most important features of the NC MOA?

   All funds to address the opioid epidemic. The NC MOA provides that all opioid settlement funds will be used to address the opioid epidemic, with an emphasis on high-impact strategies and collaborative strategic planning.

   Maximum resources to North Carolina communities. For our state to receive the maximum payout under any national settlements with the big three drug distributors or Johnson & Johnson, all relevant parties – including the state itself, all 100 counties, and all large and medium-sized municipalities – would have to sign onto the NC MOA and those national settlement agreements.

   To achieve that goal, and to maximize resources flowing to communities on the front lines of the epidemic, the NC MOA would direct settlement funds as follows:
   - 15% to the state (which the General Assembly would have authority to appropriate on a wide range of strategies to address the epidemic)
   - 80% to local governments, including all 100 counties plus 17 municipalities, allocated among those counties and municipalities through a formula developed by attorneys representing local governments in national litigation
   - An additional 5% percent into an incentive fund for any county (and any municipality in that county already receiving settlement funds under the NC MOA) in which the county itself and every municipality with at least 30,000 residents (based on 2019 population totals) in the county signs the NC MOA

   High level of transparency and accountability. The NC MOA offers a high level of transparency and accountability for the use of opioid settlement funds by local governments, including special revenue funds subject to audit, annual financial and impact reports, and a public dashboard showing how they are using settlement funds to address the epidemic.

4. How does the NC MOA ensure that opioid settlement funds would be spent on strategies to address the epidemic?

   Any national settlement with the big three drug distributors or Johnson & Johnson, and any resolution of the Purdue Pharmacy bankruptcy matter, will direct state and local governments to use most opioid settlement funds to address the epidemic.

   Consistent with this principle, the NC MOA offers local governments two options:
   - Under Option A, a local government may fund one or more strategies from a shorter list of evidence-based, high-impact strategies to address the epidemic.
   - Under Option B, a local government may fund one or more strategies from a longer list of strategies after engaging in a collaborative strategic planning process involving a diverse array of stakeholders at the local level.

5. What are the Option A strategies?

   Under Option A, local governments may use opioid settlement funds to support programs or services listed below that serve persons with Opioid Use Disorder (OUD) or any co-occurring Substance Use Disorder (SUD) or mental health conditions. Specifically, under Option A, local governments may use opioid settlement proceeds to fund:

   1. Collaborative strategic planning
   2. Evidence-based addiction treatment
   3. Recovery support services
   4. Recovery housing support
   5. Employment-related services
   6. Early intervention programs
   7. Naloxone distribution
   8. Post-overdose response teams
   9. Syringe service programs
   10. Criminal justice diversion programs
   11. Addiction treatment for incarcerated persons
   12. Reentry programs for recently incarcerated persons

   (See NC MOA Exhibit A for additional detail.)

6. What are the Option B strategies?

   Option B includes a wider array of strategies that would be allowed under any national settlement with the big three drug distributors or Johnson & Johnson, or under a resolution of the Purdue Pharma bankruptcy proceedings. This includes an array of strategies that:

   A. Treat Opioid Use Disorder (OUD)
   B. Support people in treatment and recovery
   C. Provide connections to care
   D. Address the needs of criminal-justice-involved persons with OUD
   E. Address the needs of pregnant or parenting women and their families
   F. Prevent over-prescribing of opioids
   G. Prevent misuse of opioids
   H. Prevent overdose deaths and other harms (harm reduction)
   I. Support first responders
   J. Promote leadership, planning, and coordination
   K. Fund relevant training and research

   (See NC MOA Exhibit B for a current version of the Option B national strategy list.)

7. What is the Option B collaborative strategic planning process?

   Under Option B, a local government may fund one or more strategies from the longer list of national strategies after engaging in collaborative strategic planning at the local level. This involves:

   - Engaging a wide array of local stakeholders
   - Exploring the root causes of drug misuse, addiction, and overdose death in the area
   - Identifying and evaluating potential strategies to address the epidemic
   - Looking for opportunities to fill gaps in existing programs, align strategies, and combine opioid settlement funds with other sources of funding
   - Offering comprehensive recommendations to the county board, city council, or other governing body

   (See NC MOA Exhibit C for additional detail.)

8. Are regional solutions allowed?

   Yes. Multiple counties and municipalities are allowed and encouraged to work together to address regional challenges and pursue regional solutions. Among other provisions, the NC MOA allows several local governments to engage in a single collaborative strategic planning process if they believe it will be efficient and advantageous for them to do so. (See NC MOA § E.5.b.v.)

9. How does the NC MOA ensure transparency and accountability by local governments receiving opioid settlement funds?

   The NC MOA provides a high level of transparency and accountability, including the following measures:

   Special Revenue Fund. In order to receive any funds under any opioid settlement or bankruptcy resolution, a local government must first establish a separate special revenue fund for the receipt and expenditure of opioid settlement funds. (See NC MOA §§ D & E.6.)

   Financial and compliance audits. The use of special revenue funds is subject to a range of financial and compliance audits. The State Auditor and Department of Justice have access to persons and records concerning the expenditure of opioid settlement funds. (See NC MOA § F.)

   Special budget item or resolution. In order to spend opioid settlement funds from the special revenue funds, a local government must pass a budget or separate resolution specifically authorizing the expenditure of the funds, including the amount to be spent, the strategy or strategies to be funded, and the relevant period of time. (See NC MOA § E.6.)

   Option B report and recommendations. For local governments that elect Option B, the collaborative strategic planning process will result in a public report and recommendations. (See NC MOA § E.5 and Exhibit C, right-hand column.)

Annual financial reports. Any local government that spends opioid settlement funds will be required to file annual financial reports. (See NC MOA § F.6 and Exhibit E.)

Annual impact information. Any local government that spends opioid settlement funds will be required to file impact information on an annual basis. (See NC MOA § F.6 and Exhibit F.)

Statewide public dashboard. A statewide dashboard will enable members of the public to view the special budget items or resolutions, reports and recommendations, annual financial reports, and annual impact information described above for each local government receiving or spending opioid settlement funds. (See NC MOA § F.6.)

NATIONAL OPIOID LITIGATION, SETTLEMENT TALKS, AND BANKRUPTCY PROCEEDINGS

10. How many North Carolina local governments are engaged in national litigation against opioid manufacturers or distributors?

    Seventy-six counties and eight municipalities have filed lawsuits in federal court to hold opioid manufacturers or distributors accountable for their role in fueling the opioid epidemic. Under the NC MOA, all 100 counties and every municipality with a population of 75,000 or more would receive settlement payments regardless of whether they engaged in litigation. Regardless of the municipality in which they live, all residents of a county stand to benefit from opioid settlement funds received and expended by that county.

11. What is the status of these cases?

    The federal cases have been consolidated for pretrial proceedings into so-called Multi-District Litigation (MDL) in Cleveland, Ohio. The opioid MDL has consolidated roughly 3,000 lawsuits from nearly every state. The lawsuits allege that opioid manufacturers misrepresented the risks associated with prescription opioids; that opioid distributors did not properly monitor shipments of prescription opioids to pharmacies across the country; and that these actions contributed to the opioid epidemic that continues to ravage North Carolina and the nation.

12. How large is the potential settlement with the big three drug distributors plus the drug maker Johnson & Johnson?

    The big three drug distributors and the drug maker Johnson & Johnson have announced their willingness to consider a global settlement of all the cases that have been or could be filed against them by state and local governments for a total of $26 billion, with details of such a settlement still under discussion.

12A. If there is a $26 billion global settlement with the big three drug distributors and Johnson & Johnson, how would those settlement proceeds be allocated?

While the details of such a settlement are still being worked out, it is anticipated the settlement proceeds would be divided in two parts:

- $24 billion would be available to state and local governments for opioid remediation efforts (as detailed below under the heading, "Allocation of Opioid Settlement Proceeds")
- $2 billion would be available to compensate private attorneys involved in litigation against the big three drug distributors and Johnson & Johnson

12B. Regarding the $2 billion that would be available to compensate private attorneys, how would that be divided up?

The $2 billion attorney fee fund would be divided in two parts:

- $1.65 billion would be available to compensate private attorneys involved in the litigation on behalf of local governments across the country, ***on the condition that the attorneys waive all contingent fee contracts with all local governments (including the North Carolina counties and municipalities they represent)***
- $350 million would be available to compensate private attorneys involved in the litigation on behalf of state governments (although the state of North Carolina handled the litigation through staff of the Attorney General's Office and did not retain private counsel)

13. Will the Purdue Pharma bankruptcy proceedings result in additional funds to address the opioid epidemic?

Yes. We anticipate that the Purdue Pharma bankruptcy proceedings may provide an additional $4-5 billion to support state and local efforts to address the opioid epidemic across the country.

14. How does all this relate to the McKinsey settlement that was announced in February 2021?

The McKinsey settlement is separate and apart from the potential settlements with the big three drug distributors and Johnson & Johnson, and from the Purdue Pharma bankruptcy proceedings.

In February 2021, Attorney General Josh Stein and other attorneys general from across the nation reached a $573 million settlement with one of the world's largest consulting firms, McKinsey & Company, over the company's role in advising opioid companies how to promote their drugs and profit from the opioid epidemic.

As part of the settlement with McKinsey, the state of North Carolina will receive nearly $19 million over five years, with the vast majority coming in 2021. The McKinsey settlement requires that the state use these settlement proceeds to fund strategies to address the opioid epidemic. Within these parameters, it will be up to the North Carolina General Assembly to decide how to spend the McKinsey settlement proceeds.

15. Apart from the settlement talks with the big three drug distributors and Johnson & Johnson, the Purdue Pharma bankruptcy proceedings, and the recent McKinsey settlement, is there other opioid-related litigation brought by state and local governments?

    Yes. There is litigation in federal and state courts against other opioid manufacturers, including Allergan, Endo, and Teva, and bankruptcy proceedings involving the opioid maker Mallinckrodt. And there is litigation in federal and state courts against CVS, Rite Aid, Walgreens, Walmart, and other pharmacy chains over their role in the opioid epidemic.

    Even in the event of settlements with the big three drug distributors and Johnson & Johnson and a resolution of the Purdue Pharma bankruptcy proceedings, this other litigation will continue and may (or may not) result in additional settlements or resolutions to support state and local efforts to address the opioid epidemic.

ALLOCATION OF OPIOID SETTLEMENT PROCEEDS

16. How would funds be divided among the states in the event of settlements with the big three drug distributors and Johnson & Johnson or a resolution of bankruptcy proceedings involving Purdue Pharma?

    If there are settlements with the big three drugs distributors or Johnson & Johnson, or a resolution of bankruptcy proceedings involving Purdue Pharma, or a combination of these, settlement funds would be allocated among states based on population and the impact of the opioid crisis on each state, taking into account several public health measures.

17. What is the maximum amount North Carolina could receive if there are settlements with the big three drugs distributors and Johnson & Johnson, and a resolution of bankruptcy proceedings involving Purdue Pharma?

    North Carolina could receive up to $850 million over a period of 18 years to support state and local efforts to address the opioid epidemic, in the event of national settlements with the big three drug distributors and Johnson & Johnson, as well as a resolution in the Purdue Pharma bankruptcy proceedings. The settlement payments to North Carolina (and other states) would be front-loaded, with payments in the first three years higher than payments in the remaining 15 years of any such settlement.

18. How many local governments in North Carolina are expected to receive payments as part of any settlement with the big three drug distributors or Johnson & Johnson or bankruptcy resolution involving Purdue Pharma?

    Under the NC MOA, all 100 counties – including those that have engaged in litigation against the opioid defendants and those that have not engaged in such litigation – would receive settlement payments.

    In addition, 17 municipalities would receive settlement payments – including the eight municipalities involved in the national litigation and nine other municipalities with a population

of 75,000 or greater (based on 2019 population totals). Like the 100 counties, all municipalities receiving settlement funds are subject to the terms and requirements of the NC MOA (including the establishment special revenue funds subject to financial and compliance audits, filing of annual financial and impact reports, and all of the other procedural and reporting requirements described in the NC MOA).

In situations where a county and a municipality within that county receive settlement funds, the portion of the settlement funds awarded to the county has been reduced by the amount awarded to the municipality. Residents of all municipalities in North Carolina – including those that receive settlement funds and those that do not – stand to benefit from county and state programs and services supported with opioid settlement funds.

19. How are settlement or bankruptcy funds allocated among the North Carolina counties and municipalities receiving such funds?

Under the NC MOA, settlement funds are allocated among the 100 counties and 17 municipalities through a formula developed by attorneys representing local governments in national litigation. The resulting percentage allocations are shown in NC MOA Exhibit G.

19A. What formula was used to determine these allocations among the 100 counties and 17 municipalities receiving settlement funds under the NC MOA?

The allocation formula for the NC MOA is derived directly from the allocation model developed at the national level by experts retained by the outside counsel for local governments. The national allocation model is based on three factors:

A. Opioid Use Disorder ("OUD"). Under this factor, each county is assigned a percentage derived by dividing the number of people in the county with OUD by the total number of people nationwide with OUD. The model uses data reported in the National Survey on Drug Use and Health for 2017, accessible at https://bit.ly/2HqF554.

B. Overdose Deaths. This factor assigns to each county a percentage of the nation's opioid overdose deaths. The percentage is based on Multiple Causes of Death data reported by the National Center for Health Statistics, the Centers for Disease Control and the U.S. Department of Health and Human Services. The data so reported is then adjusted using a standard, accepted method designed to address the well-established under-reporting of deaths by opioid overdose.

C. Amount of Opioids. This factor assigns to each county a percentage of the national opioid shipments during 2006-2016 (expressed as morphine molecule equivalents) that produced a negative outcome. This percentage is based on data reported by the U.S. Drug Enforcement Agency in its so-called ARCOS database. Each county's share of national shipments is multiplied by the higher of two ratios: (1) the ratio of the percentage of people in the county with OUD to the percentage of people nationwide with OUD; or (2) the ratio of the percentage of people in the county who died of an opioid overdose between 2006-2016 to the national percentage of opioid overdose deaths during that time.

The allocation model gives equal weight to each of these three factors. Thus, a hypothetical county with an OUD percentage of .3 percent and an overdose death percentage of .2 percent and an amounts of opioid percentage of .16 percent would receive an overall allocation of .22 percent. [(.3 plus .2 plus .16) then divided by 3 equals .22]

Counties and municipalities that are parties to the national litigation may wish to ask their attorneys for more information on how the national allocation model was developed. More information is available at https://allocationmap.iclaimsonline.com/

19B. For the 100 counties and 17 municipalities that would receive settlement payments under the NC MOA, does the allocation model take into account past damages incurred by these local governments?

By incorporating Opioid Use Disorder, overdose deaths, and amount of opioids experienced by each local government, the national allocation model may be seen as a rough proxy for the damages incurred by the local governments that will receive opioid settlement funds.

However, settlement funds will not directly compensate local governments for past damages they have incurred; and a local government may not deposit opioid settlement funds into its general fund as compensation for past expenses. Instead, opioid settlement funds must be used on forward-looking opioid remediation strategies as provided in the NC MOA.

19C. For the 100 counties and 17 municipalities that would receive settlement payments under the NC MOA, does the allocation model take into account whether the county or municipality has retained private counsel and engaged in litigation against the drug companies?

No. Neither the national allocation model nor the NC MOA take into account whether a county or municipality has retained private counsel or engaged in litigation against any of the drug companies.

Here is why the national allocation model and the NC MOA treat litigating and non-litigating local governments the same: We anticipate that the $26 billion settlement agreement with the big three drug distributors and Johnson & Johnson will set aside $2 billion to compensate private attorneys involved in the litigation. Of that $2 billion, $1.65 billion will be available to compensate private attorneys involved in the litigation on behalf of local governments across the country, ***on the condition that these private attorneys waive all contingent fee contracts with local governments (including the North Carolina counties and municipalities they represent).***

The $1.65 billion for private attorneys representing local governments will be taken "off the top" of the $26 billion settlement. This means that all counties and municipalities receiving settlement funds – whether they retained private counsel or not – will in effect be compensating private counsel engaged in the litigation. This is because those local governments will not be receiving the $1.65 billion going to private attorneys that they would otherwise receive to support opioid remediation efforts.

20. What is the maximum amount a particular county or municipality could receive under the terms of the MOA, and how would that be calculated?

We anticipate that North Carolina could receive up to $850 million over a period of 18 years in the event of national settlements with the big three drug distributors and Johnson & Johnson as well as a resolution in the Purdue Pharma bankruptcy proceedings, as noted above.

To determine the maximum total amount that could go to any individual county or municipality (under the best-case scenario), the $850 million total should be multiplied by 80%, to reflect the portion that will be directed to local governments for opioid remediation efforts, and then be multiplied by the percentage allocation for that county or municipality shown in NC MOA Exhibit G. For example, for a local government with a one percent allocation in NC MOA Exhibit G, the expected maximum would be $850 million multiplied by .80 (eighty percent) times .01 (one percent) for a maximum of $6.8 million.

In addition to that amount, a county or municipality may receive an additional (smaller) amount in connection with the incentive fund described in Section G to the MOA.

20A. If a county is receiving settlement funds and a municipality within the county is also receiving settlement funds, does that result in "double dipping"?

No, there is no double-dipping. In situations where a county and a municipality within that county receive settlement funds, the portion of the settlement funds awarded to the county have been reduced by the amount awarded to the municipality inside the county.

20B. How does the five percent incentive fund work?

The NC MOA directs five percent of all settlement funds flowing to the state into an incentive fund that would be divided among those counties (and any municipalities in those counties that stand to receive settlement funds under NC MOA Exhibit G) in which the county itself and any municipality in the county with at least 30,000 residents (based on 2019 population totals) signs the MOA by October 1, 2021. Once it is determined which counties and municipalities are eligible to participate in the incentive fund, funds in the incentive fund will be distributed according to the percentages set forth in NC MOA Exhibit G. (See NC MOA § G.)

20C. If a county that signs onto the NC MOA does not have any municipalities with at least 30,000 residents, would that county still be able to participate in the incentive fund?

Yes.

21. Would opioid settlement payments to a county or municipality be spread out equally over 18 years?

No. Settlement payments to local governments are expected to be front-loaded, with payments in the first three years higher than payments in the remaining 15 years of the settlement.

22. What has to happen for North Carolina counties and municipalities to receive the maximum possible amount under the terms of the MOA and any national settlement agreements?

    The precise amount that that our state as a whole would receive depends not only on the final terms of the settlement agreements and bankruptcy resolutions but also on whether North Carolina qualifies for incentive structures that would increase the payment amounts as more North Carolina counties and municipalities join the settlement.

    For our state to receive the maximum payout under any national settlements with the drug distributors or Johnson & Johnson, all relevant parties – including the state itself, all 100 counties, and all large and medium-sized municipalities – would have to sign onto the NC MOA as well as the national settlement agreements. Conversely, North Carolina stands to lose hundreds of millions of dollars under the national settlement agreements if a significant number of counties or large- to medium-sized municipalities do not sign onto those agreements.

    It should be noted that any national settlements with the big three drug distributors or Johnson & Johnson will prohibit ANY payment to ANY county or municipality that does not sign onto the national settlement agreements – and there will be reduced payments to any county or municipality that signs on late (after a yet-to-be-determined deadline).

23. How many local governments need to sign onto the NC MOA for the MOA to take effect?

    The NC MOA will become effective when enough local governments have signed on to meet the support level required by one of the national settlement agreements or bankruptcy resolutions. This level of support has not been definitively established. However, we anticipate a requirement that counties and large- and medium-sized cities representing at least half of the state's population will have to sign onto the NC MOU in order for it to take effect.

24. What happens if not enough local governments sign onto the MOA?

    If the NC MOA does not become effective, North Carolina's allocation will be governed by the default allocations that we anticipate will be included in the national settlement agreements with the distributors and Johnson & Johnson, and the resolution of the Purdue bankruptcy. We expect the default in the Purdue bankruptcy will provide direct payments to counties with a population above 400,000 (with no direct payments to counties with smaller populations or to municipalities). We anticipate that the default arrangement in the national settlement agreements would provide as little as 15% of state settlement funds in direct payments to local governments and a substantially worse arrangement for local governments than the NC MOA offers.

24A. How can a North Carolina county or municipality sign onto the NC MOA?

The county board, city council, or other governing body can pass a resolution stating its intent to sign onto the NC MOA and directing the county or city attorney to executive relevant documents. Sample resolutions are available from the North Carolina Association of County Commissioners (for counties) and the North Carolina League of Municipalities (for municipalities).

24B. If a local government signs onto the NC MOA, does that mean they automatically sign onto any national settlement with the big three drug distributors or Johnson & Johnson?

No. A local government that signs the NC MOA will have an additional opportunity to review and sign onto (or not sign onto) any national settlement with the big three drug distributors or Johnson & Johnson.

By signing onto the NC MOA, a local government is agreeing to a framework for how settlement funds would flow in the event of a national settlement. The local government is not agreeing to the national settlement itself, which will require separate consideration and deliberation.

ADDITIONAL QUESTIONS

25. What is the NC MOA coordination group?

The NC MOA creates a coordination group to help implement the NC MOA and address certain issues that may arise over the course of the 18-year settlements. (See NC MOA § E.7 and Exhibit D for details.)

26. What is the composition of the coordination group?

The coordination group will have twelve members, including:

- Five local government representatives (a county commissioner, county manager, county attorney, county local health director or consolidated human services director, and municipal manager);
- Four experts appointed by the North Carolina Department of Health and Human Services;
- One expert appointed by the North Carolina Attorney General; and
- Two experts appointed by legislative leaders, including
    - One representative from the University of North Carolina School of Government with relevant expertise appointed by the Speaker of the North Carolina House of Representatives; and
    - One representative from the board or staff of the North Carolina Institute of Medicine with relevant expertise appointed by the President Pro Tempore of the North Carolina Senate.

(See NC MOA Exhibit D for additional details.)

27. What are the responsibilities of the coordination group?

    The coordination group will have a variety of responsibilities, including the following:
    - To develop certain guidelines for audits required under the NC MOA;
    - To make adjustments as needed to certain aspects of the NC MOA, including:
        - The high-impact strategies listed in NC MOA Exhibit A;
        - The collaborative strategic planning process described in NC MOA Exhibit C;
        - The annual financial report described in NC MOA Exhibit E; and
        - The impact information described in NC MOA Exhibit F.
    - To work with counties, municipalities, the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, other associations, foundations, non-profits, and other government or nongovernment entities to provide support to Local Governments in their efforts to effectuate the goals and implement the terms of the NC MOA.

    (See NC MOA Exhibit D for additional details.)

28. Will counties and municipalities receive opioid settlement funds "up front" or will they have to seek reimbursement for opioid-related expenditures "after the fact"?

    A local government that has established a special revenue fund as the NC MOA requires may then receive opioid settlement funds "up front" and expend the funds in a manner consistent with NC MOA requirements.

29. Will a local government have to spend opioid settlement funds during the same fiscal year in which the funds are received?

    No. The NC MOA entrusts local governments with spending decisions, so long as they are consistent with the NC MOA. To encourage planning and collaboration, and to ensure that local governments have flexibility to address local needs in a thoughtful and timely manner, the NC MOA places no restriction on the ability of local governments to carry over opioid settlement funds from year to year.

30. What if a local government has funds left even after all settlement funds are received?

    This is not a problem. There is no time limit on when a local government may spend opioid settlement funds, so long as the funds are spent in a manner consistent with the NC MOA.

31. Can a local government contract with (or provide a grant to) a third party to implement a program, service, or strategy that is consistent with the terms of the NC MOA on behalf of the local government?

    Yes.

32. If a local government selects Option B and undertakes a collaborative strategic planning process that results in a report and recommendations as described in NC MOA Exhibit C, does the county board, city council, or other governing body have to accept the recommendations set forth in the report and recommendations?

    No. Under Option B, a local government may fund one or more strategies from the longer list of strategies (described in Exhibit B) after engaging in a collaborative strategic planning process that results in a report and recommendations to its governing body (described in Exhibit C). However, the governing body is not required to accept the recommendations contained in the report and recommendations. For example, the report and recommendations could recommend funding "Strategy X," but the governing body could decide to fund "Strategy Y" instead.

33. Under Option B, does anyone at the state level have to approve or "sign off" on the local collaborative strategic planning process, the resulting report and recommendations, or the ultimate decision of the governing body on what strategy or strategies to fund?

    No.

34. What happens if a county or municipality spends opioid settlement funds in a manner that is inconsistent with the NC MOA?

    Local governments are entrusted with the responsibility of spending opioid settlement funds to in a manner consistent with the terms of the NC MOA. In the unlikely event that a local government spends opioid settlement funds in a manner that is not consistent with the terms of the NC MOA, the local government has 60 days after discovery of the expenditure to cure the inconsistent expenditure in one of several ways. In the unlikely event that the local government fails to cure the inconsistent expenditure, future opioid settlement payments may be reduced by the amount of the inconsistent expenditure. (For additional details see NC MOA § E1-3.)

MEMORANDUM OF AGREEMENT
BETWEEN THE STATE OF NORTH CAROLINA AND LOCAL GOVERNMENTS
ON PROCEEDS RELATING TO THE SETTLEMENT OF OPIOID LITIGATION

Contents

Background Statement

Capitalized terms not defined below have the meanings set forth in the Definitions section of the Statement of Agreement.

WHEREAS, the State of North Carolina (the "State"), North Carolina counties and municipalities, and their people have been harmed by misconduct committed by certain entities that engage in or have engaged in the manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic ("Pharmaceutical Supply Chain Participants"); and

WHEREAS, certain North Carolina counties and municipalities, through their counsel, and the State, through its Attorney General, are separately engaged in ongoing investigations, litigation and settlement discussions seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misconduct; and

WHEREAS, the State and the Local Governments share a common desire to abate and alleviate the impacts of the misconduct described above throughout North Carolina and in its local communities; and

WHEREAS, while the Local Governments and the State recognize the sums which may be available from the aforementioned litigation will likely be insufficient to fully abate the public health crisis caused by the opioid epidemic, they share a common interest in dedicating the most resources possible to the abatement effort; and

WHEREAS, settlements resulting from the investigations and litigation with Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson are anticipated to take the form of a National Settlement Agreement; and

WHEREAS, this Memorandum of Agreement ("MOA") is intended to facilitate compliance by the State and by the Local Governments with the terms of the National Settlement Agreement and, to the extent appropriate, in other settlements related to the opioid epidemic reached by the state of North Carolina; and

WHEREAS, North Carolina's share of settlement funds from the National Settlement Agreement will be maximized only if all North Carolina counties, and municipalities of a certain size, participate in the settlement; and

WHEREAS, the National Settlement Agreement will set a default allocation between each state and its political subdivisions unless they enter into a state-specific agreement regarding the distribution and use of settlement amounts (a "State-Subdivision Agreement"); and

WHEREAS, this MOA is intended to serve as such a State-Subdivision Agreement under the National Settlement Agreement; and

WHEREAS, the aforementioned investigations and litigation have caused some Pharmaceutical Supply Chain Participants to declare bankruptcy, and it may cause additional entities to declare bankruptcy in the future; and

WHEREAS, this MOA is also intended to serve as a State-Subdivision Agreement under resolutions of claims concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic entered in bankruptcy court that provide for payments (including payments through a trust) to both the State and North Carolina counties and municipalities and allow for the allocation between a state and its political subdivisions to be set through a state-specific agreement ("Bankruptcy Resolutions"); and

WHEREAS, specifically, this MOA is intended to serve under the Bankruptcy Resolution concerning Purdue Pharma L.P. as a statewide abatement agreement, and under this MOA, a statewide abatement agreement is a type of State-Subdivision Agreement.

Statement of Agreement

The parties hereto agree as follows:

A. Definitions

As used in this MOA:

The terms "Bankruptcy Resolution," "MOA," "Pharmaceutical Supply Chain Participant," "State," and "State-Subdivision Agreement" are defined in the recitals to this MOA.

"Coordination group" refers to the group described in **Section E.7** below.

"County Incentive Fund" is defined in **Section G** below.

"Governing Body" means (1) for a county, the county commissioners of the county, and (2) for a municipality, the elected city council, town council, board of commissioners, or board of aldermen for the municipality.

"Incentive Eligible Local Government" is defined in **Section G** below.

"Local Abatement Funds" are defined in **Section B.2** below.

"Local Government" means all counties and municipalities located within the geographic boundaries of the State of North Carolina that have chosen to sign on to this MOA.

"MDL Matter" means the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the Northern District of Ohio.

"MDL Parties" means all parties who participated in the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the Northern District of Ohio as Plaintiffs.

"National Settlement Agreement" means a national opioid settlement agreement with the Parties and one or all of the Settling Defendants concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic.

"Opioid Settlement Funds" shall mean all funds allocated by the National Settlement Agreement and any Bankruptcy Resolutions to the State or Local Governments for purposes of opioid remediation activities or restitution, as well as any repayment of those funds and any interest or investment earnings that may accrue as those funds are temporarily held before being expended on opioid remediation strategies. Not included are funds made available in the National Settlement Agreement or any Bankruptcy Resolutions for the payment of the Parties' litigation expenses or the reimbursement of the United States Government.

"Parties" means the State of North Carolina and the Local Governments.

"Settling Defendants" means Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson, as well as their subsidiaries, affiliates, officers, and directors named in a National Settlement Agreement.

"State Abatement Fund" is defined in **Section B.2** below.

B. Allocation of Settlement Proceeds

1. Method of distribution. Pursuant to the National Settlement Agreement and any Bankruptcy Resolutions, Opioid Settlement Funds shall be distributed directly to the State and to Local Governments in such proportions and for such uses as set forth in this MOA, provided Opioid Settlement Funds shall not be considered funds of the State or any Local Government unless and until such time as each annual distribution is made.

2. Overall allocation of funds. Opioid Settlement Funds shall be allocated as follows: (i) 15% directly to the State ("State Abatement Fund"), (ii) 80% to abatement funds established by Local Governments ("Local Abatement Funds"), and (iii) 5% to a County Incentive Fund described in **Section G** below.

3. Allocation of funds between Local Governments. The Local Abatement Funds shall be allocated to counties and municipalities in such proportions as set forth in **Exhibit G**, attached hereto and incorporated herein by reference, which is based upon the MDL Matter's Opioid Negotiation Class Model. The proportions shall not change based on population changes during the term of the MOA. However, to the extent required by the terms of the National Settlement Agreement, the proportions set forth in **Exhibit G** shall be adjusted: (i) to provide no payment from the National Settlement Agreement to any listed county or municipality that does not participate in the National Settlement Agreement; and (ii) to provide a reduced payment from the National Settlement Agreement to any listed county or municipality that signs onto the National Settlement Agreement after the initial participation deadline.

4. Municipal allocations. Within counties and municipalities:

a. Local Governments receiving payments. The proportions set forth in **Exhibit G** provide for payments directly to (i) all North Carolina counties, (ii) North Carolina municipalities with populations over 75,000 based on the United States Census Bureau's Vintage 2019 population totals, and (iii) North Carolina municipalities who are also MDL Parties as of January 1, 2021.

b. Municipality may direct payments to county. Any municipality allocated a share in **Exhibit G** may elect to have its share of current or future annual distributions of Local Abatement Funds instead directed to the county or counties in which it is located. Such an election may be made by January 1 each year to apply to the following fiscal year. If a municipality is located in more than one county, the municipality's funds will be directed based on the MDL Matter's Opioid Negotiation Class Model.

5. Use of funds for opioid remediation activities. This MOA requires that except as related to the payment of the Parties' litigation expenses and the reimbursement of the United States Government, all Opioid Settlement Funds, regardless of allocation, shall be utilized only for opioid remediation activities.

6. Relationship of this MOA to other agreements and resolutions. All Parties acknowledge and agree the National Settlement Agreement will require a Local Government to release all its claims against the Settling Defendants to receive Opioid Settlement Funds. All Parties further acknowledge and agree based on the terms of the National Settlement Agreement, a Local Government may receive funds through this MOA only after complying with all requirements set forth in the National Settlement Agreement to release its claims. This MOA is not a promise from any Party that any National Settlement Agreement or Bankruptcy Resolution will be finalized or executed.

C. Payment of Litigating and Non-Litigating Parties

No Party engaged in litigating the MDL Matter shall receive a smaller payment than a similarly situated non-litigating Party, other than as based on the Allocation Proportions in **Exhibit G** or based on the eligibility criteria for payments from the County Incentive Fund as provided by **Section G** below.

D. Special Revenue Fund

1. Creation of special revenue fund. Every Local Government receiving Opioid Settlement Funds shall create a separate special revenue fund, as described below, that is designated for the receipt and expenditure of the Opioid Settlement Funds.

2. Procedures for special revenue fund. Funds in this special revenue fund shall not be commingled with any other money or funds of the Local Government. The funds in the

special revenue fund shall not be used for any loans or pledge of assets, unless the loan or pledge is for an opioid remediation purpose consistent with the terms of this MOA and adopted under the process described in **Section E.6** below. Although counties or municipalities may make contracts with or grants to a nonprofit, charity, or other entity, counties or municipalities may not assign to another entity their rights to receive payments from the national settlement or their responsibilities for funding decisions.

3. Interest earned on special revenue fund. The funds in the special revenue fund may be invested, consistent with the investment limitations for local governments, and may be placed in an interest-bearing bank account. Any interest earned on the special revenue fund must be used in a way that is consistent with this MOA.

E. Opioid Remediation Activities.

1. Limitation on use of funds. Local Governments shall expend Opioid Settlement Funds only for opioid-related expenditures consistent with the terms of this MOA and incurred after the date of the Local Government's execution of this MOA, unless execution of the National Settlement Agreement requires a later date.

2. Opportunity to cure inconsistent expenditures. If a Local Government spends any Opioid Settlement Funds on an expenditure inconsistent with the terms of this MOA, the Local Government shall have 60 days after discovery of the expenditure to cure the inconsistent expenditure through payment of such amount for opioid remediation activities through budget amendment or repayment.

3. Consequences of failure to cure inconsistent expenditures. If a Local Government does not make the cure required by **Section E.2** above within 60 days, (i) future Opioid Fund payments to that Local Government shall be reduced by an amount equal to the inconsistent expenditure, and (ii) to the extent the inconsistent expenditure is greater than the expected future stream of payments to the Local Government, the Attorney General may initiate a process up to and including litigation to recover and redistribute the overage among all eligible Local Governments. The Attorney General may recover any litigation expenses incurred to recover the funds. Any recovery or redistribution shall be distributed consistent with **Sections B.3 and B.4** above.

4. Annual meeting of counties and municipalities within each county. Each county receiving Opioid Settlement Funds shall hold at least one annual meeting with all municipalities in the Local Government's county invited in order to receive input as to proposed uses of the Opioid Settlement Funds and to encourage collaboration between local governments both within and beyond the county. These meetings shall be open to the public.

5. Use of settlement funds under Option A and Option B. Local Governments shall spend Opioid Settlement Funds from the Local Abatement Funds on opioid remediation activities using either or both of the processes described as Option A and Option B below, unless the relevant National Settlement Agreement or Bankruptcy Resolution further limit the spending.

a. Option A.

i. Without any additional strategic planning beyond the meeting described in **Section E.4** above, Local Governments may spend Opioid Settlement Funds from the list of High-Impact Opioid Abatement Strategies attached as **Exhibit A**. This list is a subset of the initial opioid remediation strategies listed in the National Settlement Agreement.

ii. **Exhibit A** may be modified as set forth in Exhibit D below; provided, however, that any strategy listed on **Exhibit A** must be within the list of opioid remediation activities for the then-current National Settlement Agreement. Opioid remediation activities undertaken under a previously authorized strategy list may continue if they were authorized at the time of the Local Government's commitment to spend funds on that activity.

b. Option B.

i. A Local Government that chooses to participate in additional voluntary, collaborative, strategic planning may spend Opioid Settlement Funds from the broader list of categories found in **Exhibit B**. This list contains all the initial opioid remediation strategies listed in the National Settlement Agreement.

ii. Before spending any funds on any activity listed in **Exhibit B**, but not listed on **Exhibit A**, a Local Government must first engage in the collaborative strategic planning process described in **Exhibit C**. This process shall result in a report and non-binding recommendations to the Local Government's Governing Body described in **Exhibit C** (right-hand column).

iii. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** and wishes to continue implementing a strategy listed in **Exhibit B**, but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process every four years (or more often if desired).

iv. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** that wishes to implement a new strategy listed in **Exhibit B** but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process.

v. Two or more Local Governments may undertake a single collaborative strategic planning process resulting in a report and recommendations to all of the Local Governments involved.

6. Process for drawing from special revenue funds.

   a. Budget item or resolution required. Opioid Settlement Funds can be used for a purpose when the Governing Body includes in its budget or passes a separate resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for that purpose or those purposes during a specified period of time.

   b. Budget item or resolution details. The budget or resolution should (i) indicate that it is an authorization for expenditure of opioid settlement funds; (ii) state the specific strategy or strategies the county or municipality intends to fund pursuant to Option A or Option B, using the item letter and/or number in **Exhibit A** or **Exhibit B** to identify each funded strategy, and (iii) state the amount dedicated to each strategy for a stated period of time.

7. Coordination group. A coordination group with the composition and responsibilities described in **Exhibit D** shall meet at least once a year during the first three years that this MOA is in effect. Thereafter, the coordination group shall meet at least once every three years until such time as Opioid Settlement Funds are no longer being spent by Local Governments.

F. Auditing, Compliance, Reporting, and Accountability

1. Audits under Local Government Budget and Fiscal Control Act. Local Governments' Opioid Settlement Funds are subject to financial audit by an independent certified public accountant in a manner no less than what is required under G.S. 159-34. Each Local Government must file an annual financial audit of the Opioid Settlement Funds with the Local Government Commission. If any such audit reveals an expenditure inconsistent with the terms of this MOA, the Local Government shall immediately report the finding to the Attorney General.

2. Audits under other acts and requirements. The expenditure of Opioid Settlement Funds is subject to the requirements of the Local Government Budget and Fiscal Control Act, Chapter 159 of the North Carolina General Statutes; Local Government Commission rules; the Federal Single Audit Act of 1984 (as if the Opioid Settlement Funds were federal funds); the State Single Audit Implementation Act; Generally Accepted Government Auditing Standards; and all other applicable laws, rules, and accounting standards. For expenditures for which no compliance audit is required under the Federal Single Audit Act of 1984, a compliance audit shall be required under a compliance supplement approved by the coordination group.

3. Audit costs. Reasonable audit costs that would not be required except for this Section F may be paid by the Local Government from Opioid Settlement Funds..

4. Access to persons and records. During and after the term of this MOA, the State Auditor and Department of Justice shall have access to persons and records related to this MOA and expenditures of Opioid Settlement Funds to verify accounts and data affecting fees or

performance. The Local Government manager/administrator is the point of contact for questions that arise under this MOA.

5. Preservation of records. The Local Government must maintain, for a period of at least five years, records of Opioid Settlement Fund expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA.

6. Reporting.

   a. Annual financial report required. In order to ensure compliance with the opioid remediation provisions of the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA, for every fiscal year in which a Local Government receives, holds, or spends Opioid Settlement Funds, the county or municipality must submit an annual financial report specifying the activities and amounts it has funded.

   b. Annual financial report timing and contents. The annual financial report shall be provided to the North Carolina Attorney General by emailing the report to opioiddocs@ncdoj.gov, within 90 days of the last day of the state fiscal year covered by the report. Each annual financial report must include the information described on **Exhibit E**.

   c. Reporting to statewide opioid settlement dashboard. Each Local Government must provide the following information to the statewide opioid settlement dashboard within the stated timeframes:

      i. The budget or resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for a specific purpose or purposes during a specified period of time as described in **Section E.6.b** above (within 90 days of the passage of any such budget or resolution);
      ii. If the Local Government is using Option B, the report(s) and non-binding recommendations from collaborative strategic planning described in **Section E.5.b.ii** above and **Exhibit C** (right hand column) (within 90 days of the date the report and recommendations are submitted to the local governing body for consideration);
      iii. The annual financial reports described in Section F.6.a and **Exhibit E** (within 90 days of the end of the fiscal year covered by the report); and
      iv. The impact information described in **Exhibit F** (within 90 days of the end of the fiscal year covered by the report).

   The State will create an online portal with instructions for Local Governments to report or upload each of these four items by electronic means.

d. Copy to NCDOJ of any additional reporting. If the National Settlement Agreement or any Bankruptcy Resolutions require that a Local Government file, post, or provide a report or other document beyond those described in this MOA, or if any Local Government communicates in writing with any national administrator or other entity created or authorized by the National Settlement Agreement or any Bankruptcy Resolutions regarding the Local Government's compliance with the National Settlement Agreement or Bankruptcy Resolutions, the Local Government shall email a copy of any such report, document, or communication to the North Carolina Department of Justice at opioiddocs@ncdoj.gov.

e. Compliance and non-compliance.

i. Every Local Government shall make a good faith effort to comply with all of its reporting obligations under this MOA, including the obligations described in **Section F.6.c** above.

ii. A Local Government that engages in a good faith effort to comply with its reporting obligations under **Section F.6.c** but fails in some way to report information in an accurate, timely, or complete manner shall be given an opportunity to remedy this failure within a reasonable time.

iii. A Local Government that does not engage in a good faith effort to comply with its reporting obligations under this MOA, or that fails to remedy reporting issues within a reasonable time, may be subject to action for breach of contract.

iv. Notwithstanding anything to the contrary herein, a Local Government that is in substantial compliance with the reporting obligations in this MOA shall not be considered in breach of this MOA or in breach of contract.

7. Collaboration. The State and Local Governments must collaborate to promote effective use of Opioid Settlement Funds, including through the sharing of expertise, training, technical assistance. They will also coordinate with trusted partners to collect and share information about successful regional and other high-impact strategies and opioid treatment programs.

G. County Incentive Fund

A Local Government receiving Settlement Proceeds pursuant to **Section B.4.a** shall be an Incentive Eligible Local Government if every municipality in the Local Government's county with population of at least 30,000 has executed this MOA by October 1, 2021, but no later than any such deadline set in the National Settlement Agreement for the highest possible participation in incentive structures for North Carolina. Each Incentive Eligible Local Government shall receive a share of the 5% County Incentive Fund set forth in **Section B.2.iii**, distributed pro rata among only Incentive Eligible Local Governments as set forth in **Exhibit G**. For purposes of the calculations required by this Section, populations will be based on United States Census Bureau's Vintage 2019 population totals, and a municipality with populations in multiple counties will be counted only toward the county which has the largest share of that municipality's population.

H. Effectiveness

1. When MOA takes effect. This MOA shall become effective at the time a sufficient number of Local Governments have joined the MOA to qualify this MOA as a State-Subdivision Agreement under the National Settlement Agreement or any Bankruptcy Resolution. If this MOA does not thereby qualify as a State-Subdivision Agreement, this MOA will have no effect.

2. Amendments to MOA.

    a. Amendments to conform to final national documents. The Attorney General, with the consent of a majority vote from a group of Local Government attorneys appointed by the Association of County Commissioners, may initiate a process to amend this MOA to make any changes required by the final provisions of the National Settlement Agreement or any Bankruptcy Resolution. The Attorney General's Office will provide written notice of the necessary amendments to all the previously joining parties. Any previously joining party will have a two-week opportunity to withdraw from the MOA. The amendments will be effective to any party that does not withdraw.

    b. Coordination group. The coordination group may make the changes authorized in **Exhibit D**.

    c. No amendments to allocation between Local Governments. Notwithstanding any other provision of this MOA, the allocation proportions set forth in **Exhibit G** may not be amended.

    d. General amendment power. After execution, the coordination group may propose other amendments to the MOA, subject to the limitation in **Section H.2.c** above. Such amendments will take effect only if approved in writing by the Attorney General and at least two-thirds of the Local Governments who are Parties to this MOA. In the vote, each Local Government Party will have a number of votes measured by the allocation proportions set forth in **Exhibit G**.

3. Acknowledgement. The Parties acknowledge that this MOA is an effective and fair way to address the needs arising from the public health crisis due to the misconduct committed by the Pharmaceutical Supply Chain Participants.

4. When MOA is no longer in effect. This MOA is effective until one year after the last date on which any Opioid Settlement Funds are being spent by Local Governments pursuant to the National Settlement Agreement and any Bankruptcy Resolution.

5. Application of MOA to settlements and bankruptcy resolutions. This MOA applies to all settlements under the National Settlement Agreement with the Settling Defendants and any Bankruptcy Resolutions. The Parties agree to discuss the use, as the Parties may deem appropriate in the future, of the settlement terms set out herein (after any necessary

amendments) for resolutions with Pharmaceutical Supply Chain Participants not covered by the National Settlement Agreement or a Bankruptcy Resolution.

6. Applicable law and venue. Unless required otherwise by the National Settlement Agreement or a Bankruptcy Resolution, this MOA shall be interpreted using North Carolina law and any action related to the provisions of this MOA must be adjudicated by the Superior Court of Wake County. If any provision of this MOA is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision which can be given effect without the invalid provision.

7. Scope of MOA. The Parties acknowledge that this MOA does not excuse any requirements placed upon them by the terms of the National Settlement Agreement or any Bankruptcy Resolution, except to the extent those terms allow for a State-Subdivision Agreement to do so.

8. No third party beneficiaries. No person or entity is intended to be a third party beneficiary of this MOA.

9. No effect on authority of parties. Nothing in this MOA shall be construed to affect or constrain the authority of the Parties under law.

10. Signing and execution of MOA. This MOA may be signed and executed simultaneously in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this MOA. Each person signing this MOA represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this MOA, and that all necessary approvals and conditions precedent to his or her execution have been satisfied.

(Signature pages follow.)

Signature pages will be structured as one page for the State of North Carolina, followed by separate signature pages for each county.

These signature pages will also include blanks for the county's municipalities.

To avoid having 101 signature pages in the middle of this file, the signature pages are in a separate document.

EXHIBIT A TO NC MOA:
HIGH-IMPACT OPIOID ABATEMENT STRATEGIES ("OPTION A" List)

In keeping with the National Settlement Agreement, opioid settlement funds may support programs or services listed below that serve persons with Opioid Use Disorder (OUD) or any co-occurring Substance Use Disorder (SUD) or mental health condition.

As used in this list, the words "fund" and "support" are used interchangeably and mean to create, expand, or sustain a program, service, or activity.

1. **Collaborative strategic planning.** Support collaborative strategic planning to address opioid misuse, addiction, overdose, or related issues, including staff support, facilitation services, or any activity or combination of activities listed in Exhibit C to the MOA (collaborative strategic planning).

2. **Evidence-based addiction treatment.** Support evidence-based addiction treatment consistent with the American Society of Addiction Medicine's national practice guidelines for the treatment of opioid use disorder – including Medication-Assisted Treatment (MAT) with any medication approved for this purpose by the U.S. Food and Drug Administration – through Opioid Treatment Programs, qualified providers of Office-Based Opioid Treatment, Federally Qualified Health Centers, treatment offered in conjunction with justice system programs, or other community-based programs offering evidence-based addiction treatment. This may include capital expenditures for facilities that offer evidence-based treatment for OUD. (If only a portion of a facility offers such treatment, then only that portion qualifies for funding, on a pro rata basis.)

3. **Recovery support services.** Fund evidence-based recovery support services, including peer support specialists or care navigators based in local health departments, social service offices, detention facilities, community-based organizations, or other settings that support people in treatment or recovery, or people who use drugs, in accessing addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.

4. **Recovery housing support.** Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities; or fund recovery housing programs that provide housing to individuals receiving Medication-Assisted Treatment for opioid use disorder.

5. **Employment-related services.** Fund programs offering employment support services to people in treatment or recovery, or people who use drugs, such as job training, job skills, job placement, interview coaching, resume review, professional attire, relevant courses at community colleges or vocational schools, transportation services or transportation vouchers to facilitate any of these activities, or similar services or supports.

6. **Early intervention.** Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions, including Youth Mental Health

First Aid, peer-based programs, or similar approaches. Training programs may target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents.

7. **Naloxone distribution.** Support programs or organizations that distribute naloxone to persons at risk of overdose or their social networks, such as Syringe Service Programs, post-overdose response teams, programs that provide naloxone to persons upon release from jail or prison, emergency medical service providers or hospital emergency departments that provide naloxone to persons at risk of overdose, or community-based organizations that provide services to people who use drugs. Programs or organizations involved in community distribution of naloxone may, in addition, provide naloxone to first responders.

8. **Post-overdose response team.** Support post-overdose response teams that connect persons who have experienced non-fatal drug overdoses to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.

9. **Syringe Service Program.** Support Syringe Service Programs operated by any governmental or nongovernmental organization authorized by section 90-113.27 of the North Carolina General Statutes that provide syringes, naloxone, or other harm reduction supplies; that dispose of used syringes; that connect clients to prevention, treatment, recovery support, behavioral healthcare, primary healthcare, or other services or supports they need; or that provide any of these services or supports.

10. **Criminal justice diversion programs.** Support pre-arrest or post-arrest diversion programs, or pre-trial service programs, that connect individuals involved or at risk of becoming involved in the criminal justice system to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, or other services or supports they need, or that provide any of these services or supports.

11. **Addiction treatment for incarcerated persons.** Support evidence-based addiction treatment, including Medication-Assisted Treatment with at least one FDA-approved opioid agonist, to persons who are incarcerated in jail or prison.

12. **Reentry Programs.** Support programs that connect incarcerated persons to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need upon release from jail or prison, or that provide any of these services or supports.

EXHIBIT B TO NC MOA:

Additional Opioid Remediation Activities ("OPTION B" List)

This list shall be automatically updated to match the list of approved strategies in the most recent National Settlement Agreement.

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[1]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

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[1] As used in this Exhibit B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

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

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

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

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

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice

system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

c. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

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

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

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

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

    a. Increase the number of prescribers using PDMPs;

    b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

    c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

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

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

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities that provide free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H of this Exhibit relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend Opioid Settlement Funds; to show how Opioid Settlement Funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT C to NC MOA:
COLLABORATIVE STRATEGIC PLANNING PROCESS UNDER OPTION B

	ACTIVITY NAME	ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
A	Engage diverse stakeholders	Engage diverse stakeholders, per "ITEM A DETAIL" below, throughout the collaborative strategic planning process	Report on stakeholder engagement per "ITEM A DETAIL" below
B	Designate facilitator	Designate a person or entity to facilitate the strategic collaborative planning process. Consider a trained, neutral facilitator.	Identify the facilitator
C	Build upon any related planning	Build upon or coordinate with prior or concurrent planning efforts that address addiction, drug misuse, overdose, or related issues, including but not limited to community health assessments.	Report any related planning efforts you will build upon or coordinate with
D	Agree on shared vision	Agree on a shared vision for positive community change, considering how strategic investments of Opioid Settlement Funds have the potential to improve community health and well-being and address root causes of addiction, drug misuse, overdose, and related issues	Report on shared vision for positive community change
E	Identify key indicator(s)	Identify one or more population-level measures to monitor in order to gauge progress towards the shared vision. (The NC Opioid Action Plan Data Dashboard contains several such measures.)	Report on the key indicators selected
F	Identify and explore root causes	Explore root causes of addiction, drug misuse, overdose, and related issues in the community, using quantitative data as well as stakeholder narratives, community voices, the stories of those with lived experience, or similar qualitative information	Report on root causes as described
G	Identify and evaluate potential strategies	Identify potential strategies to address root causes or other aspects of the opioid epidemic; identify these strategies (by letter or number) on EXHIBIT A or EXHIBIT B, and consider the effectiveness of each strategy based on available evidence	Identify and evaluate potential strategies
H	Identify gaps in existing efforts	For each potential strategy identified (or for favored strategies), survey existing programs, services, or supports that address the same or similar issues; and identify gaps or shortcomings	Report on survey of and gaps in existing efforts
I	Prioritize strategies	Prioritize strategies, taking into account your shared vision, analysis of root causes, evaluation of each strategy, and analysis of gaps in existing efforts	Report on prioritization of strategies
J	Identify goals, measures, and evaluation plan	For each strategy (or favored strategy), develop goals and an evaluation plan that includes at least one process measure (How much did you do?), at least one quality measure (How well did you do it?), and at least one outcome measure (Is anyone better off?)	Report on goals, measures, and evaluation plan for each chosen strategy
K	Consider ways to align strategies	For each potential strategy identified (or for favored strategies), consider opportunities to braid Opioid Settlement Funds with other funding streams; develop regional solutions; form strategic partnerships; or to pursue other creative solutions	Report on opportunities to align strategies as described
L	Identify organizations	Identify organizations and agencies with responsibility to implement each strategy; and identify the human, material, and capital resources to implement each strategy	Identify organizations and needs to implement each strategy

M	Develop budgets and timelines	Develop a detailed global budget for each strategy with anticipated expenditures, along with timelines for completing components of each strategy	Report budgets and timelines for each strategy
N	Offer recommen-dations	Offer recommendations to local governing body (e.g., the county board, city council, or other local governing body)	Report recommendations to governing body

ITEM A DETAIL: STAKEHOLDER INVOLVEMENT			
	STAKE-HOLDERS	**DESCRIPTION**	**CONTENT OF REPORT & RECOMMENDATIONS**
A-1	Local officials	County and municipal officials, such as those with responsibility over public health, social services, and emergency services	Report stakeholder involvement (who and how involved in process)
A-2	Healthcare providers	Hospitals and health systems, addiction professionals and other providers of behavioral health services, medical professionals, pharmacists, community health centers, medical safety net providers, and other healthcare providers	same as above
A-3	Social service providers	Providers of human services, social services, housing services, and community health services such as harm reduction, peer support, and recovery support services	same
A-4	Education and employment service providers	Educators, such as representatives of K-12 schools, community colleges, and universities; and those providing vocational education, job skills training, or related employment services	same
A-5	Payers and funders	Health care payers and funders, such as managed care organizations, prepaid health plans, LME-MCOs, private insurers, and foundations	same
A-6	Law enforcement	Law enforcement and corrections officials	same
A-7	Employers	Employers and business leaders	same
A-8	Community groups	Community groups, such as faith communities, community coalitions that address drug misuse, groups supporting people in recovery, youth leadership organizations, and grassroots community organizations	same
A-9	Stakeholders with "lived experience"	Stakeholders with "lived experience," such as people with addiction, people who use drugs, people in medication-assisted or other treatment, people in recovery, people with criminal justice involvement, and family members or loved ones of the individuals just listed	same
A-10	Stakeholders reflecting diversity of community	Stakeholders who represent the racial, ethnic, economic, and cultural diversity of the community, such as people of color, Native Americans, members of the LGBTQ community, and members of traditionally unrepresented or underrepresented groups	same

EXHIBIT D TO NC MOA:
COORDINATION GROUP

COMPOSITION

The Coordination Group shall consist of the following twelve members:

Five Local Government Representatives

- Four appointed by the North Carolina Association of County Commissioners including:
  - One county commissioner
  - One county manager
  - One county attorney
  - One county local health director or consolidated human services director
- One municipal manager appointed by the North Carolina League of Municipalities

Four Experts Appointed by the Department of Health and Human Services

- Four appointed by the Secretary of the Department of Health and Human Services, having relevant experience or expertise with programs or policies to address the opioid epidemic, or with behavioral health, public health, health care, harm reduction, social services, or emergency services.

One Expert Appointed by the Attorney General

- One appointed by the Attorney General of North Carolina from the North Carolina Department of Justice or another state agency, having drug policy or behavioral health experience or expertise.

Two Experts Appointed by Legislative Leaders

- One representative from the University of North Carolina School of Government with relevant expertise appointed by the Speaker of the North Carolina House of Representatives.
- One representative from the board or staff of the North Carolina Institute of Medicine with relevant expertise appointed by the President Pro Tem of the North Carolina Senate.

The coordination group may appoint a non-voting administrator to convene meetings and facilitate the work of the coordination group. The administrator will not be paid from the Opioid Settlement Funds distributed under this MOA.

Appointees shall have relevant experience or expertise with programs or policies to address the opioid epidemic, behavioral health, public health, health care, social services, emergency services, harm reduction, management of local government, or other relevant areas.

Those responsible for making appointments to the coordination group are encouraged to appoint individuals who reflect the diversity of North Carolina, taking into consideration the need for geographic diversity; urban and rural perspectives; representation of people of color and

traditionally underrepresented groups; and the experience and perspective of persons with "lived experience." Those responsible for making appointments may appoint a successor or replace a member at any time. Members of the coordination group serve until they resign or are replaced by the appointer. Eight members of the coordination group constitutes a quorum.

RESPONSIBILITIES

a. As provided in **Section F.2** of the MOA, where no compliance audit would be required under the Federal Single Audit Act of 1984 for expenditures of Opioid Settlement Funds, a compliance audit shall be required under a compliance supplement established by a vote of at least 8 members of the coordination group. The compliance supplement shall address, at least, procedures for determining:

   i. Whether the Local Government followed the procedural requirements of the MOA in ordering the expenditures.

   ii. Whether the Local Government's expenditures matched one of the types of opioid-related expenditures listed in **Exhibit A** of the MOA (if the Local Government selected Option A) or **Exhibit B** of the MOA (if the Local Government selected Option B).

   iii. Whether the Local Government followed the reporting requirements in the MOA.

   iv. Whether the Local Government (or sub-recipient of any grant or loan, if applicable) utilized the awarded funds for their stated purpose, consistent with this MOA and other relevant standards.

   v. Which processes (such as sampling) shall be used:
      i. To keep the costs of the audit at reasonable levels; and
      ii. Tailor audit requirements for differing levels of expenditures among different counties.

b. The coordination group may, by a vote of at least 8 members, propose amendments to the MOA as discussed in **Section H** of the MOA or modify any of the following:

   i. The high-impact strategies discussed in **Section E.5** of the MOA and described in **Exhibit A** to the MOA;

   ii. The collaborative strategic planning process discussed in **Section E.5** of the MOA and described in **Exhibit C** to the MOA;

   iii. The annual financial report discussed in **Section F.4** of the MOA and described in **Exhibit E** to the MOA;

   iv. The impact information discussed in **Section F.4** of the MOA and described in **Exhibit F** to the MOA; or

   v. Other information reported to the statewide opioid dashboard.

c. The coordination group may, by consensus or by vote of a majority of members present and voting, work with the parties to this MOA, the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, other associations, foundations, non-profits, and other government or nongovernment entities to provide support to Local Governments in their efforts to effectuate the goals and implement the terms of this MOA. Among other activities, the coordination group may coordinate, facilitate, support, or participate in any of the following activities:

   i. Providing assistance to Local Governments in identifying, locating, collecting, analyzing, or reporting data used to help address the opioid epidemic or related challenges, including data referred to in **Exhibit F**;

   ii. Developing resources or providing training or technical assistance to support Local Governments in addressing the opioid epidemic and carrying out the terms of this MOA;

   iii. Developing pilot programs, trained facilitators, or other resources to support the collaborative strategic planning process described in this MOA;

   iv. Developing and implementing a voluntary learning collaborative among Local Governments and others to share best practices in carrying out the terms of this MOA and addressing the opioid epidemic, including in-person or virtual convenings or connections;

   v. Developing voluntary leadership training programs for local officials on strategies to address the opioid epidemic, opportunities for Local Governments to harness the ongoing transition to value-based healthcare, and other relevant topics;

   vi. Taking other actions that support Local Governments in their efforts to effectuate the goals and implement the terms of this MOA but do not in any way change the terms of this MOA or the rights or obligations of parties to this MOA.

EXHIBIT E TO NC MOA:
ANNUAL FINANCIAL REPORT

Each annual financial report must include the following financial information:

1. The amount of Opioid Settlement Funds in the special revenue fund at the beginning of the fiscal year (July 1).
2. The amount of Opioid Settlement Funds received during the fiscal year.
3. The amount of Opioid Settlement Funds disbursed or applied during the fiscal year, broken down by funded strategy (with any permissible common costs prorated among strategies).
4. The amount of Opioid Settlement Funds used to cover audit costs as provided in Section F.3 of this MOA.
5. The amount of Opioid Settlement Funds in the special revenue fund at the end of the fiscal year (June 30).

All Local Governments that receive two-tenths of one percent (0.2 percent) or more of the total Local Government Allocation as listed in **Exhibit G** shall provide the following additional information:

6. For all Opioid Settlement Funds disbursed or applied during the fiscal year as reported in item 3 above, a single breakdown of the total amount disbursed or applied for all funded strategies during the fiscal year into the following categories:
   a. Human resource expenditures.
   b. Subcontracts, grants, or other payments to sub-recipients involved in implementing of the funded strategies listed item 4 above.
   c. Operational expenditures.
   d. Capital expenditures.
   e. Other expenditures.

7. With respect to item 6.b above, the Local Government shall provide the following information for any sub-recipient that receives ten percent or more of the total amount that the Local Government disbursed or applied during the fiscal year:
   a. The name of the sub-recipient.
   b. The amount received by the sub-recipient during the fiscal year.
   c. A very brief description of the goods, services, or other value provided by the sub-recipient (for example, "addiction treatment services" or "peer-support services" or "syringe service program" or "naloxone purchase").

The coordination group may clarify or modify specifications for this annual financial report as provided in Exhibit D.

EXHIBIT F TO NC MOA:
IMPACT INFORMATION

Within 90 days of the end of any fiscal year in which a Local Government expends Opioid Settlement Funds, the Local Government shall report impact information for each strategy that it funded with Opioid Settlement Funds during that fiscal year ("funded strategy"), using the STANDARD FORM or the SHORT FORM for each funded strategy.

The STANDARD FORM is recommended to all Local Governments for all funded strategies. However, Local Governments may use the SHORT FORM as follows:

- All Local Governments that receive less than 0.2 percent (two-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** may use the SHORT FORM for all funded strategies.

- All Local Governments that receive 0.2 percent (two-tenths of one percent) or more but less than 0.3 percent (three-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** must use the STANDARD FORM for the funded strategy that received the largest amount of settlement funds during the fiscal year and may use the SHORT FORM for all other funded strategies.

- All Local Governments that receive 0.3 percent (three-tenths of one percent) or more but less than 0.4 percent (four-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** must use the STANDARD FORM for the two funded strategies that received the largest amount of settlement funds during the fiscal year and may use the SHORT FORM for all other funded strategies.

STANDARD FORM

1. County or municipality and fiscal year covered by this report.

2. Name, title, and organization of person completing this report.

3. Name of funded strategy, letter and/or number of funded strategy on **Exhibit A** or **Exhibit B** to the MOA, and number and date of resolution(s) authorizing expenditure of settlement funds on funded strategy.

4. **Brief progress report** describing the funded strategy and progress made during the fiscal year. Recommended length: approximately one page (250 words).

5. **Brief success story** from a person who has benefitted from the strategy (de-identified unless the person has agreed in writing to be identified). Recommended length: approximately one page (250 words).

6. **One or more process measures,** addressing the question, "How much did you do?" Examples: number of persons enrolled, treated, or served; number of participants trained; units of naloxone or number of syringes distributed.

7. **One or more quality measures,** addressing the question, "How well did you do it?" Examples: percentage of clients referred to care or engaged in care; percentage of staff with

certification, qualification, or lived experience; level of client or participant satisfaction shown in survey data.

8. **One or more outcome measures,** addressing the question, "Is anyone better off?" Examples: number or percentage of clients with stable housing or employment; self-reported measures of client recovery capital, such as overall well-being, healthy relationships, or ability to manage affairs; number or percentage of formerly incarcerated clients receiving community services or supports within X days of leaving jail or prison.

9. In connection with items 6, 7, and 8 above, **demographic information** on the participation or performance of people of color and other historically marginalized groups.

The State will provide counties and municipalities with recommended measures and sources of data for common opioid remediation strategies such as those listed in **Exhibit A**.

Counties or municipalities that have engaged in collaborative strategic planning are encouraged to use the measures for items 6 through 8 above identified through that process.

SHORT FORM

1. County or municipality and fiscal year covered by this report.

2. Name, title, and organization of person completing this report.

3. Name of funded strategy, letter and/or number of funded strategy on **Exhibit A** or **Exhibit B** to the MOA, and number and date of resolution(s) authorizing expenditure of settlement funds on strategy.

4. **Brief progress report** describing the funded strategy and progress made on the funded strategy during the fiscal year. Recommended length: approximately one-half to one page (125-250 words).

EXHIBIT G TO NC MOA:
LOCAL GOVERNMENT ALLOCATION PROPORTIONS

Counties:

Alamance	1.378028967612490%
Alexander	0.510007879580514%
Alleghany	0.149090598929352%
Anson	0.182192960366522%
Ashe	0.338639188321974%
Avery	0.265996766935006%
Beaufort	0.477888434887858%
Bertie	0.139468575095652%
Bladen	0.429217809476617%
Brunswick	2.113238507591200%
Buncombe	2.511587857322730%
Burke	2.090196827047270%
Cabarrus	1.669573446626000%
Caldwell	1.276301146194650%
Camden	0.073036400412663%
Carteret	1.128465593852300%
Caswell	0.172920237524674%
Catawba	2.072695222699690%
Chatham	0.449814383077585%
Cherokee	0.782759152904478%
Chowan	0.113705596126821%
Clay	0.224429948904576%
Cleveland	1.119928027749120%
Columbus	1.220936938986050%
Craven	1.336860190247190%
Cumberland	2.637299659634610%
Currituck	0.186778551294444%
Dare	0.533126731273811%
Davidson	1.940269530393250%
Davie	0.513147526867745%
Duplin	0.382785147396895%
Durham	1.797994362444460%
Edgecombe	0.417101939026669%
Forsyth	3.068450809484740%
Franklin	0.500503643290578%
Gaston	3.098173886907710%
Gates	0.079567516632414%
Graham	0.183484561708488%
Granville	0.590103409340146%

Greene	0.123274818647799%
Guilford	3.375015231147900%
Halifax	0.453161173976264%
Harnett	0.988980772198890%
Haywood	0.803315110111045%
Henderson	1.381595087040930%
Hertford	0.206843050128754%
Hoke	0.332485804570157%
Hyde	0.027237354085603%
Iredell	2.115931374540020%
Jackson	0.507757731330674%
Johnston	1.250887468217670%
Jones	0.087966986994631%
Lee	0.653115683614534%
Lenoir	0.604282592625687%
Lincoln	0.926833627125253%
Macon	0.466767666100745%
Madison	0.237776496104888%
Martin	0.232882220579515%
McDowell	0.587544576492856%
Mecklenburg	5.038301259920550%
Mitchell	0.309314151564137%
Montgomery	0.226050543041193%
Moore	0.971739112775481%
Nash	0.845653639635102%
New Hanover	2.897264892001010%
Northampton	0.120996238921878%
Onslow	1.644001364710850%
Orange	1.055839419023090%
Pamlico	0.119936151028001%
Pasquotank	0.374816210815334%
Pender	0.585749331860312%
Perquimans	0.111833180344914%
Person	0.403024296727131%
Pitt	1.369008066415930%
Polk	0.266142985954851%
Randolph	1.525433986174180%
Richmond	0.749132839979529%
Robeson	1.359735343574080%
Rockingham	1.365368837477560%
Rowan	2.335219287913370%
Rutherford	0.928941617994687%
Sampson	0.619513740526226%
Scotland	0.449148274209402%

Stanly	0.724974208589555%
Stokes	0.623953112434303%
Surry	1.410826706091650%
Swain	0.281162928604502%
Transylvania	0.497595509451435%
Tyrrell	0.041440907207785%
Union	1.466702679869700%
Vance	0.536258255282162%
Wake	4.902455667205510%
Warren	0.106390583495122%
Washington	0.074770720453604%
Watauga	0.469675799939888%
Wayne	0.970699333078804%
Wilkes	1.997177160589100%
Wilson	0.646470841490459%
Yadkin	0.562147145073638%
Yancey	0.382114976889272%

Municipalities:

Asheville	0.235814724255298%
Canton	0.011453823221205%
Cary	0.144151645370137%
Charlotte	1.247483814366830%
Concord	0.227455870287483%
Durham	0.380405026684971%
Fayetteville	0.309769055181433%
Gastonia	0.257763823789835%
Greensboro	0.527391696384329%
Greenville	0.162656474659432%
Henderson	0.032253478794181%
Hickory	0.094875835682315%
High Point	0.206428762905859%
Jacksonville	0.095009869783840%
Raleigh	0.566724612722679%
Wilmington	0.119497493968465%
Winston-Salem	0.494459923803644%

Architectural Contract for 2022 EMS Station Projects

Description

Please see the following Item Summary

Board Action Requested

Authorize the Chairman to execute the Service Order to the Master Agreement and adopt the capital project ordinance.

Item Presenter

David Clawson, Finance Director

<u>Item Summary:</u> Architectural Contract for 2022 EMS Station Projects

The adopted 2022 Capital Improvements Plan and Capital Investment Fund Model includes a debt issuance in 2022 of $18,800,000 for renovations to and the new construction of EMS facilities and for bond costs of issuance. The amount was based on cost estimates in a feasibility study performed by Oakley Collier & Associates in 2019 and updated in 2021.

Earlier this year the County issued an RFP for a master architectural services agreement for projects in the capital improvements plan. Oakley Collier and Associates ("OCA") was selected and a master contract was executed in July.

The first attachment is a Service Order to that Master Agreement to contract with OCA for the design of the EMS facilities work.

Determination of the scope and form of the work is in progress and is not yet known. For example, the Southern Shores, Nags Head, and Rodanthe projects could be either renovations or new construction, and could be County projects or joint projects. Kill Devil Hills could be new construction of a County EMS station or a joint project with the town. For that reason, Oakley Collier is unable to determine a set fee amount and has priced the Service Order at 10% of the "owner's cost of work". We have verified with OCA that owners cost of the work means vertical construction (construction firm's contract price) and does not include 'below the line' items such as owner's costs, owner's contingency, furniture fixtures & equipment, permits, etc…

The 10% fee amount is reasonable and is the same as the DHHS project. Recent project percentages have been:

- Animal Shelter 13.19%
- COA 7.50% large project
- DHHS 10.00%
- RECC/EOC 9.98% not including technology package
- Administration Building 12.61%
- The Dare Center 7.95%
- Hatteras Office 10.41%

The Board is requested to set an initial budget amount of $250,000 in order to start OCA's work.

Staff's estimate of the final fee is $1,562,000. (Construction contract amounts have averaged 85% of the total project, so $18,385,420 of total construction times 85% times 10% equals $1,562,000.)

Board Action: Authorize the Chairman to execute the Service Order to the Master Agreement and adopt the attached capital project ordinance.

AIA® Document B221™ – 2018

Service Order for use with Master Agreement Between Owner and Architect

SERVICE ORDER number 1 made as of the 11th day of August in the year 2021

BETWEEN the Owner:

Dare County
PO Box 1000
Manteo, NC 27954

and the Architect:

Oakley Collier Architects, PA
109 Candlewood Road
Rocky Mount, NC 27804

for the following **PROJECT:**

Dare County Long Term Facility CIP MASTER Project # 21032
8 EMS Stations

1. EMS Station 1- 1632 North Croatan Hwy, Kill Devil Hills, NC 27948
2. EMS Station 2- 515 Bowsertown Road, Manteo, NC 27954
3. EMS Station 3- 50346 Hwy 12, Frisco, NC 27936
4. EMS Station 4- 28 East Dogwood Trail, Southern Shores, NC 27949 (shared space with SS Fire Department)
5. EMS Station 5- 5314 South Croatan Hwy, Nags Head, NC 27959 (shared space with NH Fire Department)
6. EMS Station 6- 24297 Atlantic Drive, Rodanthe, NC 27968 (shared space with Rodanthe Fire Department)
7. EMS Station 7- Dare Med Flight Hanger, 1078 Driftwood Drive, Manteo, NC 27954
8. EMS Station 8- 6677 Hwy 64/264, Manns Harbor, NC 27953

THE SERVICE AGREEMENT
This Service Order, together with the Master Agreement between Owner and Architect dated the 12th day of July in the year 2021

form a Service Agreement.

The Owner and Architect agree as follows.

ADDITIONS AND DELETIONS:
The author of this document has added information needed for its completion. The author may also have revised the text of the original AIA standard form. An *Additions and Deletions Report* that notes added information as well as revisions to the standard form text is available from the author and should be reviewed. A vertical line in the left margin of this document indicates where the author has added necessary information and where the author has added to or deleted from the original AIA text.

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

This document provides the Architect's scope of services for the Service Order only and is intended to be used with AIA Document B121™–2018, Standard Form of Master Agreement Between Owner and Architect

Init.
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TABLE OF ARTICLES

ARTICLE 1 INITIAL INFORMATION

§ 1.1 Unless otherwise provided in an exhibit to this Service Order, this Service Order and the Service Agreement are based on the Initial Information set forth below:

EMS Station 1. This will be a replacement facility with joint use with the Town of Kill Devil Hills. It is contemplated the facility will house County EMS & Town Fire Department. This project will be on hold until the County & Town have discussed scope and delivery method.
EMS Station 2. This shall be a complete renovation and refurbishment of the facility, with expansion of the public area, and additional sleeping areas. The on site parking shall be expanded as the available site area allows.
EMS Station 3. This shall be a complete renovation and refurbishment of the facility, with expansion of the public area, and additional sleeping areas. The on site parking shall be expanded as the available site area allows.
EMS Station 4. This shall be a complete remodel or a replacement station with space for the Town of Southern Shores. OCA shall provide two sketches depicting the Remodel and Replacement for the County to discuss with Southern Shores. Once a direction is known, OCA shall design the final solution.
EMS Station 5. This station will need to be an expansion to the Town owned Fire Station to accommodate the EMS crew or a New Facility for the County EMS. OCA shall provide a concept sketch for expansion of the existing Fire Stations.
EMS Station 6. This shall be a new station located on property owned by the Local Fire Department. OCA shall provide concept sketches that will include the Fire Department and a sketch of how to reorganize the site to accommodate a new EMS and expansion of the existing Fire Station.
EMS Station 7. OCA shall provide several different site sketches of how, and where to locate and expand the Crew quarters as well as the Med Flight Hanger.
EMS Station 8. This will be a complete remodel refurbishment with expansion of the Bays and Sleeping area. Additionally, we shall explore expansion and possible renovations to the existing Fire Department & Community Center.

§ 1.2 The Owner and Architect may rely on the Initial Information. Both parties, however, recognize that such information may materially change and, in that event, the Owner and the Architect shall appropriately adjust the schedule, the Architect's services, and the Architect's compensation. The Owner shall adjust the Owner's budget for the Cost of the Work and the Owner's anticipated design and construction milestones, as necessary, to accommodate material changes in the Initial Information.

ARTICLE 2 SERVICES UNDER THIS SERVICE ORDER

§ 2.1 The Architect's Services under this Service Order are described below or in an exhibit to this Service Order, such as a Scope of Architect's Services document.

§ 2.1.1 Basic Services

(Paragraph deleted)

OCA shall provide initial preliminary concepts for the various options as outlined above. Once a decision is reached on a concept, OCA shall provide the necessary Architectural and Engineering documents to accomplish the projects.

§ 2.1.2 Additional Services

(Paragraph deleted)

Additional Services shall be as described in the Standard Master Agreement.

ARTICLE 3 DATE OF COMMENCEMENT AND SUBSTANTIAL COMPLETION

§ 3.1 Unless otherwise provided in an exhibit to this Service Order, the Owner's anticipated dates for commencement of construction and Substantial Completion of the Work are set forth below:

.1 Commencement of construction date:

TBD.

.2 Substantial Completion date:

TBD.

ARTICLE 4 COMPENSATION

§ 4.1 For Basic Services described under Section 2.1.1, the Owner shall compensate the Architect as follows:

(Paragraphs deleted)

.1 Percentage Basis

10 (Ten) % of the Owner's budget for the Cost of the Work, as calculated in accordance with Section 4.4.

The fee breaks down as follows:

Schematic Design		20%
Design Development		15%
Construction Documents		35%
Bidding & Negotiation		5%
Construction Administration		25%
	Total	100%

.2 Hourly

Preliminary concept planning shall be completed on an hourly basis. The rates are as outlined in the Master Agreement.

§ 4.2 For Additional Services described under Section 2.1.2 or in the Master Agreement, the Architect shall be compensated in accordance with the Master Agreement unless otherwise set forth below:

(Paragraph deleted)

Ten (10%) of the estimate cost.

§ 4.3 For Reimbursable Expenses described in the Master Agreement, the Architect shall be compensated in accordance with the Master Agreement unless otherwise set forth below:

(Paragraph deleted)

All surveying, geotechnical, and environmental services shall be billed as reimbursable expenses.

§ 4.4 When compensation identified in Section 4.1 is on a percentage basis, progress payments for each phase of Basic Services shall be calculated by multiplying the percentages identified in this Article by the Owner's most recent budget for the Cost of the Work. Compensation paid in previous progress payments shall not be adjusted based on subsequent updates to the Owner's budget for the Cost of the Work.

ARTICLE 5 INSURANCE

§ 5.1 Insurance shall be in accordance with section 3.3 of the Master Agreement, except as indicated below:

See attached COI.

§ 5.2 In addition to insurance requirements in the Master Agreement, the Architect shall carry the following types of insurance.

(Paragraph deleted)

Coverage	Limits
N/A	N/A

ARTICLE 6 PARTY REPRESENTATIVES

§ 6.1 The Owner identifies the following representative in accordance with Section 1.4.1 of the Master Agreement:

Robert Outten, David Clawson, Dustin Peele
Po Box 1000
Manteo, NC 27954
Telephone Number: 252-475-5731
Email: davec@darenc.com, dustin.peele@darenc.com, outten@darenc.com

§ 6.2 The Architect identifies the following representative in accordance with Section 1.5.1 of the Master Agreement:

Timothy Oakley, Ann Collier
109 Candlewood Road
Rocky Mount, NC 27804
Telephone Number: 252-937-2500
Email: toakley@oakleycollier.com, acollier@oakleycollier.com

ARTICLE 7 ATTACHMENTS AND EXHIBITS

§ 7.1 The following attachments and exhibits, if any, are incorporated herein by reference:

.1 AIA Document, B121™-2018, Standard Form of Master Agreement Between Owner and Architect for Services provided under multiple Service Orders;

(Paragraphs deleted)

.3 Other documents:

Certificate of Insurance

This Service Order entered into as of the day and year first written above.

OWNER *(Signature)*	**ARCHITECT** *(Signature)*
Robert Outten County Manager	Timothy Oakley Principal
(Printed name and title)	*(Printed name, title, and license number, if required)*

Init.
/

Additions and Deletions Report for

AIA® Document B221™ – 2018

This Additions and Deletions Report, as defined on page 1 of the associated document, reproduces below all text the author has added to the standard form AIA document in order to complete it, as well as any text the author may have added to or deleted from the original AIA text. Added text is shown underlined. Deleted text is indicated with a horizontal line through the original AIA text.

Note: This Additions and Deletions Report is provided for information purposes only and is not incorporated into or constitute any part of the associated AIA document. This Additions and Deletions Report and its associated document were generated simultaneously by AIA software at 12:16:52 ET on 08/11/2021.

PAGE 1

SERVICE ORDER number ~~made as of the day of in the year~~
~~(In words, indicate day, month, and year.)~~1 made as of the 11th day of August in the year 2021

...

~~*(Name, legal status, address, and other information)*~~
Dare County
PO Box 1000
Manteo, NC 27954

...

~~*(Name, legal status, address, and other information)*~~

Oakley Collier Architects, PA
109 Candlewood Road
Rocky Mount, NC 27804

...

for the following **PROJECT:**

Dare County Long Term Facility CIP MASTER Project # 21032
8 EMS Stations
1. EMS Station 1- 1632 North Croatan Hwy, Kill Devil Hills, NC 27948
2. EMS Station 2- 515 Bowsertown Road, Manteo, NC 27954
3. EMS Station 3- 50346 Hwy 12, Frisco, NC 27936
4. EMS Station 4- 28 East Dogwood Trail, Southern Shores, NC 27949 (shared space with SS Fire Department)

~~(Name, location, and detailed description)~~5. EMS Station 5- 5314 South Croatan Hwy, Nags Head, NC 27959 (shared space with NH Fire Department)

6. EMS Station 6- 24297 Atlantic Drive, Rodanthe, NC 27968 (shared space with Rodanthe Fire Department)
7. EMS Station 7- Dare Med Flight Hanger, 1078 Driftwood Drive, Manteo, NC 27954
8. EMS Station 8- 6677 Hwy 64/264, Manns Harbor, NC 27953

...

This Service Order, together with the Master Agreement between Owner and Architect dated the ~~day of in the year~~
~~(In words, indicate day, month, and year.)~~12th day of July in the year 2021

PAGE 2

~~(State below details of the Project's site and program, Owner's contractors and consultants, Architect's consultants, Owner's budget and schedule, anticipated procurement method, Owner's Sustainable Objective, and other information relevant to the Project.)~~

EMS Station 1. This will be a replacement facility with joint use with the Town of Kill Devil Hills. It is contemplated the facility will house County EMS & Town Fire Department. This project will be on hold until the County & Town have discussed scope and delivery method.

EMS Station 2. This shall be a complete renovation and refurbishment of the facility, with expansion of the public area, and additional sleeping areas. The on site parking shall be expanded as the available site area allows.

EMS Station 3. This shall be a complete renovation and refurbishment of the facility, with expansion of the public area, and additional sleeping areas. The on site parking shall be expanded as the available site area allows.

EMS Station 4. This shall be a complete remodel or a replacement station with space for the Town of Southern Shores. OCA shall provide two sketches depicting the Remodel and Replacement for the County to discuss with Southern Shores. Once a direction is known, OCA shall design the final solution.

EMS Station 5. This station will need to be an expansion to the Town owned Fire Station to accommodate the EMS crew or a New Facility for the County EMS. OCA shall provide a concept sketch for expansion of the existing Fire Stations.

EMS Station 6. This shall be a new station located on property owned by the Local Fire Department. OCA shall provide concept sketches that will include the Fire Department and a sketch of how to reorganize the site to accommodate a new EMS and expansion of the existing Fire Station.

EMS Station 7. OCA shall provide several different site sketches of how, and where to locate and expand the Crew quarters as well as the Med Flight Hanger.

EMS Station 8. This will be a complete remodel refurbishment with expansion of the Bays and Sleeping area. Additionally, we shall explore expansion and possible renovations to the existing Fire Department & Community Center.

...

~~*(Describe below the Basic Services the Architect shall provide pursuant to this Service Order or state whether the services are described in documentation attached to this Service Order.)*~~

OCA shall provide initial preliminary concepts for the various options as outlined above. Once a decision is reached on a concept, OCA shall provide the necessary Architectural and Engineering documents to accomplish the projects.

PAGE 3

~~*(Describe below the Additional Services the Architect shall provide pursuant to this Service Order or state whether the services are described in documentation attached to this Service Order.)*~~

Additional Services shall be as described in the Standard Master Agreement.

...

TBD.

...

TBD.

...

~~.1 Stipulated Sum~~
~~*(Insert amount)*~~

~~.2~~

.1 Percentage Basis
~~(Insert percentage value)~~

~~(~~10 (Ten) % of the Owner's budget for the Cost of the Work, as calculated in accordance with Section 4.4.

The fee breaks down as follows:

Schematic Design	20%	
~~.3 Other~~Design Development		15%
Construction Documents	35%	
Bidding & Negotiation	5%	
Construction Administration	25%	
Total	100%	

~~(Describe the method of compensation)~~.2 Hourly

Preliminary concept planning shall be completed on an hourly basis. The rates are as outlined in the Master Agreement.

...

~~(Insert amount of, or basis for, compensation if other than as set forth in the Master Agreement. Where the basis of compensation is set forth in an exhibit to this Service Order, such as a Scope of Architect's Services document, list the exhibit below.)~~

Ten (10%) of the estimate cost.

...

~~(Insert amount of, or basis for, compensation if other than as set forth in the Master Agreement. Where the basis of compensation is set forth in an exhibit to this Service Order, such as a Scope of Architect's Services document, list the exhibit below.)~~

All surveying, geotechnical, and environmental services shall be billed as reimbursable expenses.

...

~~(Insert any insurance requirements that differ from those stated in the Master Agreement, such as coverage types, coverage limits, and durations for professional liability or other coverages.)~~
See attached COI.
PAGE 4

~~(List below any other insurance coverage to be provided by the Architect, not otherwise set forth in the Master Agreement, and any applicable limits.)~~

...

N/A N/A

...

~~(List name, address, and other information.)~~
Robert Outten, David Clawson, Dustin Peele
Po Box 1000
Manteo, NC 27954

Telephone Number: 252-475-5731
Email: davec@darenc.com, dustin.peele@darenc.com, outten@darenc.com

...

~~(List name, address, and other information.)~~
Timothy Oakley, Ann Collier
109 Candlewood Road
Rocky Mount, NC 27804
Telephone Number: 252-937-2500
Email: toakley@oakleycollier.com, acollier@oakleycollier.com

...

~~.2 Other Exhibits incorporated into this Agreement:~~
~~*(Clearly identify any other exhibits incorporated into this Agreement.)*~~

...

~~*(List other documents, if any, including additional scopes of service forming part of this Service Order.)*~~

Certificate of Insurance

...

Robert Outten County Manager

Timothy Oakley Principal

Certification of Document's Authenticity

AIA® Document D401™ – 2003

I, Timothy Oakley, hereby certify, to the best of my knowledge, information and belief, that I created the attached final document simultaneously with its associated Additions and Deletions Report and this certification at 12:16:52 ET on 08/11/2021 under Order No. 3017269151 from AIA Contract Documents software and that in preparing the attached final document I made no changes to the original text of AIA® Document B221™ – 2018, Service Order for use with Master Agreement Between Owner and Architect, as published by the AIA in its software, other than those additions and deletions shown in the associated Additions and Deletions Report.

Timothy D Oakley

(Signed)

Principal

(Title)

08/11/2021

(Dated)

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/19/2021

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

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

PRODUCER	CONTACT NAME:	
Insurance Management Consultants, Inc. P.O. Box 2490 Davidson NC 28036	PHONE (A/C, No, Ext): (704) 799-1600	FAX (A/C, No): (704) 799-2955
	E-MAIL ADDRESS: cert@imcipls.com	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : RLI Insurance Company	13056
INSURER B : Liberty Insurance Underwriters	19917
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Oakley Collier Architects, PA
109 Candlewood Road
Rocky Mount NC 27804

COVERAGES **CERTIFICATE NUMBER:** 21/22 All Lines Renewal **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☒ PRO-JECT ☐ LOC ☐ OTHER:			PSB0003333	04/19/2021	04/19/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	**AUTOMOBILE LIABILITY** ☒ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY			PSA0001740	04/19/2021	04/19/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Uninsured motorist	$ 1,000,000 $ $ $ $ 1,000,000
A	☒ **UMBRELLA LIAB** ☒ OCCUR **EXCESS LIAB** ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $			PSE0001959	04/19/2021	04/19/2022	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** Y / N: N / N/A If yes, describe under DESCRIPTION OF OPERATIONS below			PSW0002542	04/19/2021	04/19/2022	☒ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
B	Professional Liability			AEX100675-0006	04/19/2021	04/19/2022	Per claim Aggregate	$1,000,000 $2,000,000

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

CERTIFICATE HOLDER

Dare County
954 Marshall C. Collins Drive
Room 286
Manteo NC 27954

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Jeffrey Todd

County of Dare, North Carolina
Capital Project Ordinance
for
Series 2022 LOBs

BE IT ORDAINED as authorized by the Board of Commissioners of the County of Dare, North Carolina that, pursuant to Section 13.2 of Chapter 159 of the General Statutes of North Carolina, the following capital project ordinance is hereby adopted for the planned Series 2022 Limited Obligation Bonds:

Section 1 This ordinance is to establish an initial budget for architectural services for 2022 EMS facilities projects as approved in the 2022 capital improvements plan.

Section 2 The following budget shall be conducted within the Capital Projects Fund (fund #61).

Section 3 The following amounts are appropriated for the projects:

EMS Facilities – architectural services	615531-710900-60360	$250,000

Section 4 The following revenues are anticipated to be available to complete the projects as changed or added below:

Debt Proceeds S2022 LOBs	613090-470318-98734	$250,000

Section 5 The Finance Officer is directed to report the financial status of the project as a part of the normal ongoing financial reporting process.

Section 6 Copies of this capital project ordinance shall be furnished to the Budget Officer, the Finance Officer, and to the Clerk to the Board of Commissioners.

Adopted this 7th day of September, 2021.

_____
Chairman, Board of Commissioners

[SEAL]

_____
Cheryl Anby, Clerk to the Board of Commissioners

Resolution - Authorize the Use of Electronic Advertisement for Contracts Subject to G.S. 143-129

Description

G.S 143-129(b) states that "a governing board must approve a resolution authorizing the political subdivision of the State to use electronic advertising as the only method of advertising for particular contracts or generally all contracts".

There are times when contract bid dates, opening locations, or times need to be changed due to unforeseen circumstances. Being able to re-advertise these changes on the County website will increase the efficiency of awarding contracts by reducing the number of days needed to advertise in newspapers due to the frequency of printing schedules.

Board Action Requested

Adopt the resolution

Item Presenter

Dustin Peele

Resolution to Authorize the Use of Electronic Advertisement for Contracts and Services Subject to G.S. 143-129

WHEREAS, contracts for construction or repair work, and for the purchase of apparatus, supplies, materials, and equipment that meet the monetary threshold established in G.S. 143-129 must be publicly advertised; and

Whereas, G.S. 143-129(b) authorizes the governing board to allow the use of electronic advertisement as an alternative to advertisement in a newspaper of general circulation; and

Whereas, in some cases, advertisement in the newspaper may be the most effective method of obtaining competition, but in other cases, advertisement by electronic means may be a more effective and efficient method of reaching prospective bidders; and

Whereas, it is in all cases important to provide citizens an opportunity to obtain information about major contracts to be awarded by this entity;

THEREFORE, BE IT RESOLVED that the Dare County Board of Commissioners resolves to:

1. Authorize the County Manager, or his designee, to advertise solicitations for bid using electronic means in lieu of placing an advertisement in a newspaper of general circulation whenever he or she determines it to be the most effective and efficient method of obtaining competition for a contract.

2. Advertisement by newspaper and electronic means may be used together or in the alternative, and the requirements of G.S. 142-129(b) shall be met as long as one of the methods used meets the specific requirements and minimum time for advertisement under that statute.

Adopted this the 7th day of September, 2021.

_____
Robert Woodard, Sr., Chairman

Attest:

_____
Cheryl C. Anby, Clerk to the Board

One Call Non-Emergency Ambulance Service Agreement

Description

Under Medicare Transformation non-emergency transportation providers will be paying Dare EMS for non-emergency transport. The Board will review and approve the One Call Non-Emergency Ambulance Service Agreement.

Board Action Requested

Approve and authorize the County Manager to sign the One Call Non-Emergency Ambulance Service Agreement

Item Presenter

Robert Outten, County Manager

One Call Non-Emergency Ambulance Service Agreement

This Agreement is made and entered into as of the day of , 20 by and between One Call Government Solutions, LLC., (hereinafter referred to as "One Call") and DARE COUNTY ADMINISTRATIVE OFFICES, (hereinafter referred to as "Transportation Provider or Provider").

That whereas, One Call is engaged in the business of arranging for, and managing a network of, medical transportation service companies to deliver Non-Emergency Medical Transportation (NEMT) services to those members who wish to make themselves applicable of such services: and whereas, Transportation Provider is a transportation service company and is capable of and desires to provide services as described herein.

Now, therefore, in consideration of the foregoing and of the mutual covenants, promises and undertaking herein set-forth, the parties, intending to be legally bound, agree as follows:

Glossary

1. "Client" means a customer that has entered into an agreement with One Call directly to arrange for the provision of Covered Services for Client's Covered Persons.
2. "Effective Date" means the date that all credentialing matters are approved by One Call.
3. "Non-Emergency" medical transportation services mean transportation services for routine appointments to clinics, physician's offices, outpatient facilities, hospitals and other medically necessary services.
4. "Service Area" means the areas in which Transportation Provider will provide transportation services at the contracted rates negotiated between One Call and Transportation Provider.
5. "Trip" means one-way transportation from point of pick-up to destination drop-off.

Term and Termination. This Agreement shall be for a term of one (1) year, and shall automatically be renewed annually unless terminated by either party giving written notice to the other party as provided herein. Termination shall have no effect upon the rights and obligations of the parties arising out of any services performed prior to the effective date of such termination. Each renewal term is to be exercised automatically unless either party gives notice of its intent to terminate the Agreement at least thirty (30) days prior to the end of the then-current term. Provider may terminate this Agreement at any time without cause by giving sixty (60) days' written notice to One Call. Provider may terminate this Agreement for cause by giving written notice of a breach of the Agreement. One Call shall have fifteen (15) days to cure the breach following receipt of the notification. Failure to cure the breach within the fifteen (15) days shall result in the immediate termination of the Agreement. Notwithstanding the foregoing, Provider may terminate this Agreement immediately and without notice to One Call if One Call becomes insolvent, makes or has made an assignment for the benefit of creditors, is the subject of proceedings in voluntary or involuntary bankruptcy instituted on behalf of or against it, or has a receiver or trustee appointed for substantially all of its property, or if One Call allows any final judgment to stand against it unsatisfied for a period of forty-eight (48) hours.

Provider Qualifications. By providing the Medicaid Identification number referenced below, Provider represents that it is certified by the State of North Carolina and meets all qualifications required thereby to perform ambulance transport services (the "Services") to Medicaid members in accordance with State of North Carolina and Centers for Medicare & Medicaid Services ("CMS") rules, regulations and the Medicaid Ambulance Transportation Services Coverage and Limitations Handbook within your regulated service area and as may be amended or modified from time to time:

1. https://info.ncdhhs.gov/dhsr/EMS/rules.html
2. https://files.nc.gov/ncdma/documents/files/15.pdf
3. https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies
4. And any other city, county, State, Federal, and other governing regulation/s.

The HIPAA BAA (A), Medicare Regulatory Addendum (B) and Medicaid Regulatory Addendum (C) are attached hereto as Exhibits "A", "B", and "C," respectively, and incorporated herein by reference. Other requiements but not limited to on providing One Call a current W-9, Certificate of Insurance, Vehicle and Driver rosters, and appropriate State or local certifications associated to EMS.

Insurance. Provider certifies that it carries the State required amount of insurance and/or Professional Liability / Errors and Omissions insurance coverage of at least $1 million per claim (and $3 million aggregate if providing ALS, BLS, Stretcher and Wheelchair transports), Commercial Business Automobile Liability coverage of $250,000 per occurrence / $500,000 aggregate, as well as Aviation coverage of $10 million (only required for air ambulance transports).

Invoicing and Payment. In exchange for accepting a referral and fully performing the corresponding Services, One Call shall pay Provider one hundred percent (100%) of the applicable North Carolina Managed Care Ambulance Provider Fee Schedule for non-emergency medical transportation in effect at the time of Service in accordance with the associated Medicaid fee schedule as may be amended or modified from time to time, with in accordance to 42 C.F.R. § 438.6(c)(iii)(B)). Provider shall submit to One Call a complete and accurate invoice within one-hundred eighty (180) days from date of Service. Except as otherwise required by law, One Call shall use commercially reasonable efforts to pay Provider no later than forty-five (45) days after One Call's receipt of an invoice. One Call reserves the right to deny payment for any invoice One Call receives more than one-hundred eighty (180) days from the date of Service (the "Invoice Submission Period"), and Provider's need to resubmit any invoice for any reason shall not extend beyond the Invoice Submission Period.

Independent Contractor. Both One Call and Provider agree that One Call shall act as an independent contractor and shall not represent itself as an agent or employee of Provider for any purpose.

HIPAA. The parties acknowledge that they will comply with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder ("HIPAA"), as more fully set forth in the Business Associate Agreement attached hereto as Exhibit "A" and incorporated herein by reference.

Divestment from Companies that Boycott Israel. One Call hereby certifies that it has not been designated by the North Carolina State Treasurer as a company engaged in the boycott of Israel pursuant to N.C.G.S. § 147-86.81.

Debarment. One Call hereby certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this Agreement by any governmental department or agency. One Call must notify Provider within thirty (30) days if debarred by any governmental entity during this Agreement.

Non-Discrimination in Employment. One Call shall not discriminate against any employee or applicant for employment because of race, ethnicity, gender, gender identity, sexual orientation, age, religion, national origin, disability, color, ancestry, citizenship, genetic information, political affiliation or military/veteran status, or any other status protected by federal, state or local law or other unlawful form of discrimination. One Call shall take affirmative action to ensure that applicants are employed and that employees are treated fairly during employment. In the event One Call is determined by the final order of an appropriate agency or court of competent jurisdiction to be in violation of any non-discrimination provision of federal, state or local law or this provision, this Agreement may be cancelled, terminated or suspended in whole or in part by Provider, and One Call may be declared ineligible for further agreements with Provider.

Compliance with E-Verify Program. Pursuant to N.C.G.S. § 143-133.3, One Call understands that it is a requirement of this Agreement that One Call and its subcontractors must comply with the provisions of Article 2 of Chapter 64 of the North Carolina General Statutes. In doing so, One Call agrees that, unless it is exempt by law, it shall verify the work authorization of its employees utilizing the federal E-Verify program and standards as promulgated and operated by the United States Department of Homeland Security, and One Call shall require its subcontractors to do the same. Upon request, One Call agrees to provide Provider with an affidavit of compliance or exemption.

No Assignment Without Consent. One Call shall not assign this Agreement (or assign any right or delegate any obligation contained herein whether such assignment is of service, of payment or otherwise) without the prior written consent of Provider. Any such assignment without the prior written consent of Provider shall be void. An assignee shall acquire no rights, and Provider shall not recognize any assignment in violation of this provision.

Governing Law and Venue. This Agreement shall be governed by applicable federal law and by the laws of the State of North Carolina without regard for its choice of law provisions. All actions relating in any way to this Agreement shall be brought in the General Court of Justice of the State of North Carolina of their respective County or in the Federal District Court within North Carolina

Dispute Resolution. Should a dispute arise as to the terms of this Agreement, both parties agree that neither may initiate binding arbitration. The parties may agree to non-binding mediation of any dispute prior to the bringing of any suit or action.

Governmental Immunity. Provider, to the extent applicable, does not waive its governmental immunity by entering into this Agreement and fully retains all immunities and defenses provided by law with regard to any action based on this Agreement.

Entire Agreement. This Agreement and the Exhibits A, B, C hereto constitute the entire agreement between the parties with respect to the subject matter herein. There are no other representations, understandings or agreements between the parties with respect to such subject matter. This Agreement supersedes all prior agreements, negotiations, representations and proposals, written or oral, related to the subject matter herein.

Severability. The invalidity of one or more of the phrases, sentences, clauses or sections contained in this Agreement shall not affect the validity of the remaining portion of the Agreement so long as the material purposes of this Agreement can be determined and effectuated. If a provision of this Agreement is held to be unenforceable, then both parties shall be relieved of all obligations arising under such provision, but only to the extent that such provision is unenforceable, and this Agreement shall be deemed amended by modifying such provision to the extent necessary to make it enforceable while preserving its intent.

Amendments. No amendments to this Agreement shall be valid unless in writing and signed by authorized agents of both Provider and One Call.

Signatures. This Agreement, together with any amendments or modifications, may be executed in one or more counterparts, each of which shall be deemed an original and all of which shall be considered one and the same agreement. This Agreement may also be executed electronically. By signing electronically, the parties indicate their intent to comply with the Electronic Commerce in Government Act (N.C.G.S § 66-358.1 et seq.) and the Uniform Electronic Transactions Act (N.C.G.S § 66-311 et seq.). Delivery of an executed counterpart of this Agreement by either electronic means or by facsimile shall be as effective as a manually executed counterpart.

NOTICES. Wherever under this Agreement one party is required or permitted to give notice to the other, such notice shall be deemed given (i) when delivered in hand to the address specified below; (ii) when received by the other party after being sent by overnight courier service to the address specified below (return receipt requested) or by United States Mail postage prepaid by certified mail (return receipt requested) to the address specified below; (iii) when sent by electronic mail to the address specified below. Any notice Provider wishes to give hereunder must identify (in writing) the Provider's legal name, the type of Services Provider performs hereunder and the Effective Date of the Agreement.

Notices to One Call shall be delivered to:
One Call
841 Prudential Dr., Suite 204
Jacksonville, FL 32207, Attn: Provider Relations Network Programs
Email to: GroupHealth_ProviderRelations@onecallcm.com

With a Copy to:
One Call
841 Prudential Dr., Suite 204
Jacksonville, FL 32207, Attn: Legal Dept.

Exhibit A
HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "BAA") is entered into by and between Transportation Provider, through its Emergency Medical Services division ("Business Associate") and One Call Government Solutions, LLC, on behalf of itself and its Affiliates, if any (individually and collectively, the "Covered Entity"). This BAA adds to and is made an integral part of the Non-Emergency Ambulance Service Agreement entered into between the Covered Entity and Business Associate ("Agreement") of even date herewith and to which it is attached.

On behalf of Covered Entity, and pursuant to the Agreement, Business Associate may perform certain functions or activities involving the use, disclosure, creation, transmission, and/or maintenance of protected health information ("PHI"). Therefore, Business Associate agrees to the following terms and conditions set forth in this HIPAA Business Associate Agreement.

1. Definitions. For purposes of this BAA, the terms used herein, unless otherwise defined, shall have the same meanings as used in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and any amendments thereto or implementing regulations thereunder, (collectively "HIPAA Rules"). Without limitation of the foregoing, the parties acknowledge and agree that "Protected Health Information" shall include, but is not necessarily limited to, information that identifies an Individual (e.g., name or postal address), together with an indication that Individual has been treated by a particular Health Care Provider, or has been or is a member of a particular Health Plan. In addition, the use of the term Affiliates in this BAA shall mean natural persons or legal entities that, through ownership of voting interests, contract rights or otherwise, directly or indirectly control, are controlled by or are under common control with other natural persons or legal entities. A subsidiary is included in this definition of Affiliates.

2. Compliance with Applicable Law. The parties acknowledge and agree that, beginning with the relevant effective dates and during the term of the Agreement and this concurrent BAA, Business Associate shall comply with its obligations under this BAA and with all obligations of a business associate under HIPAA, HITECH, the HIPAA Rules, and other applicable laws and regulations, as they exist at the time this BAA is executed and as they are amended, for so long as this BAA is in place.

3. Permissible Use and Disclosure of PHI. Business Associate may use and disclose PHI (a) as required by law, and (b) as necessary to carry out its duties to Covered Entity pursuant to (i) the terms of this BAA and (ii) the Agreement or any SOW or other written arrangement under which Business Associate performs functions or activities on Covered Entity's behalf. Business Associate may also use and disclose PHI (i) for its own proper management and administration, and (ii) to carry out its legal responsibilities. If Business Associate discloses Protected Health Information to a third party for either above reason, prior to making any such disclosure, Business Associate must obtain: (i) reasonable assurances from the receiving party that such PHI will be held confidential and be disclosed only as required by law or for the purposes for which it was disclosed to such receiving party; and (ii) an agreement from such receiving party to immediately notify Business Associate of any known breaches of the confidentiality of the PHI.

4. Limitations on Use and Disclosure of PHI. Business Associate shall not, and shall ensure that its directors, officers, employees, subcontractors, and agents do not, use or disclose PHI in any manner that is not permitted by this BAA or that would violate Subpart E of 45 CFR 164
("Privacy Rule") if done by Covered Entity including not using or disclosing genetic information for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(i). Business Associate is not authorized to create de-identified information from PHI. All uses and disclosures of, and requests by, Business Associate for PHI are subject to the minimum necessary rule of the Privacy Rule and consistent with Covered Entity's minimum necessary policies and procedures.

5. Required Safeguards To Protect PHI. Business Associate shall develop, implement, maintain and use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 ("Security Rule") with respect to electronic PHI, to prevent the use or disclosure of PHI other than as provided for by the terms and conditions of this BAA. Furthermore, with respect to electronic PHI, Business Associate shall encrypt such electronic PHI prior to saving it on portable media, and in other circumstances shall encrypt electronic PHI whenever reasonably practicable.

6. Reporting to Covered Entity. Business Associate shall immediately report to Covered Entity: (a) any use or disclosure of PHI not permitted or required by this BAA of which it becomes aware; (b) any breach of unsecured PHI in accordance with 45 CFR Subpart D of 45 CFR 164 ("Breach Notification Rule"); and (c) with respect to any incident not subject to reporting under (a) and (b) above, Business Associate shall report to Covered Entity any successful unauthorized access, use, disclosure, modification, or destruction of Covered Entity's electronic PHI or unauthorized interference with system operations in Covered Entity's information system, of which Business Associate becomes aware. Business Associate shall cooperate with Covered Entity's investigation, analysis, notification and mitigation activities, and shall be responsible for all costs incurred by Covered Entity for those activities.

7. Mitigation of Harmful Effects. Business Associate agrees to mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA or the HIPAA Rules.

8. Agreements by Third Parties. Business Associate shall enter into a written agreement with any subcontractor of Business Associate that creates, receives, maintains or transmits PHI on behalf of Business Associate. Pursuant to such agreement, the subcontractor shall agree to be bound by the same restrictions, conditions, and requirements that apply to Business Associate under this BAA with respect to such PHI.

9. Access to PHI. Within five (5) days of a request by Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to Covered Entity such PHI for so long as such information is maintained by Business Associate in the Designated Record Set, as required by 45 CFR 164.524. In the event any individual delivers directly to Business Associate a request for access to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

10. Amendment of PHI. Within five (5) days of receipt of a request from Covered Entity for the amendment of an individual's PHI or a record regarding an individual contained in a Designated Record Set (for so long as the PHI is maintained in the Designated Record Set), Business Associate shall provide such information to Covered Entity for amendment and incorporate any such amendments in the PHI as required by 45 CFR 164.526. In the event any individual delivers directly to Business Associate a request for amendment to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

11. Documentation of Disclosures. Business Associate agrees to document disclosures of PHI 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 PHI in accordance with 45 CFR 164.528 and HITECH. Business Associate agrees to implement an appropriate record keeping process that will track, at a minimum, the following information: (i) the date of disclosure; (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of such disclosure that includes an explanation of the basis for such disclosure.

12. Accounting of Disclosures. Within five (5) days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity information to permit Covered Entity to respond to the request for an accounting of disclosures of PHI, as required by 45 CFR 164.528 and HITECH.

13. Other Obligations. To the extent that Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with such requirements that apply to Covered Entity in the performance of such delegated obligations.

14. Judicial and Administrative Proceedings. In the event Business Associate receives a subpoena, court or administrative order or other discovery request or mandate for release of PHI, including, without limitation, requests pursuant to the Public Records Laws of North Carolina contained in Chapter 132 of the North Carolina General Statutes, Business Associate shall promptly notify Covered Entity of such request, and Covered Entity shall have the opportunity to defend against production of such PHI at Discloser’s sole expense.

15. Availability of Books and Records. Business Associate hereby agrees to make its internal practices, books, and records available to the Covered Entity, or at request of Covered Entity to the Secretary of the Department of Health and Human Services, in a time and manner designated by Covered Entity or the Secretary, as applicable, for purposes of determining compliance with the HIPAA Rules.

16. Breach of Contract by Business Associate. In addition to any other rights Covered Entity may have by operation of law or in equity, Covered Entity may (a) immediately terminate this BAA and the Agreement if Covered Entity determines that Business Associate has violated a material term of this BAA; or (b) at Covered Entity's option, permit Business Associate to cure or end any such violation within the time specified by Covered Entity. Covered Entity's option to have cured a breach of this BAA shall not be construed as a waiver of any other rights Covered Entity has in the Agreement, this BAA or by operation of law or in equity.

17. Notice. All notices required under the Agreement shall be in writing and shall be deemed to have been given on the next day by fax or other electronic means or upon personal delivery, or in ten (10) days upon delivery in the mail, first class, with postage prepaid. Notices shall be sent to the addressees indicated below unless written notification of change of address shall have been given.

18. Effect of Termination of BAA. Upon the termination of either the Agreement or this BAA for any reason, Business Associate shall return to Covered Entity or, at Covered Entity's direction, destroy all PHI received from Covered Entity that Business Associate maintains in any form, recorded on any medium, or stored in any storage system. This provision shall apply to PHI that is in the possession of Business Associate, subcontractors, and agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall remain bound by the provisions of this BAA, even after termination of the Agreement or this BAA, until such time as all PHI has been returned or otherwise destroyed as provided in this Section.

19. Injunctive Relief. Business Associate stipulates that its use or disclosure of PHI not authorized by this BAA would cause immediate and irreparable harm to Covered Entity, and in such event, Covered Entity shall be entitled to institute proceedings in any court of competent jurisdiction to obtain injunctive relief, and to recover from Business Associate the damages and costs, including reasonable attorneys' fees, incurred by Covered Entity arising out of or relating to the breach of the BAA.

20. Indemnification. To the extent permitted by law, Business Associate shall indemnify and hold harmless Covered Entity and its officers, trustees, employees, and agents from any and all losses, claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Covered Entity arising from Business Associate's breach of its obligations under this BAA, the HIPAA Rules, or relating to its use, disclosure, creation, maintenance, transmission or safeguarding of PHI.

21. Exclusion from Limitation of Liability. To the extent that Business Associate has limited its liability under the terms of the Agreement, any SOW or other written arrangement between Business Associate and Covered Entity, whether with a maximum recovery for direct damages or a disclaimer against any consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any and all losses and damages to Covered Entity arising from Business Associate's breach of its obligations under this BAA, the HIPAA Rules, or relating to its use, disclosure, creation, maintenance, transmission or safeguarding of PHI.

22. Owner of PHI. Under no circumstances shall Business Associate be deemed in any respect to be the owner of any PHI created or received by Business Associate on behalf of Covered Entity.

23. Right to Audit. To allow Covered Entity to certify compliance with the HIPAA Rules, Business Associate will permit Covered Entity to audit Business Associate's systems and services, with specific emphasis on Business Associate's compliance with the provisions of this BAA. Such audit, which may be conducted by Covered Entity's personnel under obligations of confidentiality or by an independent auditing firm, will not interfere unreasonably with Business Associate's legitimate business activities, and will be conducted no more than once per calendar year, unless Covered Entity has received a request from the Secretary, or unless Covered Entity has reason to believe that this BAA has been breached. Covered Entity will use information received during an audit solely for the purposes of the Agreement and will otherwise maintain the confidentiality of such information.

24. Third Party Rights. The terms of this BAA do not grant any rights to any parties other than Business Associate and Covered Entity.

25. Independent Contractor Status. For the purposes of this BAA, Business Associate is an independent contractor of Covered Entity, and shall not be considered an agent of Covered Entity.

26. Electronic Transactions. If Business Associate conducts in whole or part a HIPAA transaction as defined in 45 CFR 160.103 of the HIPAA standards for electronic transactions, Business Associate shall comply, and shall require any subcontractor involved with the conduct of such HIPAA transaction to comply, with each applicable requirement of 45 CFR Part 162.

27. Changes in the Law. The parties shall amend this BAA to conform to any new or revised legislation, rules and regulations to which Covered Entity is subject now or in the future including, without limitation, HIPAA, HITECH, and the HIPAA Rules.

28. Interpretation. Any ambiguity in the BAA shall be resolved to permit Covered Entity to comply with HIPAA, HITECH, and the HIPAA Rules.

29. Conflicts. If there are any direct conflict between the Agreement and this BAA, the terms and conditions of this BAA shall control.

Exhibit B
MEDICARE REGULATORY ADDENDUM

A. Record Keeping. In accordance with 42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 4222.504(e)(4); 42 CFR 422.504(i)(2)(i) and 42 CFR 422.504(i)(2)(ii), HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records, including medical records, of the subcontractor involving transactions related to One Call , or a Medicare Advantage Program participant's contract with CMS or that pertain to any aspect of services performed, pursuant to this Agreement. Only One Call or its designees shall have direct access to Contractor for these purposes, and Contractor will make such books and records available for such inspection, evaluation, and audit through One Call. With respect to all other downstream entities, HHS, CMS, the Comptroller General, and their designees shall have direct access (e.g., on site access) to such downstream entities, and the downstream entities will make such books and records directly available to HHS, CMS, the Comptroller General, or their designees for such inspection, evaluation, and audit. This right exists through: (1) ten (10) years from the final date of this Agreement's termination date or (2) from the date of completion of any audit, whichever is later, or (3) in excess of ten (10) years if CMS so determines pursuant to 42 CFR 422.504(e) (e.g., possibility of fraud, etc.). Contractor agrees to provide to One Call all books and records described above which One Call will then provide to CMS. Contractor acknowledges and agrees that One Call or any third party authorized on behalf of One Call to conduct an audit of Contractor may share with CMS or an any third party solely in the event that CMS requires or requests such third party to produce such additional information or audit results directly: (i) any information about One Call’s arrangement with Contractor demonstrating One Call’s compliance under federally or the Providers state funded health care programs; and (ii) the results of any audit conducted by One Call or provided by Contractor pursuant to the Agreement.

B. Delegation. In accordance with 42 CFR 422.504(i)(3)(ii), 42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5), Contractor will perform the delegated activities and the reporting responsibilities described in Section B of this Agreement. Contractor agrees not to delegate any professional duties under this Agreement to any subcontractor without the approval of One Call. Upon One Call's approval, Contractor shall submit to One Call credentials for subcontractor to whom professional duties may be delegated. Contractor acknowledges and agrees that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a written agreement with Contractor will be consistent and comply with a Medicare Advantage Program participant's obligations under its contract with CMS, the Agreement or this Amendment. Contractor also acknowledges and agrees that if any of a Medicare Advantage Program participant's activities or responsibilities under its contract with CMS are delegated to Contractor or other parties, all delegation requirements under the applicable federal regulations must be met and One Call must oversee and remain accountable to CMS for any delegated functions. One Call shall monitor the performance of Contractor on an ongoing basis. One Call retains all its legal remedies, including the right of revocation, if the activities are not performed satisfactorily or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner as determined by CMS or One Call. One Call further retains the right to approve, suspend, or terminate any provider selected by Contractor on behalf of One Call.

C. Credentialing. In accordance with 42 CFR 422.504(i)(3)(ii) and 42 CFR 422.504(i)(4)(iv)(B), One Call will review and approve the credentialing process used by Contractor. Further, One Call will audit the credentialing process used by Contractor on an ongoing basis.

D. Compliance With Laws. Contractor acknowledges and agrees that payments received from One Call are, in whole or in part, federal funds. As a recipient of federal funds, Contractor shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part Exhibit E -2- 46, pertaining to research involving human subjects; (g) 42 CFR 422.504(i)(4)(v); and (h) all applicable Medicare laws, regulations, and CMS instructions. Both parties agree to comply with all state and federal laws, rules, and regulations applicable to this Agreement.

E. Confidentiality and Enrollee Record Accuracy. In accordance with 42 CFR 422.118 and 42 CFR 504(a)(13), Contractor agrees to comply with all state and federal requirements for accuracy and confidentiality of a Medicare Advantage Program participant's member's records, including the requirements established by One Call and CMS for any medical records or other health and enrollment information Contractor maintains with respect to a Medicare Advantage Program participant's members. Contractor will establish procedures to do the following:

1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Contractor will safeguard the privacy of any information that identifies a particular member and have procedures that:
    a. Specify for what purposes the information will be used within the organization;
    b. Specify to whom and for what purposes it will disclose the information outside the organization;

c. Ensure that any protected health information sent to Contractor by, or on behalf of Medicare Advantage Program participants and other personal information remains secure; and
d. Prohibit Contractor from accessing data not associated with the specific Medicare Advantage Program participant's contracts

2. Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by members to the records and information that pertain to them.

F. Satisfactory Performance. In accordance with 42 CFR 504(i)(4)(ii), if CMS or One Call determines that Contractor has not performed satisfactorily under this Agreement, the delegated activities and reporting responsibilities of the Contractor may be revoked, the matter may be handled in accordance with One Call corrective action plan, and/or the matter may be considered an act in default under this Agreement pursuant to terms and conditions of this Agreement.

G. Contract Compliance. In accordance with 42 CFR 422.504(i)(1) and CFR 422.504(i)(3)(iii), notwithstanding anything to the contrary agreed to by the parties, a Medicare Advantage Program participant maintains ultimately responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS and for ensuring that Contractor's services are consistent and comply with a Medicare Advantage Program participant's contract with CMS.

H. Monitoring. In accordance with 42 CFR 422.504(i)(1), 42 CFR 422.504(i)(3)(ii), and 42 CFR 422.504(i)(4)(iii), One Call will establish and maintain ongoing monitoring and oversight of all aspects of Contractor's performance of its obligations.

I. Hold Harmless. Contractor agrees to hold a Medicare Advantage Program participant's enrollees harmless for payment of any fees that are the obligation such Medicare Advantage Program participant.

J. Security Breach. The parties agree that a significant security breach is considered a material breach of the Agreement of a type or nature that is not capable of being cured and One Call shall have the right, in such event, to immediately terminate the Agreement for cause.

Exhibit C
MEDICAID REGULATORY ADDENDUM

A. Record Keeping. One Call and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Medicaid must retain and make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42 CFR 438.5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610) available at the Contractor's, providers, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the OIG, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

1. Access will be either through on-site review of records or by any other means at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time.
a. Upon request, the Contractor, its provider or subcontractor must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonable accommodate OIG or other State or federal agency.

2. Contractor must send all requested records to OIG within 30 business days of request unless otherwise specified by rules and regulations.

3. Records other than medical records may be kept in original paper state or preserved on micromedia or electronic format. Medical records must be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and 10 years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

B. Compliance with Laws. Contractor and subcontractors must comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and Contract provisions.

C. Right to Audit.

1. Contractor and subcontractors agree that the state, CMS, the DHHS Inspector General, the Comptroller General or their agents have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the state.

2. Contractor and subcontractors must make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Enrollees.

3. Contractor and subcontractors agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their agents will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4. The state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

One Call Non-Emergency Ambulance Agreement Signature Page

Transportation Provider certifies and acknowledges that Transportation Provider has carefully read all the provisions of this Agreement and that Transportation Provider understands and will fully and faithfully comply with such provisions. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, Transportation Provider and One Call agree to be bound by this Agreement as of the Effective Date.

PROVIDER:

DARE COUNTY ADMINISTRATIVE OFFICES

Signature: _____
Name: _____
Title: _____
Date: _____

One Call:

Signature: _____
Name: _____
Title: _____
Date: _____

Provider Type: Transportation - NEMT

Provider Medicaid ID#:

Provider TIN#:

Provider NPI#:

Provider Address:

WellCare Health Plans, Inc. Provider Agreement

Description

Under Medicare Transformation various companies will contract with the state to cover patients on behalf of Medicaid and pay Dare County for the Medicaid services. The Board will review and approve the WellCare Health Plans, Inc. Provider Agreement.

Board Action Requested

Approve and authorize the County Manager to sign the WellCare Health Plans, Inc. Provider Agreement

Item Presenter

Robert Outten, County Manager

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Dare County Administrative Offices ("***Provider***") and WellCare Health Plans, Inc. ("***WellCare***"). This Agreement is effective as of the date designated by WellCare on the signature page of this Agreement ("***Effective Date***"). For purposes of this Agreement, each of Provider and WellCare may be referred to herein as a "***Party***" and collectively as the "***Parties***."

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth; and

WHEREAS, WellCare desires for Provider to provide such health care services to individuals in such products, and WellCare desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with such entity.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.8, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, WellCare and/or one or more of its Affiliates listed on Schedule D of this Agreement, except those specifically excluded by WellCare.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by WellCare.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with WellCare to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by WellCare. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by WellCare (e.g., WellCare Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by WellCare).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and

the Provider Manual, in each case, to the same extent as if the Contracted Providers were parties hereto. Provider shall be responsible for any breach of this Agreement by any Contracted Provider.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Contracted Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide WellCare with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide WellCare, from time to time or on a periodic basis as requested by WellCare, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide WellCare with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. The effective date of any Contracted Provider added under this Agreement shall be the later of the Agreement Effective Date or date by which the Contracted Provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks. In such case, Provider shall provide written notice to WellCare of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. WellCare shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means as promptly as possible following WellCare's receipt of any and all necessary regulatory review and approval thereof (whether by the North Carolina Department of Health and Human Services, the North Carolina Division of Health Benefits or otherwise); provided, however, that in no event shall WellCare be required to make the Provider Manual available earlier than one hundred and twenty (120) days prior to North Carolina's effective date of the Medicaid managed care program. Upon Provider's reasonable request, WellCare shall provide Provider with a written copy of the Provider Manual. In the event of a material change to the Provider Manual, WellCare will provide Provider with at least sixty (60) days' advance written notice of such change. Such notice may be given by WellCare through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program or eligible to enroll as a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred.

2.8. Treatment Decisions. No Company or Payor shall be liable for, or exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted

Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company (each a "Non-Disparagement Party") shall not disparage any other Non-Disparagement Party during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of WellCare, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other WellCares consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting any Non-Disparagement Party's ability to use and disclose information and data obtained from or about another Non-Disparagement Party, including this Agreement, to the extent determined reasonably necessary or appropriate by such Non-Disparagement Party in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to WellCare and Payor of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any final adverse determinations in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify WellCare and Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify WellCare and Payor in writing within 30 days, from the date it first obtains knowledge of any such final adverse determination.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company and/or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they

participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to WellCare complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain patient data and identifying information, diagnosis and service codes, and provider identifiers, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. Unless Company provides prior written approval to Provider, Provider shall make arrangements for and only accept Compensation Amounts by way of electronic funds transfer via the automated clearing house network (EFT-ACH).

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage

Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider following not less than thirty (30) days' advance written notice to Provider. Such notice will be accompanied by adequate specific information to identify the specific claim and the specific reason for the offset or recoupment. All offsets or recoupments will be made within the two (2) years after the date of the original claim payment unless Payor has a reasonable belief of fraud or other intentional misconduct by Provider, Contracted Provider or their respective agents or the claim involves the receipt of payment for the same service from a government payor. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider. If the recoupment is standard in scope, then Payor or its delegate may immediately offset any and all overpayments or payments made in error without prior notice to Provider. "Standard" means those overpayments or payments made in error that are discovered by Payor or its delegate on an individual account review basis. If the recoupment is non-standard in scope, then Payor or its delegate will provide written or electronic notice to Provider before using an offset as a means to recover an overpayment, and will not implement the offset if, within thirty (30) days after the date of the notice, Provider refunds the overpayment or initiates an appeal. The written or electronic notice from the Payor or its delegate shall explain the reason and calculation of the overpayment or payment made in error. "Non-standard" means those overpayments or payments made in error that are discovered by Payor or its delegate during an audit that is being conducted to correct a systemic error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations, to the extent such access is necessary for WellCare to maintain or apply for certain accreditations, as applicable. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Company and Payor agree to limit the number of copies of records requested of Provider and each Contracted Provider to the minimum necessary to satisfy the applicable obligation. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to WellCare, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 annual aggregate unless a lesser amount is accepted by WellCare or where State law mandates otherwise. Provider and each Contracted Provider will provide WellCare with at least 15 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon WellCare's request, Provider and each Contracted Provider will furnish WellCare with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at WellCare's request defend) Company, Payor and each of their respective officers, directors, agents, and employees from and against any and all claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations (collectively, "Losses") arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by WellCare. WellCare agrees to indemnify and hold harmless (and at Provider's request (as applicable) defend) Provider, Contracted Providers, and each of their respective officers, directors, agents and employees from and against any and all Losses arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and WellCare and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the Dispute is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within 1 year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the Dispute has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any

proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Effective Date, and will, subject to Section 7.1.2 of this Agreement, remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 120 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 120 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, WellCare has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when WellCare determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by WellCare, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by WellCare giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 5.4, 6.1, 6.2, 7.3, 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among WellCare, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any "Company" under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to WellCare. Each Company (each an "Unaffiliated Party" and collectively, the "Unaffiliated Parties") acknowledge that references herein to their respective rights and obligations under this Agreement are references to the rights and obligations of each such Unaffiliated Party individually and not of the Unaffiliated Parties collectively. Notwithstanding anything that may be construed herein to the contrary, all such rights and obligations are individual and specific to each Unaffiliated Party and the reference to one Unaffiliated Party herein in no way imposes any cross-guarantees or joint responsibility or liability on the other Unaffiliated Party. A breach or default hereunder by an Unaffiliated Party shall not constitute a breach or default by the other Unaffiliated Party.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without the WellCare's prior written consent; provided, however, WellCare shall, in addition to the rights provided under Section 8.2, have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of WellCare, or purchaser of the assets or stock of WellCare, or the line of business or business unit primarily responsible for carrying out WellCare's obligations under this Agreement. Any attempted assignment or delegation in violation of this Section 8.3 shall be void.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of WellCare, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties for their benefit, as well as, in the case of WellCare, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4, Section 5.2, Section 5.3 and/or Section 5.4 hereof, no Covered Person or any other third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. WellCare may amend this Agreement by giving the Parties written notice of the amendment to the extent such amendment is deemed necessary or appropriate by WellCare to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by the Parties upon the giving of such notice.

8.7.2. WellCare may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. When such an amendment proposes to modify Provider's reimbursement or addresses Covered Services routinely rendered by Provider to Covered Persons, the amendment will be evaluated by WellCare's Medical Affairs and Financial Matters Committees prior to WellCare giving written notice to Provider. Unless Provider notifies WellCare in writing of its objection to such amendment during the 30 day period following the giving of such notice by WellCare, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to this Agreement, WellCare may exclude one or more of the Contracted Providers from being Participating Providers in the Product (or any component program of, or Coverage Agreement in connection with, such Product) to which such amendment relates.

8.8. Entire Agreement. This Agreement, together with any attached or incorporated amendments, schedules, exhibits, attachments and appendices, constitute the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior oral and written and all contemporaneous oral negotiations, commitments and understandings between them. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between WellCare and Provider relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. Any term or condition of this Agreement may be waived at any time by the Party that is entitled to the benefit thereof, but no such waiver shall be effective, unless set forth in a written instrument duly executed by or on behalf of the Party waiving such term or condition; provided, however, that no Party shall be permitted to make any such waiver by or on behalf of any other Party. The waiver by any Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To WellCare at:	To Provider at:
Attn: President	Attn:
WellCare Health Plans, Inc.	Dare County Administrative Offices
3128 Highwoods Blvd	1632 N Croatan Hwy
Raleigh, NC 27604	Kill Devil Hills, NC 27948

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, WellCare may provide notices to Provider by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. No Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by the employees of such Party, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information, and except for such disclosures as are required by Regulatory Requirements, Provider shall not disclose such information to any person or entity without WellCare's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of this Agreement. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to WellCare.

8.15. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement. Upon Provider's reasonable written request, WellCare shall provide Provider with a fully executed copy of this Agreement.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

WELLCARE:	**PROVIDER:**
WellCare Health Plans, Inc.	Dare County Administrative Offices (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Troy Hildreth	Print Name:
Title: State President	Title:
Signature Date:	Signature Date:
ICM #: ICMProviderAgreement_52586	Tax Identification Number: 56-6000293
	State Medicaid Number:
To be completed by WellCare only: Effective Date:	National Provider Identifier:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital's performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provisions apply.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and WellCare has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to WellCare at any time upon request. FQHC shall promptly notify WellCare if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community. Long-term care ("LTC") is another subset of LTSS which provides benefits as specified through the SMMC LTC Program.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of WellCare. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. WellCare acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to WellCare, via written notice or via telephone contact at a number to be provided by WellCare, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify WellCare of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within twenty-four (24) hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify WellCare of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify WellCare if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify WellCare of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify WellCare of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify WellCare of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to WellCare or its designee the Minimum Data Set as defined by CMS and required under federal law and WellCare policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by WellCare.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in WellCare's LTSS quality improvement plan. Each Contracted Provider shall permit WellCare to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and WellCare's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by WellCare thereafter. Provider shall provide the results of such background checks to WellCare and member, if self-directed, upon request. WellCare within a reasonable time period following the completion thereof. Contracted Provider agrees to immediately notify WellCare of any criminal convictions of any Contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7 Person-Centered Planning, Care/Service Plan, and Services. Provider and Contracted Providers shall comply with all State and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by State and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Person.

7.3 LTSS providers shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 WellCare agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if State requirements differ) and provide a copy to LTSS provider(s) responsible for implementation.

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: Medicare
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide WellCare with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to WellCare hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Laws, Program Requirements, and Government Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE D
COMPANY AFFILIATES

As of the Effective Date, the Affiliates of WellCare included as the "Company" are listed below.

Affiliates	State
Celtic Insurance Company	Multiple States
Health Net Community Solutions, Inc.	Multiple States
Health Net Life Insurance Company	Multiple States
WellCare Health Plans, Inc.	Multiple States
WellCare of Alabama, Inc.	Alabama
Bridgeway Health Solutions of Arizona, Inc. Care1st Health Plan of Arizona Inc. Health Net of Arizona, Inc., d/b/a Arizona Complete Health One Care by Care1st Health Plan of Arizona Inc. WellCare Health Insurance of the Southwest, Inc. WellCare Health Plans of Arizona, Inc.	Arizona
Arkansas Health & Wellness Health Plan, Inc. Arkansas Total Care, Inc. NovaSys Health, Inc. WellCare Health Insurance Company of America	Arkansas
Harmony Health Plan, Inc.	Arkansas, Illinois, Mississippi, South Carolina, Tennessee
California Health and Wellness Plan Health Net of California, Inc. WellCare of California, Inc., f/k/a Easy Choice Health Plan, Inc.	California
WellCare Health Insurance of Connecticut, Inc.	Connecticut
WellCare of Connecticut, Inc.	Connecticut, North Carolina
Sunshine Health Plan Community Solutions, Inc. Sunshine State Health Plan, Inc. WellCare Health Insurance of Arizona, Inc.WellCare of Florida, Inc.	Florida
Ambetter of Peach State, Inc. Peach State Health Plan, Inc. WellCare of Georgia, Inc.	Georgia
WellCare Health Insurance of Arizona, Inc., d/b/a 'Ohana Health Plan, Inc. WellCare Health Insurance of Hawaii, Inc.	Hawaii
IlliniCare Health Plan, Inc. Meridian Health Plan of Illinois, Inc. WellCare of Illinois, Inc.	Illinois
Meridian Health Plan of Michigan, Inc.	Illinois, Indiana, Michigan, Ohio
Coordinated Care Corporation, d/b/a Managed Health Services - IN	Indiana
Iowa Total Care, Inc.	Iowa
Sunflower State Health Plan, Inc.	Kansas
WellCare Health Insurance Company of Kentucky, Inc., d/b/a WellCare of Kentucky, Inc.	Kentucky
Louisiana Healthcare Connections, Inc. WellCare Health Insurance Company of Louisiana, Inc.	Louisiana
WellCare of Maine, Inc.	Maine
CeltiCare Health Plan of Massachusetts, Inc. WellCare Health Plans of Massachusetts, Inc.	Massachusetts
Meridian Health Plan of Michigan, Inc. Michigan Complete Health, Inc.	Michigan
Ambetter of Magnolia, Inc.	Mississippi

Affiliates	State
Magnolia Health Plan, Inc. WellCare of Mississippi, Inc.	
Home State Health Plan, Inc.	Missouri
Nebraska Total Care, Inc.	Nebraska
SilverSummit Healthplan, Inc.	Nevada
Granite State Health Plan, Inc. WellCare Health Insurance Company of New Hampshire, Inc. WellCare of New Hampshire, Inc.	New Hampshire
WellCare Health Insurance Company of New Jersey, Inc. WellCare Health Plans of New Jersey, Inc.	New Jersey
Western Sky Community Care, Inc.	New Mexico
New York Quality Healthcare Corporation, d/b/a Fidelis Care WellCare Health Insurance of New York, Inc. WellCare of New York, Inc.	New York
American Progressive Life and Health Insurance Company of New York	New York, Maine
WellCare Health Insurance of North Carolina, Inc. WellCare of North Carolina, Inc.	North Carolina
Buckeye Community Health Plan, Inc. Buckeye Health Plan Community Solutions, Inc.	Ohio
WellCare Health Insurance Company of Oklahoma, Inc. WellCare of Oklahoma, Inc.	Oklahoma
Health Net Health Plan of Oregon, Inc. Trillium Community Health Plan, Inc.	Oregon
Pennsylvania Health & Wellness, Inc.	Pennsylvania
WellCare Health Plans of Rhode Island, Inc.	Rhode Island
Absolute Total Care, Inc. WellCare of South Carolina, Inc.	South Carolina
WellCare Health Insurance of Tennessee, Inc.	Tennessee
SelectCare Health Plans, Inc. SelectCare of Texas, Inc. Superior HealthPlan Community Solutions, Inc. Superior Healthplan, Inc. WellCare National Health Insurance Company WellCare of Texas, Inc.	Texas
WellCare Health Plans of Vermont, Inc.	Vermont
WellCare of Virginia, Inc.	Virginia
Coordinated Care of Washington, Inc. WellCare Health Insurance Company of Washington, Inc. WellCare of Washington, Inc.	Washington
Managed Health Services Insurance Corporation	Wisconsin

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT ("***Attachment***") is made and entered between WellCare Health Plans, Inc., a North Carolina corporation ("***WellCare***") and Dare County Administrative Offices ("***Provider***").

WHEREAS, WellCare and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "Agreement"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is part of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "***Participating Providers***" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement, or, if not defined there, in the State Contract (as herein defined). All technical managed care terms used in this Attachment are defined in the Agreement or this Attachment, and are consistent with definitions included in Covered Person materials issued in conjunction with the Medicaid managed care program.

1.1. "***Amendment***" means any change to the terms of a contract, including terms incorporated by reference that modifies fee schedules. A change required by federal or state law, rule, regulation, administrative hearing, or court order is not an amendment.

1.2. "***Clean Claim***" means a claim for services submitted to WellCare by a Medicaid managed care medical or pharmacy services provider that can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

1.3. "***Emergency Medical Condition***" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in the following: placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. "Emergency Medical Condition" also means a medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.

1.4. "***Emergency Services***" means inpatient and outpatient services furnished by a qualified provider needed to evaluate or stabilize an Emergency Medical Condition.

1.5. "***Health Care Provider***" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes of North Carolina or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes of North Carolina or is owned or operated by the State of North Carolina in which health care services are provided to patients.

1.6. ***"Medicaid Product"*** refers to those programs and health benefit arrangements offered by WellCare or other Company pursuant to a State Contract. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.7. "***Medically Necessary Service***" or "***Medically Necessary***" means definition as found in Section III.A.78.

1.8. "***Objective Quality Standards***" means the objective standards for quality determinations identified by WellCare that assess a provider's ability to deliver care; include specific defined thresholds for adverse quality determinations; meet standards established by the National Committee on Quality Assurance (NCQA); and are not discriminatory.

1.9. "***Primary Care Provider***" or "***PCP***" means the participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Covered Person to provide and coordinate the Covered Person's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.

1.10. "***State***" means North Carolina.

1.11. "***State Contract***" means a contract between WellCare or other Company and one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so.

2. Medicaid Product.

2.1. Medicaid and/or CHIP Product. This Product Attachment constitutes the "Medicaid Product Attachment" and is incorporated into the Agreement between Provider and WellCare. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2. Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3. Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

2.4. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from WellCare. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

4. Governmental Program Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract to be included in the Agreement with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

5. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the North Carolina Medicaid Product under the State Contract.

1. Compliance.

1.1 Compliance with State and Federal Laws. Participating Provider understands and agrees that it, he or she is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and State Contract, and all persons or entities receiving state and federal funds. Participating Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. *(Section VII, Section G(3)(a)).*

1.2 Department Authority Related to the Medicaid Program. Participating Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services ("***NC DHHS***") is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs. *(Section VII, G(3)(e)).*

1.3 Credentialing. Each Participating Provider shall be enrolled as a Medicaid provider as required by 45 C.F.R. § 455.410 and maintain enrollment for the term of the Agreement. Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet WellCare's network participation requirements, as outlined in WellCare's Provider Manual and its Credentialing and Re-credentialing Policy. Participating Provider shall notify WellCare of changes in the status of any information relating to Participating Provider's professional credentials. Participating Provider shall complete reenrollment or re-credentialing before renewal of the Agreement as set forth below:

(a) during the provider credentialing transition period, no less frequently than every five (5) years; and

(b) during the provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the NC DHHS. *(Section VII, G(1)(f))*

1.4 Liability Insurance. Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to WellCare. Participating Provider shall notify WellCare of subsequent changes in the status of Participating Provider's professional liability insurance on a timely basis. *(Section VII, G(1)(g)).*

1.5 Utilization Management. Participating Provider shall comply with WellCare's utilization management programs, quality management programs, and provider sanction programs, except to the extent that any of these programs conflict with Participating Provider's professional or ethical responsibility or interfere with Participating Provider's ability to provide information or assistance to patients. WellCare utilizes only NC Medicaid's Clinical Coverage Policies for utilization management/clinical guidelines and other NC DHHS-approved utilization management/clinical guidelines. *(Section VII, G(1)(o)).*

1.6 Dispute Resolution. Participating Provider shall utilize the applicable dispute resolution procedures outlined in the Agreement to resolve disputes between WellCare and Participating Provider. *(Section VII, G(1)(q))*.

1.7 Reporting Requirements. Participating Provider shall promptly provide WellCare with the data and information that WellCare requests in order to meet its reporting requirements under the State Contract. *(Section VII, J. Table 1).*

1.8 Hours of Operation. Participating Provider will offer hours of operation to Covered Persons that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Participating Provider serves only Medicaid or NC Health Choice members. *(Section V, D(1)(d)(iii)).*

2. Entire Agreement. The Agreement identifies the documents that constitute the entire contract between the parties. *(Section VII, G(1)(a)).*

3. Hold Harmless. Participating Provider agrees to hold the Covered Person harmless for charges for any Covered Service. Participating Provider agrees not to bill a Covered Person for Medically Necessary Services covered by WellCare so long as the Covered Person is eligible for coverage. *(Section VII, G(3)(b))*. Participating Provider will not hold Covered Person's responsible for any of the following: (a) WellCare's debts in the event of its insolvency; (b) Covered Services provided to the Covered Person for which: (i) NC DHHS does not pay WellCare, or (ii) NC DHHS, or WellCare, does not pay the Participating Provider; (c) payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if WellCare covered the services directly. 42 C.F.R. § 438.106. *(Section V, C(1)(i)(iii) and Section V, C(2)(r)(iii))*.

4. Liability. Participating Provider understands and agrees that NC DHHS does not assume liability for the actions of, or judgments rendered against, WellCare, Payors, its employees, agents or subcontractors. Further, Participating Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to Participating Provider by WellCare or Payor or any judgment rendered against WellCare or Payor. *(Section VII, G(3)(c)).*

5. Non-Discrimination.

5.1 Equitable Treatment of Covered Persons. Participating Provider agrees to render provider services to Covered Persons with the same degree of care and skills as customarily provided to Participating Provider's patients who are not Covered Persons, according to generally accepted standards of medical practice. Participating Provider and WellCare agree that Covered Persons and non-Covered Persons should be treated equitably. Participating Provider agrees not to discriminate against Covered Persons on the basis of race, color, national origin, age, sex, gender, or disability. *(Section VII, G(3)(d))*.

5.2 Interpreting and Translation Services. Participating Provider shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Covered Person. Participating Provider shall ensure that Participating Provider's staff are trained to appropriately communicate with patients with various types of hearing loss. Participating Provider shall report to WellCare, in a format and frequency determined by WellCare, whether hearing loss accommodations are needed and provided and the type of accommodation provided. *(Section VII, G(1)(t)).*

6. Term; Termination.

6.1 Term. This Attachment is coterminous with the Agreement, unless otherwise agreement by the parties, but in no event will the term of this Attachment exceed the term of the State Contract (including, for avoidance of doubt, any renewals of the State Contract) *(Section VII, G(1)(c))*.

6.2 Termination. The Agreement sets forth the basis for termination of the Agreement by either party and the related notice requirements. Notwithstanding anything in the Agreement or this Attachment to the contrary, WellCare may immediately terminate the Agreement or this Attachment and a Participating Provider's participation thereunder upon: (1) a confirmed finding of fraud, waste or abuse by the NC DHHS or the North Carolina Department

of Justice Medicaid Investigations Division, or (2) failure of the Participating Provider to maintain enrollment as a Medicaid provider. *(Sections VII, G(1)(d) and G(1)(f)(i))*.

6.3 Insolvency. If the Agreement or this Attachment terminates as a result of WellCare's or Payor's insolvency, Participating Provider will cooperate in the transition of administrative duties and records and ensure the continuation of care when inpatient care is on-going in accordance with the requirements of the Agreement, this Attachment and the State Contract. If WellCare or Payor provides for or arranges for the delivery of health care services on a prepaid basis, Participating Provider will continue inpatient care until the patient is ready for discharge. *(Section VII, G(1)(e))*.

7. Covered Person Services.

7.1 Covered Person Billing. Participating Provider shall not bill any Medicaid Managed Care Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. Participating Provider is responsible for collecting applicable deductibles, copayments, coinsurance and fees for non-Covered Services. This provision does not prohibit a Participating Provider and Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense, as long as the Participating Provider has notified the Covered Person in advance that a Payor may not cover or continue to cover specific services and the Covered Person to receive the services *(Section VII, G(1)(h))*.

7.2 Provider Accessibility. Participating Provider shall provide call coverage or other back-up to provide service in accordance with WellCare's standards for provider accessibility addressed set forth herein, in the Provider Manual and/or in the State Contract. *(Section VII, G(1)(i))*. Participating Provider agrees to meet the NC DHHS standards for timely access to care and services, taking into account the urgency of need for services. *(Section V, D(1)(d)(ii))*. Participating Provider shall provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Covered Persons with physical or mental disabilities. *(Section V, (1)(d)(vi))*.

7.3 Eligibility Verification. WellCare or Payor shall provide a mechanism that allows Participating Provider to verify Covered Person eligibility, based on current information held by WellCare or Payor, as applicable, before rendering Covered Services. *(Section VII, G(1)(j))*.

7.4 Covered Person Appeals and Grievances. Participating Provider shall cooperate with Covered Person in regard to Covered Person appeals and grievance procedures. *(Section VII, G(1)(l))*. Participating Provider has the right to file a grievance or appeal. WellCare's internal appeal processes must be completed before seeking other legal or administrative remedies under state or federal law. *(Section V, D(2)(c)(xi))*.

7.5 Appointment Wait Times. Participating Provider shall cooperate with WellCare to ensure that appointment wait times for Covered Persons do not exceed the requirements set forth below, to the extent applicable. *(Section VII, F. Table 3)*.

(a) If Participating Provider is a PCP providing preventative care services, appointment wait time shall not exceed thirty (30) calendar days for adults (21 years of age and older) and children ages six (6) months to twenty (20) years of age, and fourteen (14) calendar days for children less than six (6) months of age.

(b) If Participating Provider is a PCP providing urgent care services, appointment wait time shall not exceed twenty-four (24) hours.

(c) If Participating Provider is a PCP providing services for routine/check-up without symptoms, appointment wait time shall not exceed thirty (30) calendar days.

(d) If Participating Provider is a PCP providing after-hours access for emergent and urgent care, care shall be administered immediately upon presentation at a service delivery site.

(e) If Participating Provider provides prenatal care, appointment wait time for initial appointments within the first or second trimester shall not exceed fourteen (14) calendar days and appointment wait time for initial appointments within the third trimester or for a high-risk pregnancy shall not exceed five (5) calendar days.

(f) If Participating Provider provides specialty care, appointment wait time shall not exceed twenty-four (24) hours for urgent care services or thirty (30) calendar days for routine/check-up without symptoms services. For after-hours access for emergent and urgent care, care shall be administered immediately upon immediately upon presentation at a service delivery site.

(g) If Participating Provider provides behavioral health care, appointment wait time shall not exceed thirty (30) minutes for Mobile Crisis Management Services; twenty-four (24) hours for Urgent Care Services for Mental Health or Urgent Care Services for SUDs; and fourteen (14) calendar days for Routine Services for Mental Health or Routine Services for SUDs. For Emergency Services for Mental Health or SUDs, care should administered immediately upon presentation at a service delivery site.

(h) To the extent Participating Provider performs Emergency Services, Participating Provider shall make Emergency Services available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

8. Records.

8.1 Medical Records. Participating Provider shall maintain confidentiality of Covered Person medical records and personal information and other health records as required by law. Participating Provider shall maintain adequate medical and other health records according to industry and WellCare standards. Participating Provider shall make copies of such records available to WellCare, Payor and NC DHHS in conjunction with its regulation of WellCare. Participating Provider shall make available and furnish the records immediately upon request in either paper or electronic form, at no cost to the requesting party. *(Section VII, G(1)(k))*.

8.2 Access to Provider Records.

(a) Participating Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to WellCare or Payor and the Agreement and any records, books, documents, and papers that relate to WellCare or Payor and the Agreement and/or Participating Provider's performance of its responsibilities under this Agreement for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions: (i) the United States Department of Health and Human Services or its designee; (ii) the Comptroller General of the United States or its designee; (iii) NC DHHS, its Medicaid managed care program personnel, or its designee; (iv) the Office of Inspector General; (v) North Carolina Department of Justice Medicaid Investigations Division; (vi) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS; (vii) the North Carolina Office of State Auditor, or its designee; (viii) a state or federal law enforcement agency; and (ix) any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

(b) Participating Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the NC DHHS.

(c) Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation. *(Section VII, G(3)(f))*.

9. Provider Ownership Disclosure. Participating Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other

federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Participating Provider agrees to notify, in writing, WellCare and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction. *(Section VII, G(3)(g))*.

10. Provider Payment.

10.1 Methodology. The Agreement includes a provider payment provision that describes the methodology to be used as a basis for payment. Such provision does not include a rate methodology that provides for automatic increases in rates, consistent with N.C. Gen. Stat. 58-3-227(a)(5). *(Section VII, G(1)(m))*.

10.2 G.S. 58-3-225, Prompt Claim Payments under Health Benefit Plans. Unless otherwise provided by the NC DHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy, or Care Management for At-Risk Children Policy, Participating Provider shall submit all claims to the Payor for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Participating Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Participating Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required. *(Section VII, G(3)(h))*.

(a) For medical claims (including behavioral health), Payor shall comply with the requirements set forth below.

(i) The Payor shall within eighteen (18) calendar days of receiving a Medical Claim notify Participating Provider whether the claim is a Clean Claim, or pend the claim and request from Participating Provider all additional information needed to process the claim.

(ii) The Payor shall pay or deny a medical Clean Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

(iii) A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

(b) For pharmacy claims, Payor shall comply with the requirements set forth below.

(i) The Payor shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a pharmacy Clean Claim or notify Participating Provider that more information is needed to process the claim.

(ii) A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.

(c) If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the Payor shall deny the claim per § 58-3-225 (d). The Payor shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

(d) If the Payor fails to pay a Clean Claim in full pursuant to this provision, the Payor shall pay interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

(e) Failure to pay a Clean Claim within thirty (30) days of receipt will result in the Payor paying Provider a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

(f) The Payor shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require Provider to requests the interest or the penalty.

10.3 Government Funds. Participating Provider and WellCare acknowledge that funds used for provider payments are government funds. (Section VII, G (1)(s)).

11. Data to Provider. WellCare will provide certain data and information to the Provider, and changes to such information, which may include performance feedback report if compensation is related to efficiency criteria, information on benefit exclusions, administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies *(Section VII, G(1)(n))*.

12. Provider Directory. Participating Provider authorizes WellCare and/or Payor to include, and WellCare and/or Payor shall include, the name of Participating Provider and/or Participating Provider's group in the provider directory distributed to Covered Persons. *(Section VII, G (1)(p))*.

13. Assignment. Participating Provider shall not assign, delegate, or transfer any of its duties and/or responsibilities under the Agreement without prior written consent of WellCare. WellCare shall notify Provider in writing of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. (Section VII, G (1)(r)).

14. Providers of Perinatal Care. To the extent that Participating Provider offers prenatal, perinatal, and postpartum services or is an obstetrician, Participating Provider shall comply with NC DHHS's Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs among participating providers. Participating Provider shall: (a) complete the standardized risk-screening tool at each initial visit; (b) allow WellCare or WellCare's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators; (c) commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation; (d) commit to decreasing the cesarean section rate among nulliparous women; (e) offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation; (f) complete a high-risk screening on each pregnant Medicaid Managed Care Covered Person in the program and integrate the plan of care with local pregnancy care management; (g) decrease the primary cesarean delivery rate if the rate is over NC DHHS's designated cesarean rate (NC DHHS will set the rate annually at or below 20%); and (h) ensure comprehensive post-partum visits occur within fifty-six (56) days of delivery *(Section VII, G(1)(u)) and M(3))*.

14.1 High-Risk Pregnancies Information Requirement. Participating Provider shall send all screening information and applicable medical record information for Covered Persons in the Care Management of High-Risk Pregnancies to WellCare and the Local Health Departments or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the provider completing the screening (Section VII, M(3.3.i.)).

15. Advanced Medical Homes. To the extent Participating Provider is an Advanced Medical Home (AMH), Participating Provider shall comply with NC DHHS' Advanced Medical Home Program, including the requirements set forth below. *(Section VII, G(1)(v))*.

15.1 Identified as PCP. Participating Provider shall accept Covered Persons and be listed as a PCP in WellCare's Covered Person-facing materials for the purpose of providing care to Covered Persons and managing their health care needs.

15.2 Care Coordination Services. Participating Provider shall provide primary care and patient care coordination services to each Covered Person, in accordance with WellCare policies. *(Section VII, G(1)(v)(i))*

15.3 Primary Care Coverage. Participating Provider shall provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

15.4 Minimum Office Hours. Participating Provider shall provide direct patient care a minimum of 30 office hours per week.

15.5 Preventive Services. Participating Provider shall provide preventive services, in accordance with Section VII. Attachment M. Table 1: Required Preventive Services of the State Contract as set forth on Attachment A: Medicaid, Appendix A to Schedule A, Governmental Program Requirements to the Agreement.

15.6 Unified Medical Record. Participating Provider shall maintain a unified patient medical record for each Covered Person following the WellCare's medical record documentation guidelines.

15.7 Referrals. Participating Provider shall promptly arrange referrals for Medically Necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

15.8 Medical Record Transfer. Participating Provider shall transfer the Covered Person medical record to the receiving provider upon the change of PCP at the request of the new PCP or WellCare (if applicable) and as authorized by the Covered Person within thirty (30) days of the date of the request, free of charge.

15.9 Appointments. Participating Provider shall authorize care for the Covered Person or provide care for the Covered Person based on the standards of appointment availability as defined by the WellCare's network adequacy standards.

15.10 Second Opinion. Participating Provider shall refer for a second opinion as requested by the Covered Person, based on NC DHHS guidelines and WellCare standards.

15.11 Utilization Management.

15.11.1.Participating Provider shall review and use Covered Person utilization and cost reports provided by WellCare for the purpose of AMH level utilization management and advise WellCare of errors, omissions, or discrepancies if they are discovered.

15.11.2.Prepaid Health Plans utilizes only North Carolina Medicaid's Clinical Coverage Policies for utilization management/clinical guidelines and other Department-approved utilization management/clinical guidelines.

15.12 Enrollment Report. Participating Provider shall review and use the monthly enrollment report provided by WellCare for the purpose of participating in WellCare or practice-based population health or care management activities. *(Section VII, M(2))*

15.13 Advanced Medical Home Tier 3 Standard Terms and Conditions. If Provider or a Contracted Provider is a Tier 3 Advanced Medical Home ("AMH") Participating Provider, the Agreement must include provisions that outline the AMH Tier 3 care management model and requirements consistent with the State Contract as set forth below. *(Section VII, M(2 - 4 (a-e))*

(a) (The AMH has primary responsibility for care management, and when the Prepaid Health Plan ("PHP") and AMH offer the same or similar disease management programs, the PHP will defer to the AMH

program when the member's AMH is contracted as an Tier 3 AMH ("AMH3" or "AMH Level 3") except where the AMH is not performing to the operational or quality levels contractually required; and

(b) The PHP's disease management and care coordination program shall coordinate and work with the member's Advanced Medical Home's care coordination when the member's AMH is contracted as a Tier 3 AMH.

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network ("CIN") with which the practice has a contractual agreement that contains equivalent contract requirements. The WellCare shall maintain a contractual relationship with the AMH (not the CIN).

15.13.1. Tier 3 AMH practices must be able to risk stratify all empaneled patients.

(a) The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the WellCare are reconciled with the practice's panel list and up to date in the clinical system of record.

(b) The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.

(c) The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the WellCare with clinical information to score and stratify the patient panel.

(d) The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.

(e) The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.

(f) The Tier 3 AMH practice must define the process and frequency of risk score review and validation.

15.13.2. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.

(a) The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.

(b) The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:

i) Patients immediate care needs and current services;

ii) Other state or local services currently used;

iii) Physical health conditions, including dental;

iv) Current and past behavioral and mental health and substance use status and/or disorders;

v) Physical, intellectual developmental disabilities;

vi) Medications — prescribed and taken;

vii) Priority domains of social determinants of health (housing, food, transportation; and interpersonal safety);

viii) Available informal, caregiver, or social supports, including peer supports.

(c) The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.

(d) For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

15.13.3. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

(a) The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

(b) The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.

(c) The Tier 3 AMH practice must incorporate findings from the WellCare Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

(d) The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:

i) Measurable patient (or patient and caregiver) goals;

ii) Medical needs including any behavioral health and dental needs;

iii) Interventions, including medication management and adherence;

iv) Intended outcomes; and

v) Social, educational, and other services needed by the patient.

(e) The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

(f) The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

(g) The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.

(h) The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

(i) The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

i) Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.

ii) Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital; and

iii) Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

15.13.4. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

(a) The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

i) Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;

ii) Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;

iii) NICU discharges; and

iv) Clinical complexity, severity of condition, medications, risk score.

(b) For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

(c) The Tier 3 AMH practice must include the following elements in transitional care management:

i) Ensuring that a care manager is assigned to manage the transition
ii) Facilitating clinical handoffs;
iii) Obtaining a copy of the discharge plan/summary;
iv) Conducting medication reconciliation;
v) Following-up by the assigned care manager rapidly following discharge;
vi) Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
vii) Developing a protocol for determining the appropriate timing and format of such outreach.

15.13.5. Tier 3 AMH practices must use electronic data to promote care management.

(a) The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

16. Care Management for High-Risk Pregnancy. To the extent Participating Provider is a Local Health Department ("***LHD***") offering care management for high-risk pregnancy, this Section applies. Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by LHDs *(Section VII, M(4))*.

16.1 General Contracting Requirement. Participating Provider shall accept referrals from WellCare for Care Management for High-Risk Pregnancy Services. Participating Provider shall comply with the requirements NC DHHS' Care Management for High-Risk Pregnancy Policy.

16.2 Care Management for High-Risk Pregnancy: Outreach. Participating Provider shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy. Participating Provider shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

16.3 Care Management for High-Risk Pregnancy: Population Identification and Engagement. Participating Provider shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) calendar days of receipt of risk screening forms. Participating Provider shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome. Participating Provider shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need. Participating Provider shall review available WellCare data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to Participating Provider. Participating Provider shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

16.4 Care Management for High-Risk Pregnancy: Assessment and Risk Stratification. Participating Provider shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support. Participating Provider shall utilize assessment findings, including those conducted by WellCare to determine level of need for care management support. Participating Provider shall document assessment findings in the care management documentation system. Participating Provider shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained. Participating Provider shall assign case status based on level of patient need.

16.5 Care Management for High-Risk Pregnancy: Interventions. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals. Participating Provider shall provide care management services based upon level of patient need as determined through ongoing assessment. Participating Provider shall develop patient-centered care plans, including appropriate goals, interventions and tasks. Participating Provider shall utilize NC Resource Platform and identify additional community resources once NC DHHS has

certified it as fully functional. Participating Provider shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Covered Person's WellCare network. Participating Provider shall document all care management activity in the care management documentation system.

16.6 Care Management for High-Risk Pregnancy: Integration with WellCare and Providers. Participating Provider shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. Participating Provider shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program. Participating Provider shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers. Participating Provider shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county. Participating Provider shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population. Participating Provider shall ensure awareness of WellCare Covered Persons' "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of WellCare's prior authorization processes relevant to referrals.

16.7 Care Management for High-Risk Pregnancy: Collaboration with WellCare. Participating Provider shall work with WellCare to ensure program goals are met. Participating Provider shall review and monitor WellCare reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk. Participating Provider shall communicate with WellCare regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers. Participating Provider shall participate in pregnancy care management and other relevant meetings hosted by WellCare.

16.8 Care Management for High-Risk Pregnancy: Training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by WellCare and/or NC DHHS, including webinars, new hire orientation or other programmatic training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by WellCare and/or NC DHHS. Participating Provider shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes. Participating Provider shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

16.9 Care Management for High-Risk Pregnancy: Staffing.

(a) Participating Provider shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Care Managers for High- Risk Pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position. Participating Provider shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager. Participating Provider shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team. If the Participating Provider only has a single Care Manager for High-Risk Pregnancy, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following WellCare /NC DHHS guidance about communication with WellCare about

any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by WellCare.

(b) Participating Provider shall ensure that Pregnancy Care Managers must demonstrate: (i) a high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes; (ii) proficiency with the technologies required to perform care management functions; (iii) motivational interviewing skills and knowledge of adult teaching and learning principles; (iv) ability to effectively communicate with families and providers; and (v) critical thinking skills, clinical judgment and problem-solving abilities.

(c) Participating Provider shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; (iv) utilization of reports to actively assess individual care manager performance; and (v) compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

17. Care Management for At-Risk Children. To the extent Participating Provider is a LHD offering care management for at-risk children, this Section applies. Care Management for At-Risk Children is care management services provided by to a subset of the Medicaid population ages 0-5 identified as being "high-risk" *(Section VII, M(5))*.

17.1 Care Management for At-Risk Children: General Requirements. Participating Provider shall accept referrals from WellCare for children identified as requiring Care Management for At-Risk Children. Participating Providers shall comply with the requirements of NC DHHS' Care Management for At-Risk Children Policy.

17.2 Care Management for At-Risk Children: Outreach. Participating Provider shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources. Participating Provider shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services. Participating Provider shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county. Participating Provider shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population. Participating Provider shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by NC DHHS.

17.3 Care Management for At-Risk Children: Population Identification. Participating Provider shall use any claims-based reports and other information provided by WellCare, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations. Participating Provider shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population. Participating Provider shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

17.4 Care Management for At-Risk Children: Family Engagement. Participating Provider shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care. Participating Provider shall foster self-management skill building when working with families of children. Participating Provider shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

17.5 Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level. Participating Provider shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description. Participating Provider shall review and monitor WellCare reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk. Participating Provider shall use the information gained from the assessment to determine the need for and the level of service to be provided.

17.6 Care Management for At-Risk Children: Plan of Care. Participating Provider shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards. Participating Provider shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals. Participating Provider shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need. Participating Provider shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

17.7 Care Management for At-Risk Children: Integration with WellCare and Providers. Participating Provider shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs. Participating Provider shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team. Where care management is being provided by WellCare and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the WellCare/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services Participating Provider shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical home PCP and/or care team and to WellCare. Participating Provider shall ensure awareness of WellCare Covered Person's "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of WellCare's prior authorization processes relevant to referrals.

17.8 Care Management for At-Risk Children: Service Provision. Participating Provider shall document all care management activities in the care management documentation system in a timely manner. Participating Provider shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

17.9 Care Management for At-Risk Children: Training. Participating Provider shall participate in NC DHHS/ WellCare-sponsored webinars, trainings and continuing education opportunities as provided. Participating Provider shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

17.10 Care Management for At-Risk Children: Staffing.

(a) Participating Provider shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address

the needs of patients with both medically and socially complex conditions. Participating Provider shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors. If the Participating Provider has only has a single Care Management for At-Risk Children care manager, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, Participating Provider shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following NC DHHS guidance regarding vacancies or extended staff absences and adhering to NC DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight. Participating Provider shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications. Participating Provider shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

(b) Participating Provider shall ensure that Care Management for At-Risk Children Care Managers must demonstrate: (i) proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system; (ii) ability to effectively communicate with families and providers; (iii) critical thinking skills, clinical judgment and problem-solving abilities; and (iv) motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles.

(c) Participating Provider shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; and (iv) utilization of monthly and on-demand reports to actively assess individual care manager performance.

18. N.C. Gen. Stat. Ch. 58 Requirements.

18.1 N.C. Gen. Stat. § 58-3-200(c), Coverage Determinations. If WellCare or Payor determines that services, supplies or other items are Covered Services, WellCare or Payor shall not subsequently retract its determination after such services have been provided, or reduce payments for such services furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person's health condition that was knowingly made by the Covered Person or the provider of the service, supply or other item. *(Section VII, G (1)(x)(i))*.

18.2 N.C. Gen. Stat. § 58-3-227(h), Contract Negotiations. When offering a contract to a Health Care Provider, WellCare or Payor shall make available to Health Care Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by the class of Provider. Upon the request of the Health Care Provider, WellCare or Payor shall also make available the full schedule of fees for services or procedures billed by that class of provider(s). If Health Care Provider requests fees for more than 30 services and procedures, WellCare or Payor may require the Health Care Provider to specify the additional requested services and procedures and may limit the Health Care Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by such Health Care Provider. *(Section VII, G(1)(x)(ii))*.

18.3 N.C. Gen. Stat. § 58-50-275(a)-(b), Notice Contact. Provider and WellCare have set forth in the Agreement a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed Amendments and other notices, pertaining to the contractual relationship between the Parties shall be sent. Notwithstanding anything in the Agreement to the contrary, means for sending all notices provided under the Agreement is one or more of the following, calculated as (i) five business days following

the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an Amendment if agreed to by WellCare and Provider (Section VII, G(1)(x)(iv)).

18.4 N.C. Gen. Stat. § 58-50-280(a)-(d), Proposed Amendment. WellCare shall date, label "Amendment," sign, include an effective date, and send any proposed Amendment to this Agreement or this Attachment to the notice contact of Provider. Provider will have sixty (60) days from the date of receipt to object to the proposed Amendment in writing. If Provider fails to object in writing within such sixty (60) days, the Amendment will be effective. If Provider timely objects to a proposed Amendment in writing, then WellCare may terminate the Agreement or this Attachment upon sixty (60) days' written notice to Provider. *(Section VII, G(1)(x)(v))*.

18.5 N.C. Gen. Stat. § 58-50-285 (a)-(b), Policies and Procedures. WellCare or Payor shall provide a Health Care Provider with a copy of its policies and procedures prior to execution of a new or amended contract and annually to all Participating Providers. Such policies and procedures may be provided in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on the WellCare or Payor website. Such policies and procedures will not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail. (Section VII, G(1)(x)(vi)).

18.6 N.C. Gen. Stat. § 58-51-37(d)-(e), Pharmacy Participation. To the extent Participating Provider is a pharmacy or pharmacist, this Section applies. Participating Provider shall not waive, discount, rebate, or distort a copayment or a Covered Person's portion of a prescription drug coverage or reimbursement. If Participating Provider provides a pharmacy service to a Covered Person that meets the terms and requirements of the Coverage Agreement, Participating Provider shall provide its pharmacy services to all Covered Persons covered by that Coverage Agreement on the same terms and requirements. A violation of the foregoing is a violation of the Pharmacy Practice Act subjecting the pharmacist to disciplinary authority of the North Carolina Board of Pharmacy. At least sixty (60) days before the effective date of a Payor providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, WellCare or Payor shall notify, in writing, all pharmacies within the geographical coverage area of the Coverage Agreement and offer to the pharmacies the opportunity to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. WellCare shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the Covered Persons of the Coverage Agreement of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and WellCare. The pharmacy notification provisions of this section do not apply when an individual or group is enrolled, but when WellCare enters a particular county of the State. *(Section VII, G(1)(x)(vii))*.

19. Indian Health Care Providers. To the extent Participating Provider is an Indian Health Care Provider, Participating Provider shall execute and comply with the Medicaid Managed Care Addendum for Indian Health Care Providers. *(Section VII, H)*.

20. Conflict of Interest. Participating Provider will comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the Social Security Act, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C. Participating Provider agrees that financial considerations will not influence decisions to provide medically appropriate care. Participating Provider shall abide by his or her professional obligations to patients and Covered Persons and will not take any actions that conflict with such obligations. *(Section V, A.9.i)*

21. Vaccines for Children Program. If Participating Provider is a Primary Care Provider who services Covered Persons under age 19, Participating Provider is encouraged to participate in the Vaccines for Children Program. If Participating Provider is a Primary Care Provider, Participating Provider will administer vaccines consistent with the AAP/Bright Future periodicity schedule. *(Section V, C(1)(c)(ix)* and *Section V, C(2)(v)(vii))*.

22. PCPs. If Participating Provider is a Primary Care Provider, Participating Provider will: (a) perform, during preventive service visits, and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the NC DHHS's Oral Health Periodicity Schedule; (b) refer infant Medicaid Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one (1), per the requirements of the NC DHHS's Oral Health Periodicity Schedule; and (c) include all of the following components in each medical screening: (i) routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents", screening for developmental delay at each visit through the 5th year and screening for Autistic Spectrum Disorders per AAP guidelines, (ii) comprehensive, unclothed physical examination, (iii) all appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices, (iv) laboratory testing (including blood lead screening appropriate for age and risk factors); and (e) health education and anticipatory guidance for both the child and caregiver. *(Section V, C.2.i)*.

23. Behavioral Health Providers. If Participating Provider is a behavioral health provider, Participating Provider will coordinate with Primary Care Providers and specialists conducting EPSDT screenings. *(Section V, C.2.j)*.

24. 340B Covered Entities. If Participating Provider is a 340B covered entity, the Participating Provider will: (a) submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program; (b) identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the NC DHHS (42 C.F.R. § 438.3(s)(3)); (c) comply with the point of sale identification of drugs purchased through the 340B program (42 C.F.R. § 438.3(s)(3)); and (d) resubmit the claims with the appropriate NCPDP 340B claims identification codes when 340B claims are retroactively identified (42 C.F.R. § 438.3(s)(3)). *(Section V, C(3)(i)(v))*.

25. Exclusion. Participating Provider represents and warrants that he, she or it is not excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b). Participating Provider will immediately notify WellCare in writing upon any change regarding foregoing. *(Section V, D(2)(c)(iv))*.

26. High Level Clinical Setting Discharge. Participating Provider will notify WellCare when a Covered Person in a high level clinical setting is being discharged. For the purpose of this section, a High Level Clinical Setting includes but is not limited to:

(a) Hospital/Inpatient acute care and long-term acute care
(b) Nursing Facility
(c) Adult Care Home
(d) Inpatient behavioral health services
(e) Facility-based crisis services for children
(f) Facility-based crisis services for adults
(g) ADATC

(Section V, D(2)(c)(xiv)).

27. Claim Submission. Participating Provider will not submit claim or encounter data for services covered by Medicaid managed care and WellCare directly to the NC DHHS. *(Section V, D(2)(c)(xviii))*.

28. Provider Preventable Conditions. Participating Provider will comply with 42 C.F.R. § 438.3(g), which, at a minimun, means non-payment of provider-preventable conditions as well as appropriate reporting, as required by WellCare. *(Section V, D(2)(d)(ii))*.

29. Program Integrity. Participating Provider: (a) will have compliance plans that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005; (b) will have policies and procedures that recognize and accept Medicaid as "the payer of last resort"; and (c) is prohibited from billing Covered Persons for Covered Services any amount greater than would be owed if the Participating Provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). *(Section V, D(2)(f)*; *Section V, J(2)(b)(iii)(c))*.

30. No Auto-Enrollment in Other Products. WellCare will not require individual practitioners, as a condition of contracting with it, to agree to participate or accept other products offered by the WellCare nor will WellCare automatically enroll the provider in any other product offered by it. This requirement does not apply to facility providers. *(Section V, D(2)(c) (viii))*

31. Grievance and Appeals. WellCare shall handle appeals and grievances raised by Provider in connection with the Medicaid Product promptly, consistently, fairly, and in compliance with state and federal law and Department requirements, through an appeals and grievance system that is distinct from that offered to Covered Persons. Such appeals and grievance system, additional information about which is set forth in the Provider Manual, shall meet the requirements set forth below:

(a) Grievances. WellCare will have a process in place to receive and resolve complaints or disputes with Provider, in a timely manner, where remedial action is not requested. WellCare will accept and resolve Provider's grievances regarding WellCare that are referred from the Department. WellCare will make available to Provider a method for submitting grievances through WellCare's provider portal.

(b) Appeals. WellCare will offer Provider appeal rights as described in the State Contract and Provider Manual. WellCare will provide written notice of Provider's right to appeal along with any notice of a decision giving rise to Provider's right to appeal. WellCare will make available to Provider a method for submitting appeals through WellCare's provider portal. WellCare will accept a written request for an appeal from Provider within thirty (30) calendar days of the date on which (i) Provider received written notice from WellCare of the decision giving rise to the right to appeal; or (ii) WellCare should have taken a required action and failed to take such actions. WellCare will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request, and will extend such timeframe by thirty (30) calendar days if Provider's request is for an appeal for good cause shown, as determined by WellCare. WellCare will consider the voluminous nature of required evidence/supporting documentation, and the appeal of an adverse quality decision, as good cause reasons to extend such timeframe. Provider shall exhaust WellCare's internal appeals process before seeking recourse under any other process permitted by contract or law.

(c) Resolution of Appeal. WellCare will establish a committee to review and make decisions on Provider's appeals, which committee will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal, as well as an external peer reviewer when the issue on appeal involves whether the provider met the Objective Quality Standards. WellCare will provide written notice of decision of the appeal (which notice shall include information regarding further appeal rights) within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all evidence is submitted to WellCare. Provider may be represented by an attorney during the appeals process.

(d) Appeals of Suspension or Withhold of Provider Payment. In cases of the suspension or withholding of Provider payments, WellCare will limit the issue on appeal to whether WellCare had good cause to commence the withholding or suspension of payments to Provider; WellCare will not address whether Provider has or has not committed fraud or abuse. WellCare will offer Provider an in-person or telephone hearing when Provider is appealing whether WellCare has good cause to withhold or suspend payments to Provider. WellCare will schedule such hearing and issue a written decision regarding whether WellCare had good cause to suspend or withhold payments within fifteen (15) business days of receiving Provider's appeal. Upon a finding that WellCare did not have good cause to suspend or withhold payments, WellCare will reinstate any payments that were withheld or suspended within five (5) business days. WellCare will pay interest and penalties for overturned denials, underpayments, or

findings that it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial. *(Attachment G-1.q)*

32. Material Changes to Provider Manual, Reimbursement Policies or Clinical Policies. WellCare shall notify Participating Provider of updates to WellCare's clinical policies electronically no later than 30 calendar days prior to the effective date of the policy, or at a date defined by the NC DHHS, directed to Participating Provider's contact for notices under this Agreement via WellCare's provider portal. Participating Provider may request written notification, at no additional cost, to be mailed no later than 30 days prior to the effective date of the policy, or at a date defined by the NC DHHS, of the policy. WellCare shall not implement any material changes to the clinical policies without express approval from the NC DHHS. *(Section VII, Attachment G(3)(i))*

33. Contract Amendments with Individual Providers. For the purposes of this Section 33 only, the following terms shall have the following definitions:

(i) "***Amendment***" shall mean any change to the terms of this Medicaid Product Attachment, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an Amendment.

(ii) "***Contract***" shall mean this Agreement, which is an agreement between WellCare and Provider for the provision of health care services by the provider on a preferred or in-network basis.

(iii) "***Health Benefit Plan***" shall mean a policy, certificate, contract, or plan as defined in N.C. Gen. Stat. §58-3-167.

(iv) "***Health Care Provider***" shall mean Provider if Provider is an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(v) "***Insurer***" shall mean WellCare (as otherwise defined herein), which is an entity as defined in N.C. Gen. Stat. §58-3-227(a)(4).

Insurer shall send any proposed Contract Amendment to the notice contact of Health Care Provider pursuant to N.C. Gen. Stat. §58-50-275. The proposed Amendment shall be dated, labeled "Amendment," signed by the Insurer, and include an effective date for the proposed Amendment. Health Care Provider receiving a proposed Amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed Amendment. The proposed Amendment shall be effective upon Health Care Provider failing to object in writing within sixty (60) days. If Health Care Provider objects to a proposed Amendment, then the proposed Amendment is not effective and the initiating Insurer shall be entitled to terminate the Contract upon sixty (60) days written notice to Health Care Provider. Nothing in this Part prohibits Health Care Provider and Insurer from negotiating Contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative notice contacts. *(Attachment G-1.x.iii)*

34. Exemption from Notification of Emergent or Observation Admissions. For all contracts with a hospital who attests live in production status with North Carolina HealthConnex, the contract shall indicate the provider is exempted from reporting any emergent or observation admissions to the PHP, and that the PHP shall utilize NC*Notify for such admission information. Except the exemption from notification shall not apply when the hospital has technical or data quality issues, in which case the hospital shall notify the PHP directly.

35. Incident Reporting Procedures and Peer Review Process. Providers rendering Covered Services to Members or Covered Persons shall report critical incidents to Health Plan and to the Department in accordance with all applicable Laws and Governmental Authority's mandated requirements and procedures for reporting such incidents, and Providers shall cooperate with Health Plan in its investigation of critical incidents. Notwithstanding the foregoing,

nothing in this Agreement shall require Providers who participate in Health Plan's peer review, medical review, or quality review committees to take any actions that are contrary to the confidentiality and liability protections afforded such Providers under N.C. Gen. Stat. §§90-21.22A, 131E-76, or 131E-95, as applicable.

36. Patient Choice Counseling Limitations. Nothing in this Agreement shall be construed to limit the ability of Provider to inform its patients of Provider or its Contracted Provider's participation or non-participation in specific Medicaid Managed Care health plans. Provider may also inform its patients of the categories of Medicaid participants remaining in North Carolina Medicaid Direct.

APPENDIX A TO
SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

Section VII Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (The age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes.)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
ANCILLARY SERVICES
PUBLIC AMBULANCE

Dare County Administrative Offices

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is 100% of the amount payable based on the Medicaid Managed Care Ambulance Fee Schedule set forth by the North Carolina Division of Health Benefits ("NCDHB") at the date of service.

Additional Directed Payments. WellCare shall make additional payments as directed and determined by NCDHB and approved by CMS.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

4. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

5. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

6. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claim processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered into as of the Effective Date of the Agreement by and between WellCare Health Plans, Inc. ("***Health Plan***") and Dare County Administrative Offices ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain provider agreement, including all Attachments, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this *"**Product**"*). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Health Plan or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "Medicare Product Type"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product Type for which a Compensation Schedule(s) is attached to this Medicare Product Attachment.

2.2 Participation. Except as otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicare Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicare Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual). Provider acknowledges that all or certain of Health Plan's duties with respect to the Medicare Product may be

delegated to a Company, a Payor or their delegates. Neither Health Plan, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product Type.

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicare Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicare Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule applicable to the various Medicare Product Types.

5.1 Schedule. The Compensation Schedule for the Medicare Product at any given time is the lesser of (i) the Allowable Charges for the particular Covered Service, or (ii) the appropriate amount for such Covered Service under the Company's fee schedule in effect on the date of service for the Medicare Product. Upon Provider's reasonable written request from time to time the Company will provide Provider with a representative sample of the fees then in effect under the Company's fee schedule applicable to the Medicare Product.

5.2 Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medicare Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

SCHEDULE A
CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. **DEFINITIONS**. The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Health Plan or a Payor and CMS, or among Health Plan or a Payor, CMS and the State, that governs the terms of Health Plan's or Payor's participation in a Medicare Plan.

1.5 ***Completion of Audit*** means completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Advantage Organization, First Tier, Downstream or Related Entity.

1.6 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.7 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.8 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.9 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.10 ***HHS*** means the United States Department of Health and Human Services.

1.11 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.12 ***Preclusion List*** means the CMS-compiled list of individuals and entities that -

a. Meet all of the following requirements: (i) The individual or entity is currently revoked from Medicare under 42 § 424.535. (ii) The individual or entity is currently under a reenrollment bar under 42 § 424.535(c). (iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (iii), CMS considers the following factors: (A) The

seriousness of the conduct underlying the individual's or entity's revocation. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program. (C) Any other evidence that CMS deems relevant to its determination; or

b. Meet both of the following requirements: (i) The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare. (ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (ii), CMS considers the following factors: (A) The seriousness of the conduct involved. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and (C) Any other evidence that CMS deems relevant to its determination. *42 C.F.R. § 422.2*

1.13 ***Related Entity*** means any entity that is related to Health Plan by common ownership or control and (1) performs some of Health Plan's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Health Plan at a cost of more than $2,500 during a contract period.

1.14 ***State*** means one or more applicable state governmental agencies of the State of North Carolina, unless otherwise defined in an Attachment for the purposes of that Attachment.

2. **COVERED SERVICES**. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. **SUBCONTRACTOR OBLIGATIONS**. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. **GOVERNMENT RIGHT TO INSPECT**.

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of Completion of Audit, whichever is later. *42 C.F.R. §§ 422.504 (i)(2)(i) and (ii), 423.505(i)(2)(i) and (iv).*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii), 423.505(i)(2)(ii) and (iii).*

5. **PRIVACY, CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS**. Provider shall comply with all privacy, confidentiality and accuracy requirements with respect to Covered Person record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) safeguarding the privacy of any information that identifies a particular Covered Person and, as applicable, having procedures that specify (i) for what purposes the information is used within the organization; and (ii) to whom and for what purposes it discloses the information outside the organization; (3) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (4) maintaining the records and information in an accurate and timely manner; and (5) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §§422.504(a)(13). 422.118 and 423.136*

6. **HOLD HARMLESS**.

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i), 422.504(g)(1)(i), 423.505(i)(3)(i) and 423.505(g)(1)(i).*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Health Plan or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT**. Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Health Plan's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §§422.504(i)(3)(iii), 423.505(i)(3)(iii).*

8. **PROMPT PAYMENT**. Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Medicare Product Attachment. Any Clean Claim shall be paid within thirty (30) days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, as designated by Provider or such Downstream Entity, as applicable. *42 C.F.R. §422.520(b)(1) and (2)*

9. **EFFECT OF PRECLUSION LIST**. Provider acknowledges and agrees that Payor may not pay, directly or indirectly, on any basis, for items or services furnished to a Covered Person by any individual or entity that is excluded by the HHS Office of the Inspector General or is included on the Preclusion List. Provider acknowledges and agrees that, after the expiration of the 60-day period specified in 42 C.F.R. § 422.222: (i) Provider will no longer be eligible for payment from Payor and will be prohibited from pursuing payment from the Covered Person as stipulated by the terms of the contract between CMS and the Payor per 42 C.F.R. § 422.504(g)(1)(iv); and (ii) Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point Provider will have already received notification of the preclusion. *42 C.F.R. §§422.224; 422.504(g)(1)(v)*

10. **COMPLIANCE WITH FEDERAL AND STATE LAWS**. Health Plan, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §§422.504(i)(4)(v), 423.505(i)(4)(iv)*

11. **DELEGATION OF DUTIES**. In the event that Health Plan delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Health Plan or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

11.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement,

Statement of Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

11.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or Payor determine that such parties have not performed satisfactorily.

11.3 Health Plan or Payor will monitor the performance of the parties on an ongoing basis.

11.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Health Plan, or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

11.5 If Health Plan or Payor delegates the selection of providers, contractors, or subcontractors, Health Plan or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5), and 423.505(i).*

12. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS**. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

13. **SERVICE AVAILABILITY**. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. **CULTURAL COMPETENCE**. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

15. **FOLLOW-UP CARE**. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

16. **ADVANCE DIRECTIVES**. Provider shall comply with Health Plan's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

17. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE**. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

18. **CONTINUATION OF BENEFITS**. Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. **PHYSICIAN INCENTIVE ARRANGEMENTS**. If Provider is a physician or physician group, neither Payor nor Health Plan shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider

agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). *42 C.F.R. §422.208.*

20. **INFORMATION DISCLOSURES TO CMS**. Provider shall cooperate with Health Plan and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. **NOTICE OF PROVIDER TERMINATIONS**. Health Plan shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. **RISK ADJUSTMENT DATA**. Provider shall provide to Health Plan risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4)*. Upon Health Plan's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

23. **COMPLIANCE WITH HEALTH PLAN POLICIES AND PROCEDURES**. Provider shall comply with Health Plan's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Health Plan's request, consult with Health Plan regarding Health Plan's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b)*. Provider shall comply with Health Plan's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

24. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION**. In the event Health Plan suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Health Plan shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Health Plan, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

25. **NOTICE OF WITHOUT CAUSE TERMINATION**. Health Plan and Provider must provide a minimum of sixty (60) days written notice, or such longer period specified in this Agreement, to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4)*.

26. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS**. Health Plan and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

27. **FEDERAL FUNDS**. Provider acknowledges that payments Provider receives from Health Plan or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any

of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

28. **EXCLUDED PERSONS/PROGRAM INTEGRITY**. Provider warrants to Health Plan and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Health Plan and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8)*. Provider shall promptly notify Health Plan and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

29. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS**. Provider shall cooperate and comply with all applicable State, federal Health Plan and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Health Plan and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. **OFFSHORE SUBCONTRACTORS**. In addition to the applicable requirements of Section 11 of this Medicare Product Attachment, Provider shall disclose to Health Plan in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *CMS Health Plan Management System Memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. **SCOPE AND CONFLICTS**. Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Health Plan, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. **TERMINATION**. This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Health Plan immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid or is listed on the Preclusion List.

33. **PART D**. If Subcontractor provides pharmacy benefit services, the following provisions shall apply.

33.1 Prompt Payment. Subcontractor shall issue, mail, or otherwise transmit payment with respect to all Clean Claims submitted by Participating Providers that are network pharmacies ("***Participating Pharmacies***") (other than mail-order and long-term care pharmacies) within the following timeframes:

a. Fourteen (14) days after the date on which the Clean Claim is received, as defined in paragraph (a)(2)(i) of this section, for an electronic claim; or

b. Thirty (30) days after the date on which the Clean Claim is received, as defined in paragraph (a)(2)(ii) of this section, for any other claim.

33.2 Access to Covered Part D Drugs. Subcontractor shall comply with the following requirements:

a. *Use of Standardized Technology*. Subcontractor shall issue and reissue, as necessary, a card or other type of technology that Covered Persons may use to access negotiated prices for covered Part D drugs as provided under § 423.104(g). The card or other technology must comply with standards CMS establishes.

b. *Submission of Claims*. Subcontractor shall require its Participating Pharmacies to submit claims unless the Covered Person expressly requests that a particular claim not be submitted to the Health Plan or its intermediary.

33.3 Disclosing Drug Pricing**.** Subcontractor shall (i) update any prescription drug pricing standard (as defined in 42 C.F.R. §423.501) based on the cost of the drug used for reimbursement of Participating Pharmacies by January 1st of each contract year and not less frequently than once every seven (7) days thereafter; (ii) indicate the source used for making any such updates; and (iii) disclose all individual drug prices to be updated to the applicable pharmacies in advance of their use for reimbursement of claims, if the source for any prescription drug pricing standard is not publicly available.

33.4 Validation of Part D Reporting Requirements. Subcontractor shall comply with the following reporting requirements:

a. *Required Information*. Subcontractor shall have an effective procedure to develop, compile, evaluate, and report to Health Plan, to Covered Persons, and to the general public, at the times and in the manner that CMS requires, statistics indicating the following:

i. The cost of its operations.

ii. The patterns of utilization of its services.

iii. The availability, accessibility, and acceptability of its services.

iv. Information demonstrating that Health Plan has a fiscally sound operation.

v. Other matters that CMS may require.

b. *Reporting Requirements*. Subcontractor must provide upon request to Health Plan, and Health Plan must provide to CMS, in a manner specified by CMS, the following with respect to Covered Persons:

i. The total number of prescriptions that were dispensed.

ii. The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies.

iii. The percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by Health Plan.

iv. The aggregate amount and type of rebates, discounts, or price concessions (excluding bona fide service fees as defined in 42 C.F.R. §423.501) that the Subcontractor negotiates that are attributable to patient utilization under the plan.

v. The aggregate amount of the rebates, discounts, or price concessions that are passed through to the Health Plan, and the total number of prescriptions that were dispensed.

vi. The aggregate amount of the difference between the amount the Health Plan pays Subcontractor and the amount that the Subcontractor pays retail pharmacies, and mail order pharmacies.

c. *Confidentiality of Subcontractor Data*. Information disclosed by Subcontractor is confidential and must not be disclosed by Health Plan, except that the Secretary may disclose the information in a form which does not disclose the identity of Subcontractor or Health Plan, or prices charged for drugs, for the following purposes:

i. As the Secretary determines necessary to carry out section 1150A of the Act or Part D of Title XVIII.

ii. To permit the Comptroller General to review the information provided.

iii. To permit the Director of the Congressional Budget Office to review the information provided.

42 CFR §423.514(d) and (e)

Attachment B: Medicare

EXHIBIT 1
COMPENSATION SCHEDULE
MA PLAN/MA-PD PLAN/DSNP PLAN
ANCILLARY SERVICES
AMBULANCE

Dare County Administrative Offices

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicare fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

4. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS

guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Proclamation - Constitution Week

Description

The Virginia Dare Chapter of the Daughters of the American Revolution (DAR) promotes the observance of the U.S. Constitution. The DAR is a patriotic organization that encourages education and historic preservation in communities across America. The Proclamation that follows is being presented to the Board of Commissioners to proclaim September 17 through 23 as Constitution Week.

Board Action Requested

Issue Proclamation

Item Presenter

Virginia Dare Chapter of the DAR

CONSTITUTION WEEK PROCLAMATION

WHEREAS: The Constitution of the United States of America, the guardian of our liberties, embodies the principles of limited government in a Republic dedicated to rule by law; and

WHEREAS: September 17, 2021, marks the two hundred and thirty-fourth anniversary of the drafting of the Constitution of the United States of America by the Constitutional Convention; and

WHEREAS: It is fitting and proper to accord official recognition to this magnificent document and its memorable anniversary; and to the patriotic celebrations which will commemorate the occasion; and

WHEREAS: It is the privilege and duty of the American people to commemorate the two hundred and thirty-second anniversary of the drafting of the Constitution of the United States of America with appropriate ceremonies and activities; and

WHEREAS: Public Law 915 guarantees the issuing of a proclamation each year by the President of the United States of America designating September 17 through 23 as Constitution Week**.**

NOW, **THEREFORE**, the Dare County Board of Commissioners, does hereby proclaim the week of September 17 through 23 as

CONSTITUTION WEEK

and urge all citizens of Davidson County to study the Constitution and reflect on the privilege of being an American with all the rights and responsibilities which that privilege involves.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the County of Dare to be affixed this 7th day of September, 2021.

_____

Robert Woodard, Sr., Chairman

Attest:

_____

Cheryl C. Anby, Clerk to the Board

Resolution Opposing the United States Fish & Wildlife Service's Proposed Designation of Critical Habitat Unit NC-1 and NC-1A (Outer Banks-Hatteras Island and Shoals) for the Red Knot Rufa

Description

The U.S. Fish and Wildlife Service proposes to designate critical habitat for the federally threatened rufa red knot under the Endangered Species Act of 1973, as amended. In total, approximately 649,066 acres are proposed in 61 counties in 13 states (Massachusetts, New York, New Jersey, Delaware, Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana and Texas).

Board Action Requested

Adopt Resolution

Item Presenter

Robert Outten, County Manager

Resolution Opposing the United States Fish & Wildlife Service's Proposed Designation of Critical Habitat Unit NC-1 and NC-1A (Outer Banks-Hatteras Island and Shoals) for the Red Knot Rufa

WHEREAS, on December 11, 2014, the United States Fish and Wildlife Service (USFWS) listed the Red Knot Rufa shorebird as a threatened species under the auspices of the Endangered Species Act and disclosed a compulsory critical habitat designation would be forthcoming in 2015, and

WHEREAS, the designation of critical habitat can impact a wide variety of coastal projects involving federal action, which include activities or programs of any kind authorized, funded, or carried out, in whole or in part by federal agencies pertaining to coastal and inlet management activities, such as dredging and beach renourishment projects that are permitted, and/or funded and implemented by the United States Army Corps of Engineers and hurricane recovery activities financially supported by the Federal Emergency Management Agency, and

WHEREAS, other federal actions can involve the administration of the National Flood Insurance Program, implementation of building codes, federal grants for public access and infrastructure improvements, and other programs/policies, and

WHEREAS, on July 15, 2021 and nearly seven years after listing the Red Knot Rufa as threatened, the USFWS is proposing to indiscriminately designate the Outer Banks, NC, (11,367 acres of occupied habitat in Dare and Hyde Counties) as critical habitat identified as "Unit NC-1" and Outer Banks-Hatteras Island and Shoals; Dare County, NC which is 5,754 acres of occupied habitat in Dare County consisting of beach shoreline from the southeast side of Oregon Inlet, south along the ocean-facing side of the island including Pea Island National Wildlife Refuge, encompassing a total geographic footprint of 13.25 miles west to the east side of Hatteras Inlet and 4,940 acres in Cape Hatteras National Seashore and 814 acres that are uncategorized, and

WHEREAS, Outer Banks (Unit NC-1 and NC-1A) has never been identified as an important stopover for the Red Knot Rufa in any previous publication authored by the USFWS, and

WHEREAS, the USFWS also specifically disclosed **special management considerations** for the Red Knot Rufa will be necessitated to address threats to critical habitat and are divided into seven categories, and moreover some the activities citied in these categories include; recreational beach use, beach driving, predation, beach nourishment, sand fencing, dredged material disposal, inlet relocation, and human-caused disasters, and

WHEREAS, these special management considerations therefore can unnecessarily and negatively impact the local, State, and federal economies; and the public's access and enjoyment of the beach, and

WHEREAS, not only has the USFWS proposed all of Hatteras Island and Shoals to be designated as critical habitat but all of the remaining beaches of Dare County as well which includes over 50.8 miles of oceanfront shoreline encompassing the entire Cape Hatteras National Seashore and Pea Island National Wildlife Refuge 3, meaning all oceanfront shoreline is proposed as Red Knot Rufa critical habitat, and

WHEREAS, the USFWS has also proposed to extend the continuous Red Knot Rufa critical habitat in–the Cape Hatteras National Seashore as identified as Units NC-1 and NC-1A and when combined with other areas totals over a 150 continuous mile stretch of North Carolina oceanfront that is proposed as Red Knot Rufa critical habitat, and

WHEREAS, the proposed designation of more than 150-mile continuous stretch of Red Knot Rufa oceanfront shoreline strongly implies the USFWS designation methodology is too sensitive and broad, and therefore is capturing all habitat instead of critical habitat for the Red Knot Rufa.

THEREFORE, BE IT RESOLVED, that Dare County is strongly opposed to the USFWS proposed designation of Red Knot Rufa critical habitat along the shorelines of Outer Banks (Unit NC-1 and NC-1A) as set forth in Document Number 2021-14406 of the Federal Register and will work with State and federal resource officials and elected representatives to ensure the critical habitat designation, as proposed, is not included in the final rule.

BE IT FURTHER RESOLVEDF, that Dare County hereby requests the USFWS revisit the Red Knot Rufa critical habitat designation methodology in a manner resulting in a more fine-tuned designation of important habitats for the Red Knot Rufa rather than broad, indiscriminate continuous stretches of oceanfront shoreline; most notably, a more than 150 mile continuous stretch in North Carolina that includes proposed Unit NC-1, NC-1A and Dare County

This the 7th day of September, 2021.

_____

Robert Woodard, Sr., Chairman

Attest:

_____

Cheryl C. Anby, Clerk to the Board

Consent Agenda

Description

1. Approval of Minutes - August 16, 2021
2. 2021 CRS Annual Report
3. Designated Agent Approval Form
4. Health & Human Services-Public Health Div., School Health Liaison Funding
5. Health & Human Services-Public Health Div., Breaking Through Task Force-Public Awareness Campaign to Address Community Mental Health Grant
6. Health & Human Services-Public Health Div., Quality Improvement Design Team Stipend
7. Health & Human Services - Johnson Controls, Inc. Service Agreement

Board Action Requested

Approval

Item Presenter

Robert Outten, County Manager

Approval of Minutes

Description

The Board of Commissioners will review and approve their previous Minutes, which follow this page.

Board Action Requested

Approve Previous Minutes

Item Presenter

Robert Outten, County Manager

County of Dare
P.O. Box 1000 | Manteo, NC 27954

MINUTES
DARE COUNTY BOARD OF COMMISSIONERS MEETING
Dare County Administration Building, Manteo, NC

5:00 p.m., August 16, 2021

Commissioners present: Chairman Robert Woodard, Sr., Vice Chairman Wally Overman Rob Ross, Steve House, Jim Tobin, Danny Couch, Ervin Bateman

Commissioners absent: None

Others present: County Manager/Attorney, Robert Outten
Deputy County Manager/Finance Director, David Clawson
Master Public Information Officer, Dorothy Hester
Clerk to the Board, Cheryl C. Anby

A full and complete account of the entire Board of Commissioners meeting is archived on a video that is available for viewing on the Dare County website www.darenc.com.

At 5:01 p.m. Chairman Woodard called to order the regularly scheduled meeting with appropriate prior public notice having been given. He invited Rev. George Lurie from the Jewish Community of the Outer Banks to share a prayer, and then he led the Pledge of Allegiance to the flag.

ITEM 1 – OPENING REMARKS – CHAIRMAN'S UPDATE
Following is a brief outline of the items mentioned by Chairman Woodard during his opening remarks, which can be viewed in their entirety in a video on the Dare County website:

- Reported on the completion of the main roof of the COA project as a "major milestone" in the ongoing construction of the brand new campus. He shared pictures of the site.
- The NC 12 Task Force and stakeholders continue to meet on a regular basis. They have begun prioritizing the seven hotspots along NC 12 highway and he would provide updates as available.
- Remembered the passing of Mary Magdeline Turcich Utz. She had been only eight days from her ninetieth birthday and had been a great supporter to his mother while at Spring Arbor of the Outer Banks.
- Announced Dare County would soon offer COVID-19 booster shots for those with compromised immune systems. DCHHS was accepting registrations and he suggested registration on the website or call for an appointment.
- On August 11, 2021 the Dare County senior leaders had met with Dr. Sheila Davies to discuss the escalating numbers of COVID-19 positive cases in Dare with a high level of community infection. With the third largest daily number of new cases since the pandemic

began, the group agreed to take measures to protect both the community and county employees. Beginning August 12, masks would be required for all county employees and visitors to county offices. He recommended the Dare website for more information or contacting the health department at 252-475-5008 from 8:30 a.m. – 5:00 p.m., Monday through Friday.

ITEM 2 – PUBLIC COMMENTS

At 5:20 p.m. the Manager outlined the procedure for making public comments in Manteo and via the video link to the Fessenden Center Annex in Buxton. Following is a summary of all citizen remarks, which can be viewed in their entirety in a video on the County website:

The following comments were made in Manteo:

1. George Lurie addressed the Board and stated the schools, hospital, expansion of the local COA and construction of a county dredge were all things which made Dare a great place to live. We still have no relatively low cost places for residents. He stated there had been very little progress and asked for a major effort to Dare's infrastructure by the Board in this area of concern.

2. Ray Hollowell spoke about the possibilities of supplying $3-6 million dollars of sand for the beach nourishment project. He would like to save the county money and stated they had the sand and the economics to cover it and meet the needs for beach nourishment. As to any environmental concerns, he stated the sand was definitely in the ball park of quality.

3. Jeanine Emery, resident of Manteo, commended the Board for their efforts during the pandemic, as well as the other good projects of schools and the hospital, as mentioned by Rev. Lurie. However, she felt the problems of affordable housing issues had not been adequately addressed by the Board.

There were no comments made in Buxton and Public Comments closed at 5:36 p.m.

ITEM 3 – REIMBURSEMENT RESOLUTION FOR SERIES 2021B LIMITED OBLIGATION BONDS AND CAPITAL PROJECT ORDINANCE FOR JUSTICE CENTER IMPROVEMENTS

Mr. Clawson explained the County's share towards the beach nourishment projects for the towns of Duck, Southern Shores, Kitty Hawk and Kill Devil Hills along with improvements to the Justice Center would be financed by the Series 2021B LOBs. A deed of trust would be held against the Justice Center as collateral. The improvements would include roof and carpet replacement, improvements in the Clerk area, as well as sound panel replacements in courtrooms A, B and D. The Justice Center renovations would not be obligated until the beach nourishment bids were opened and determined feasible.

MOTION

Commissioner House motioned to adopt the Reimbursement Resolution and the Capital Project Ordinance for Justice Center improvements.
Commissioner Tobin seconded the motion.
VOTE: AYES unanimous

ITEM 4 – RESOLUTION IN SUPPORT OF THE DARE COUNTY TOURISM BOARD EVENT CENTER CONCEPT (Att. #1)

At the last meeting of the Board, August 2, 2021, Lee Nettles had made a presentation regarding a proposed concept for the Nags Head Soundside Event Site. At that meeting, Commissioner Couch had offered a resolution of support with the consensus of the Board. Mr. Outten read the proposed resolution.

MOTION

Commissioner Couch motioned to adopt the resolution in support of the Dare County Tourism Board event center concept as presented.
Commissioner Ross seconded the motion.
VOTE: AYES unanimous

ITEM 5 – CONSENT AGENDA

The Manager announced the items as they were visually displayed in the meeting room.

MOTION

Commissioner House motioned to approve the Consent Agenda:

1) Approval of Minutes (08.02.21) **(Att. #2)**
2) Southern Albemarle Assoc. Annual Meeting Invitation List
3) Charge to the Tax Collector
4) Tax Collector's Report
5) Dare County Transportation – Additional Full-time Driver
6) Statewide Mutual Aid Agreement

Commissioner Tobin seconded the motion.
VOTE: AYES unanimous

ITEM 6 - CLOSED SESSION

The Manager asked for a Closed Session pursuant to NCGS 143-318.11(a)(3) to consult with an attorney employed or retained by the County in order to preserve the attorney-client privilege regarding the opioid settlement; and to approve the minutes of the last Closed Session.

At 5:55 p.m., the Commissioners exited the room to meet in Closed Session. They reconvened at 6:20 p.m. and Mr. Outten reported that during the Closed Session the Board approved previous Closed Session Minutes, had discussion with the County Attorney, and took no action.

ITEM 7 – COMMISSIONERS' BUSINESS & MANAGER'S/ATTORNEY'S BUSINESS

Commissioners and the County Manager frequently make extensive remarks, which can be viewed in their entirety in a video on the Dare County website. Following is a brief summary outline of the items mentioned by Commissioners during this segment:

Commissioner Bateman and Vice-Chairman Overman – had nothing new to report.

Commissioner House

- For a day in history: He remembered the birth of his youngest daughter, Brittney. He also recalled the lasting influence of Elvis Presley who died August 16, 1977.
- Shared the Pet of the Week from SPCA, a ten-year old cat named Baby, and urged everyone to visit the new location to check out adoptable pets.

Commissioner Ross

- Expressed his displeasure with the current events in Afghanistan and stated he often thinks about the words in the U.S. pledge and national anthem and what it means to stand behind them, not just when convenient but when it was tough.

Commissioner Tobin

- Shared an update on the dredge construction with pictures. The interior machinery equipment and thruster motor had been installed. Mid-sections were also being attached to the stern sections. He stated the project was still on track for completion. He had successfully worked with Congressman Murphy and Senator Burr's office to expedite the FOIA request to make patterns from the Corps dredge drag head available.
- Reported the fishing tournament had been successful with 144 boats in the ladies tournament and 99 boats in the billfish event.

Commissioner Couch

- Reported on the winding down of the summer season with the start of schools in many areas.

MANAGER'S/ATTORNEY'S BUSINESS
County Manager Outten had nothing further to report.

At the conclusion of the meeting, Chairman Woodard asked for a motion to adjourn.
MOTION
Commissioner Tobin motioned to adjourn the meeting.
Commissioner House seconded the motion.
VOTE: AYES unanimous

At 6:33 p.m., the Board of Commissioners adjourned until 9:00 a.m., September 7, 2021.

Respectfully submitted,

[SEAL]

By: _____
Cheryl C. Anby, Clerk to the Board

APPROVED: By: _____
Robert Woodard, Sr., Chairman
Dare County Board of Commissioners

Note: Copies of attachments (Att.) and supporting material considered by the Board of Commissioners at this meeting are on file in the office of the Clerk to the Board.

Consent Agenda -- 2021 CRS Annual Report

Description

Attached with this cover sheet are the Program for Public Information Committee's (PPIC) annual meeting report and schedule of outreach activities for the Community Rating System (CRS) program. The CRS program requires an update be provided to the elected officials each year. There is no requested action.

Board Action Requested

Information item only

Item Presenter

Donna Creef, Planning Director

The Dare County –Town of Manteo Program for Public Information Committee (PPIC) met on Monday, August 9, 2021 at 3:30 p.m. in Room 168 of the Dare County Administrative Building. The following committee members were in attendance:

Donna Creef, Dare County Planning Director
Noah Gillam –Dare County Assistant Planning Director
Melissa Dickerson- Town of Manteo Planner
Dorothy Hester - Dare County Public Relations
Katelin Kight – Dare County Public Relations
Drew Pearson – Dare County Emergency Management
John Finelli – Martin's Point representative
John Deboy – Outer Banks Homebuilders representative
Stephanie Walker – Outer Banks Association of Realtors representative
Willo Kelly – Outer Banks Association of Realtors
Calvin Gibbs – Manns Harbor representative
Fletcher Willey – Insurance industry representative
Hal Goodman – Town of Manteo representative

Donna called the meeting to order at 3:35 p.m. and thanked everyone for attending.

CRS Ratings

All the towns and Dare County had completed their five-year CRS cycle reviews in 2020 and it was a cruelling process. Melissa advised that Manteo was improving to a Class 5 effective October 1, 2021. They currently are Class 7. With the changes in the flood maps, Manteo scored almost 1,000 points for open space, which accounts for the jump to Class 5. Donna indicated Dare will improve to Class 6 up from their current ranking of Class 7. The CRS reviewers only allowed 25 points for the local elevation standard and this was extremely disappointing but Donna is continuing to work with them in hopes of increasing the credit given for the local elevation standard. With the transition to the new flood insurance rating Risk Rating 2.0 in October 1, 2021, the CRS discounts will be applied uniformly to all property owners with flood policies and not just property owners in special flood hazard areas. Fletcher commented that he doesn't think folks realize the hard work the Town and Dare County put forth with the CRS program.

Annual PPI Outreach Matrix

The matrix of annual outreach activities was presented to the PPIC. John Finelli indicated the date on page five needed to be changed to 2021. Stephanie made a motion to approve the outreach matrix, seconded by Hal. The vote was unanimous. This will now be presented to the Dare County Board of Commissioners and the Manteo Commissioners for adoption and submission to the CRS reviewers as part of the annual CRS recertification.

Future Outreach Campaign

Donna said she felt the Low Risk is Not No Risk campaign needed to be updated. The LRNR slogan was developed in 2017 and has been used by Dare County and all six

towns in our outreach activities since then. A new slogan and updated brochure is needed for outreach activities. This topic was discussed by the OBX CRS User group at their meeting on August 5 and the consensus was to develop a new campaign. This will be the focus of the September CRS users group meeting. Donna said the LRNR focused on the changing flood maps and the new campaign should emphasize the importance of flood insurance and recognize the Risk Rating 2.0 flood insurance system. Katelin indicated she would plan to attend the September CRS users group meeting to help brainstorm new ideas. The PPIC agreed with the need for an updated slogan and brochure.

Risk Rating 2.0

The transition to the Risk Rating 2.0 flood insurance system was discussed with Donna outlining the criteria that will be used to rate structures starting October 1, 2021 – distance to water bodies, height of first floor, use of flood vents and replacement costs values. Elevation certificate would not be required to determine height of first floor and compliance of flood vents but could be used by property owners if they submitted an elevation certificate to their insurance agent. Fletcher said it would be very important for property owners to keep their elevation certificates. He is concerned about the RR 2.0 and thinks many property owners will move to the private insurance market instead of the NFIP. The biggest impact will be on Pre-Firm structures. Stephanie said Pre-Firms will experience 18% annual increases in most instances until their rates are actualized. Willo asked Fletcher if the $250,000 cap still applied and he responded that it would still apply under RR 2.0.

Fletcher said the private markets offer different options than available with NFIP coverage such as evacuation coverage, basement coverage and decreased deductibles. Donna said the private market can cancel after a claim whereas the NFIP does not cancel and Fletcher confirmed this statement.

John Finelli asked if Fletcher thought the COVID price increases would affect insurance costs and Fletcher said he did not think so.

There being no other business, the meeting concluded at 4:15 p.m.

Donna Creef

Prepared by Donna Creef

8-10-2021

Date

TOPIC #1 KNOW YOUR FLOOD HAZARD
MESSAGE A: Find out the flood hazard for the area where you live
MESSAGE B: Low Risk is NOT No Risk
MESSAGE C: Be aware -- Flooding can occur at any time of year.

Target Audiences	Outcome	Projects	Agencies Involved	Schedule	Stakeholders
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Increase in number of map information inquiries. Increased awareness that floods can happen anywhere Increased awareness of all flood hazards and that flooding can occur at any time depending on wind conditions and rainfall event.	Map info service and financial assistance advice offered by local governments. Direct mailings on flood hazards and erosion hazards – (RL area residents, oceanfront property owners) Presentations to civic and neighborhood groups Govt TV programming and webpage on flood hazards and map information services offered by local governments. Display NFIP brochures in County and Town offices; local libraries. local retailers and stakeholders offices. Distribution of press packet of information for release to local media as needed depending on conditions and events.	Dare and Manteo Planning Public Relations	Continuous July –August 2021 Year-round Year-round Displayed year-round Packet updated as needed annually	Local homeowners associations Outer Banks Chamber of Commerce Insurance and mortgage professionals

TOPIC #2 INSURE YOUR PROPERTY FOR YOUR FLOOD HAZARD
MESSAGE A: Don't rely on your landlord to cover your losses --flood insurance for renters is available
MESSAGE B: Low Risk is NOT No Risk

Target Audiences	Outcome	Projects	Agencies Involved	Schedule	Stakeholders
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Increase in number of tenant flood insurance policies With revised FIRMS effective, transition to preferred risk or X zone policy versus discontinuation of flood coverage.	Presentations to civic and neighborhood groups Local government programming and webpage on flood insurance basics Monthly mailings to new lot purchasers Display NFIP brochures in County and Town offices; local libraries; local retailers and stakeholders offices Update press packet as needed depending on conditions and events. Stakeholders meetings on flood insurance awareness, sponsor flood insurance seminars for insurance agents and other community officials	Dare and Manteo Planning Public Relations	At various times during 2021. Year-round Monthly Displayed year-round Updated as needed annually At various times during 2021	Insurance representatives Outer Banks Chamber of Commerce Local homeowners associations Manteo Merchant Association

TOPIC #3 PROTECT PEOPLE FROM THE HAZARD **MESSAGE A: After a flood, follow proper safety precautions before using your food, water, wastewater system and utilities.** **MESSAGE B: Prepare a response plan.**					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Public health measures will be publicized to ensure the community is aware of any health risks after an event. Increased awareness of what families or others should do to prepare for emergency events.	Presentations to civic and neighborhood groups on preparedness activities. Local Govt TV programming and webpage awareness and preparedness tasks. Use of County's mass messaging, webpage and other social media to disseminate information about safety measures and response plans. Display NFIP brochures in County and Town offices; local libraries, local retailers and stakeholders offices. Distribute LRNR brochure at community meetings and in direct mailing. National Weather Service forums	Dare and Manteo Planning Public Relations Manteo Utilities Dept Dare County Health . Emergency Mgmt	Year-round Year-round Year-round Displayed year-round Year-round June 2021	Property mgmt. agencies Local homeowners associations Health Dept. National Weather Service

TOPIC #4 PROTECT YOUR PROPERTY FROM THE HAZARD **MESSAGE A: Don't walk or drive through flooded streets or flood waters MESSAGE B: Check your propane gas tanks** **MESSAGE C: Make an inventory of important documents and possessions**					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Decrease in number of stranded vehicles during and after flood events Decrease in the number of propane tanks that float away during a flood. Awareness of need for inventory of possessions and documents.	Presentations to civic and neighborhood groups. Govt TV programming and webpage safety actions. Use of County webpage and other social media to disseminate preparedness and safety information. Display NFIP brochures in County and Town offices; local libraries, local retailers and stakeholders offices. Distribution of press packet of information for release to local media as needed depending on conditions and events. Direct mailing to local propane companies on proper anchoring methods.	Dare and Manteo Planning Emergency Mgmt Public Relations	Throughout year and more frequently during storm events Year-round Displayed year-round Updated as needed annually August 2021	OB Homebuilders Fire Marshal Insurance agents Real Estate Agencies

TOPIC #4 PROTECT YOUR PROPERTY FROM THE HAZARD **MESSAGE D : Mitigate when possible. Retrofit or elevate to reduce losses.** **MESSAGE E: Keep your flood vents open. MESSAGE F: Low Risk is NOT No Risk**					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Increase in number of elevated structures or other mitigation actions to reduce flood losses. Increase in inquiries to staff about potential actions to mitigate future losses, such as flood vents, elevation of equipment.	Direct mailing about mitigation actions and property protection, LRNR brochures Presentations to civic and neighborhood groups on mitigation actions. Govt TV programming and webpage on mitigation techniques and importance of flood vents Display NFIP brochures in County and Town offices; local libraries, local retailers and stakeholders offices. Distribution of press packet of information for release to local media as needed depending on conditions and events. Pursue grant funding for FEMA mitigation funds to elevate structures.	Dare and Manteo Planning Public Relations Emergency Management	February – November 2021 Throughout year Year-round Displayed year-round Updated as needed annually Annually and following declared disasters	Outer Banks Homebuilders Association Local homeowners associations Real Estate agencies

TOPIC #5 BUILD RESPONSIBLY **MESSAGE A: Get a permit before you build.** **MESSAGE B: Building permits are needed for storm repair work.** **MESSAGE C: Know the rules that apply to construction** **MESSAGE D: PAS – parking, access and storage** **MESSAGE E: Low Risk is NOT No Risk**					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Increased awareness of need for repair permits Increased number of permits issued after flood events Decrease in conversion of enclosed areas for use as living area.	Adoption and enforcement of Local Elevation Standard in Shaded X and X zone areas. Distribute information flood response packet to disseminate after a flood event. Presentations to civic and neighborhood groups on construction techniques Govt TV programming and webpage on use of enclosed areas and other building issues. Use of County's webpage and other social media to disseminate information. Use deed restrictions and acknowledgement forms to advise property owners on use of enclosed areas for parking, access and storage only.	Dare and Manteo Planning Public Relations	May 2021 Throughout year Throughout year Year-round Year-round As needed on individual projects throughout year.	Outer Banks Homebuilders Associations Local homeowners associations Real estate and property mgmt. firms.

TOPIC #6 PROTECT NATURAL FLOODPLAIN FUNCTIONS **MESSAGE A: Don't dump trash or storm debris in ditches and canals** **MESSAGE B: Only rain down the drain!** **MESSAGE C: Wetlands are important**					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Prospective buyers SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community at large	Increased awareness of importance of wetlands for water quality, fisheries development, and floodplain development.	Presentations to civic and neighborhood groups on natural functions of resources. Govt TV programming and webpage on importance of protecting wetlands and dune systems. Use of County's webpage and other social media to disseminate information about not dumping in local ditches and other topic related issues. Update stormwater management plan	Planning Soil and Water Conservation Manteo Public Works	Throughout year Year-round Year-round August 2021 - late2022	Soil and Water Conservation Nature Conservancy

TOPIC #7 KNOW YOUR FLOOD HAZARD BEFORE YOU BUY MESSAGE A: Check Before You Buy MESSAGE B: Low Risk is NOT No Risk					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Prospective buyers Sh X/ X Zone Property Owners Community Stakeholder Groups	Increase in number of contacts to Planning offices about flood hazards from potential buyers With revised FIRMS effective, transition to preferred risk or X zone policy versus discontinuation of flood coverage.	Govt TV programming and webpage. Use of County's webpage and other social media to disseminate information about map information services offered by local government. Update and Implement Flood Insurance Awareness and Coverage Improvement Plan Distribute LRNR brochure about flood hazard for distribution at local realty firms.	Dare and Manteo Planning	Throughout year Year-round August 2021 June 2021 and as needed	Insurance representatives Outer Banks Association of Realtors

TOPIC #8 HURRICANE PREPAREDNESS AND RECOVERY
MESSAGE A: Join mass distribution lists of Dare County EM. Evacuate when advised to do so by officials and return when authorized to do so.
MESSAGE B: Stay home so officials can do their job to assess conditions.
MESSAGE C. Learn about storm surge and how it affects your neighborhood.
MESSAGE D: Make a checklist of pre-storm activities
MESSAGE E: Complete recovery efforts and debris removal as instructed by local officials.
MESSAGE F: Submit your re-entry applications early, not as storm approaches.

Target Audiences	Outcome	Projects	Agencies Involved	Schedule	Stakeholders
Year-round tenants Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Awareness of evacuation orders if issued Awareness of re-entry orders when issued. Increased participation in EM mass notification system. Non-resident property owner re-entry system implementation	Presentations to civic and neighborhood groups. Govt TV programming on hurricane preparedness and recovery efforts, Use of County's webpage and other social media to disseminate information on general topics and as needed during events Display NFIP brochures in govt offices; local libraries local retailers, and stakeholders offices. Update press packet of information for release to local media and as needed depending on conditions and events. Link to National Hurricane Center on the Emergency Mgmt webpage about storm surge and its potential impacts. Collaborate with NWS on community fourms.	Emergency Management, Public Relations	On -going and more frequently during storm events Year-round Displayed year-round Updated as needed annually Maintained year-round. June 2021	Property management firms Local homeowners and civic associations. National Weather Service

TOPIC #9 EDUCATE PROPERTY OWNERS AND CONTRACTORS ON STORMWATER MANAGEMENT OPTIONS MESSAGE A: Low impact development (LID) techniques work					
Target Audiences	**Outcome**	**Projects**	**Agencies Involved**	**Schedule**	**Stakeholders**
Year-round tenants Prospective buyers Repetitive loss area residents SFHA Residents Sh X/ X Zone Property Owners Oceanfront residents Community Stakeholder Groups Community at large	Increased use of low impact development (LID) stormwater techniques	Distribute information on LID techniques for distribution and display in County/Manteo offices. Presentations to civic and neighborhood groups. Govt TV programming and webpage. Posting of LID information on County/Manteo webpage Update stormwater plan for unincorporated Dare County.	Dare and Manteo Planning Soil and Water Conservation	Throughout year Throughout year Year-round August 2021-late 2022	Soil and Water Nature Conservancy

Consent Agenda -- Designated Agent Approval Form

Description

Barton Grover is now serving as the Grants and Waterways Administrator. His duties will include administration of the FEMA mitigation grants to elevate homes. The State has requested an updated designated agent form for Barton participation.

Board Action Requested

Approval of DA form

Item Presenter

Donna Creef, Planning Director

RESOLUTION
DESIGNATION OF APPLICANT'S AGENT
North Carolina Division of Emergency Management

Organization Name (hereafter named Organization) Dare County	Disaster Number:
Applicant's State Cognizant Agency for Single Audit purposes (If Cognizant Agency is not assigned, please indicate):	
Applicant's Fiscal Year (FY) Start 2021 Month: July Day: 1	
Applicant's Federal Employer's Identification Number - 56-6000293	
Applicant's Federal Information Processing Standards (FIPS) Number - - NC 37-55	

PRIMARY AGENT	**SECONDARY AGENT**
Agent's Name ***Barton Grover***	Agent's Name Robert L. Outten
Organization County Of Dare	Organization County Of Dare
Official Position Grants Administrator	Official Position County Manager
Mailing Address PO Box 1000	Mailing Address PO Box 1000
City ,State, Zip Manteo, NC 27954	City ,State, Zip Manteo, NC 27954
Daytime Telephone 252-475-5628	Daytime Telephone 2524755811
Facsimile Number 2524736653	Facsimile Number 2524731817
Pager or Cellular Number	Pager or Cellular Number 2522029540

BE IT RESOLVED BY the governing body of the Organization (a public entity duly organized under the laws of the State of North Carolina) that the above-named Primary and Secondary Agents are hereby authorized to execute and file applications for federal and/or state assistance on behalf of the Organization for the purpose of obtaining certain state and federal financial assistance under the Robert T. Stafford Disaster Relief & Emergency Assistance Act, (Public Law 93-288 as amended) or as otherwise available. BE IT FURTHER RESOLVED that the above-named agents are authorized to represent and act for the Organization in all dealings with the State of North Carolina and the Federal Emergency Management Agency for all matters pertaining to such disaster assistance required by the grant agreements and **the assurances printed on the reverse side hereof**. BE IT FINALLY RESOLVED THAT the above-named agents are authorized to act severally. PASSED AND APPROVED this _7____ day of ____September _____, 2021_.

GOVERNING BODY Dare County Board of Commissioners	**CERTIFYING OFFICIAL**
Name and Title	Name
Name and Title	Official Position
Name and Title	Daytime Telephone

CERTIFICATION

I, _____, (Name) duly appointed and _____ (Title) of the Governing Body, do hereby certify that the above is a true and correct copy of a resolution passed and approved by the Governing Body of _____ (Organization) on the _____ day of _____, 20__.

Health & Human Services-Public Health Division
School Health Liaison Funding

Description

The Public Health Division has been awarded funding from NC DHHS Division of Public Health for ELC Reopening Schools-School Health Liaison. Funding will be used to support staff and activities that improve population and individual health for students and school staff and to enhance the working relationships between the schools and local health authorities.

Board Action Requested

Approve Budget Amendment

Item Presenter

N/A

DARE COUNTY

BUDGET AMENDMENT

F/Y 2021-2022

ACCOUNT	CODE			INCREASE	DECREASE
	Org	Object	Project		
Department:					
Health & Human Services-Public Health					
Revenues:					
State/Federal-COVID-19	103027	424206	45120	$115,000	
Expenses:					
Salary	104600	500200	45120	$68,575	
FICA	104600	500300	45120	$5,246	
Operating	104600	513400	45120	$40,000	
Travel	104600	513400	45120	$1,179	

Explanation:
School Health Liaison funding to be used to hire part-time RNs and administrative staff, puchase supplies, staff development and travel

Approved by:

Board of Commissioners:_____ Date:_____

County Manager:_____ Date:_____
(sign in red)

Finance only:

Date entered:_____ Entered by:_____ Reference number:_____

Division of Public Health
Agreement Addendum
FY 21-22

Dare County of Health & Human Services – Public Health Division **Local Health Department Legal Name**	Women's & Children's Health / Children & Youth **DPH Section / Branch Name**
361 ELC Reopening Schools SH Liaison **Activity Number and Description**	Ann Nichols, 919-707-5667 ann.nichols@dhhs.nc.gov **DPH Program Contact** (name, phone number, and email)
06/01/2021 – 05/31/2022 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2021 – 06/30/2022 **Payment Period**	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** ___

I. Background:

In support of safe, in-person instruction in kindergarten through grade 12 (K-12) schools, screening testing can provide an additional layer of prevention to protect students, teachers, and staff and slow the spread of SARS-CoV-2, the virus that causes Coronavirus Disease 2019 (COVID-19). While it is critical for schools to remain open for academic, social, and emotional benefits, it is equally important to do so safely. (See: https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/operation-strategy.html.) To enable schools to establish and expand COVID-19 screening testing programs to support and maintain in-person learning, the federal government is providing financial resources through the Centers for Disease Control and Prevention (CDC) under the ELC Reopening Schools award.

Public health and education are necessary partners for safe and healthy schools. Successful testing programs with the appropriate response to test results are enhanced by close collaborative working relationships between schools and local health authorities. Efforts should be taken to foster, grow and maintain the tie between public health and education to support COVID testing and response programs and other activities that improve population and individual health for students and school staff. Funding from the ELC award will support staff positions that encourage continuity of existing COVID-related activities, maintain the health department's integral role in screening testing, build upon the work already begun, and ensure a holistic assessment and monitoring of disease burden within any given community.

II. Purpose:

This Agreement Addendum provides temporary funding for the Local Health Department to hire Public Health Nurse (PHN) School Health Liaisons for the coordination of COVID-19 screening, testing, and

Health Director Signature (use blue ink) — Date: 8/18/21

Local Health Department to complete: (If follow-up information is needed by DPH)	LHD program contact name: Phone number with area code: Email address:	Debbie Dutton 202-475-9366 debbie.dutton@darenc.com

Signature on this page signifies you have read and accepted all pages of this document. Template rev. July 2020

vaccine administration efforts, and to coordinate other school health/public health services as described in the Memorandum of Agreements referenced in the Attachment A, Paragraph B of the Agreement Addendum for FY22 351 Child Health.

III. <u>Scope of Work and Deliverables</u>:

The Local Health Department (LHD) shall:

1. Employ one or more PHN School Health Liaisons by the start of the 2021-2022 school year to liaise with all school types within the jurisdiction of the LHD. Allowable uses of funds include salary and fringe benefits, staff development and training, IT hardware and software, supplies including cell phones and office supplies, and travel.

2. Establish a job description for the PHN School Health Liaison that includes the following activities in addition to other local needs:
    a. Administration/Joint Planning for School Health
        1. Coordinate school health efforts between the LHD and all LEAs and schools in the LHD county (or counties if a District LHD) served.
        2. Conduct ongoing evaluation of cooperative efforts and collaborate on needed changes.
        3. Serve as the LHD liaison for the School Health Nursing Program in all LEAs and schools in the LHD county (or counties if a District LHD) served.
        4. Participate in the LEA School Health Advisory Committee (SHAC).
    b. Communicable Disease
        1. Coordinate shared activities related to COVID-19 testing programs in schools and related response to test results and mitigation efforts.
        2. Coordinate investigation and/or follow-up of other reportable communicable disease events.
        3. Participate in procedure development for response to communicable disease outbreaks in schools.
        4. Coordinate local media response in conjunction with school administration regarding communicable disease events and efforts in K-12 schools.
    c. School Site Vaccine Administration Opportunities
        1. Provide Vaccine Information Statements (VIS) to schools and encourage on-site clinic opportunities.
        2. Coordinate vaccine, medical supplies, and documentation supplies as needed for clinics when scheduled.
        3. Assure completion of administration processes related to vaccines through data entry.
    d. OSHA Compliance Program
        1. Coordinate the availability of OSHA-required vaccines for identified school staff through LHD clinics and the billing of LEA for required services.
        2. Act as a resource to the Lead Nurses/designees for OSHA Blood Born Pathogens training and incidents in schools.
    e. Professional Development
        1. Include local school nurses in educational and workshop opportunities related to school health program needs.
        2. Ensure initial training and annual updates are provided for local school nurses on their duties regarding county disaster response as defined in the Memorandum of Agreements

referenced in the Attachment A, Paragraph B of the Agreement Addendum for FY22 351 Child Health.

f. Privacy Protection

1. Facilitate 'read only' access to the North Carolina Immunization Registry for county school nurses.
2. Ensure local school nurses have reviewed and signed the LHD Annual Confidentiality Statement.
3. Act as a resource in ensuring compliance with HIPAA and FERPA in coordinated activities.

3. Ensure the execution of Memorandums of Agreement (MOAs) inclusive of the job description activities between the LHD and schools/districts (LEA, Charter, Independent) that are providing COVID testing programs. This MOA requirement can be accomplished through amending the existing annual agreement referenced in the Attachment A, Paragraph B of the Agreement Addendum for FY22 351 Child Health if Liaison activities are included and consistent with the MOA guidelines provided by the DPH School Health Unit.

Number of PHN Liaison Positions Funded	Amount of Funding Allocated
1	$115,000

IV. Performance Measures/Reporting Requirements:

1. Performance Measures

a. Employ one or more PHN School Health Liaisons by the start of the 2021-2022 school year to liaise with all school types and LEAs served by the LHD.

b. Upload job descriptions of all nurses hired with these funds into the Smartsheet Dashboard.

https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb

2. Reporting Requirements

The reporting below shall be provided by the LHD to DPH via the Smartsheet dashboard, which can be accessed at https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb

The LHD shall:

a. Complete the **COVID-19 Response Plan** in the Smartsheet Dashboard. This response plan is to provide information related to the LHD's broader goals and partnerships for COVID-19 preparedness and response. The Smartsheet dashboard will present a series of questions to be answered in a short-answer format, with topics including aspects of testing, contact tracing, vaccination, equity, and preparedness in general.

The LHD will be providing responses for a single COVID-19 Response Plan and this plan will meet the reporting requirements described under the FY22 Agreement Addenda for this Activity 361 as well as other Activities. (The specific Activities to be included for this COVID-19 Response Plan continue to evolve; the complete list of Activities can be found on the Smartsheet dashboard.)

The COVID-19 Response Plan will receive DPH oversight from the DPH Branch staff members representing each relevant aspect. Any question the LHD has about the COVID-19 Response Plan should be directed to the DPH Division Director's Office at lhdhealthserviceta@dhhs.nc.gov

b. Complete a **Monthly Financial Report** each month via the Smartsheet dashboard. These monthly financial reports will report on the prior month, with the exception of the first months' reports, consistent with the due dates posted on the Smartsheet dashboard. The financial reports for June 2021, July 2021, August 2021, and September 2021 are due by October 22, 2021.

Maintain all receipts and invoices for drawdowns that support the allowable use expenses which include salary and fringe benefits, staff development and training, IT hardware and software, supplies (including cell phones and office supplies), and travel.

Seek prior approval from DPH program staff for any expenditure that is not consistent with allowable use listed.

c. The LHD shall complete a **Quarterly Progress Report** each quarter via the Smartsheet dashboard. These periodic progress reports will report about the prior period's progress on implementing the Agreement Addendum's required school health nurse liaison activities as listed in the job description. The due dates are posted on the Smartsheet dashboard. The first progress report is to report for July – September 2021 and is due by October 22, 2021. This first progress report must include an estimated timeline for completion of 21/22 program deliverables. The quarterly periods for these progress reports are defined as:

July – September 2021

October – December 2021

January – March 2022

V. Performance Monitoring and Quality Assurance:

1. This Activity will be monitored by the Children & Youth Branch according to the following plan:

   a. The Regional School Health Nurse Consultant (RSHNC) will review the Financial Reports each month to ensure that funds are spent only on allowable uses.

   b. The RSHNC will review the Progress Reports each quarter.

   c. An annual monitoring report will be completed by the DPH program staff (RSHNC) at the end of the year (May, 2022), and a copy made available to the Local Health Director. If the report indicates failure to adhere to deliverables in this Agreement Addendum, the Local Health Director or designee will work with the RSHNC to develop a corrective action plan.

2. The Local Health Department shall adhere to the following service quality measures:

   a. Services are provided in accordance with standards established by the North Carolina Nurse Practice Act and the North Carolina Board of Nursing. The North Carolina School Health Program Manual, Sixth edition, shall be consulted as a resource, as well as the Scope and Standards of School Nursing developed by American Nurses Association and National Association of School Nurses.

   b. Services are provided in a culturally sensitive manner.

   c. Services are provided with adherence to federal law in relation to privacy of student records, following both HIPAA (Health Insurance Portability and Accountability Act) and FERPA (Family Educational Rights and Privacy Act), as applicable. Where HIPAA and FERPA may appear to be in conflict, FERPA shall be followed regarding records that become part of the

student's educational record; US Department of Education and North Carolina Department of Public Instruction guidelines are resources.

VI. Funding Guidelines or Restrictions:

1. Requirements for pass-through entities: In compliance with *2 CFR §200.331 – Requirements for pass-through entities*, the Division of Public Health provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda.
   a. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.
   b. Frequency: Supplements will be generated as the Division of Public Health receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

2. Allowable uses of this Activity's funds include salary and fringe benefits, staff development and training, IT hardware and software, supplies including cell phones and office supplies, and travel.

DPH-Aid-To-Counties **For Fiscal Year: 21/22** **Budgetary Estimate Number : 0**

Activity 361 Service Period Payment Period		AA	1332 892A L5 06/01-05/31 07/01-06/30	Proposed Total	New Total
01 Alamance	*	0	115,000	115,000	115,000
D1 Albemarle	*	0	920,000	920,000	920,000
02 Alexander	*	0	115,000	115,000	115,000
04 Anson	*	0	115,000	115,000	115,000
D2 Appalachian	*	0	345,000	345,000	345,000
07 Beaufort	*	0	115,000	115,000	115,000
09 Bladen	*	0	115,000	115,000	115,000
10 Brunswick	*	0	115,000	115,000	115,000
11 Buncombe	*	0	115,000	115,000	115,000
12 Burke	*	0	115,000	115,000	115,000
13 Cabarrus	*	0	115,000	115,000	115,000
14 Caldwell	*	0	115,000	115,000	115,000
16 Carteret	*	0	115,000	115,000	115,000
17 Caswell	*	0	115,000	115,000	115,000
18 Catawba	*	0	115,000	115,000	115,000
19 Chatham	*	0	115,000	115,000	115,000
20 Cherokee	*	0	115,000	115,000	115,000
22 Clay	*	0	115,000	115,000	115,000
23 Cleveland	*	0	115,000	115,000	115,000
24 Columbus	*	0	115,000	115,000	115,000
25 Craven	*	0	115,000	115,000	115,000
26 Cumberland	*	0	115,000	115,000	115,000
28 Dare	*	0	115,000	115,000	115,000
29 Davidson	*	0	115,000	115,000	115,000
30 Davie	*	0	115,000	115,000	115,000
31 Duplin	*	0	115,000	115,000	115,000
32 Durham	*	0	115,000	115,000	115,000
33 Edgecombe	*	0	115,000	115,000	115,000
D7 Foothills	*	0	230,000	230,000	230,000
34 Forsyth	*	0	115,000	115,000	115,000
35 Franklin	*	0	115,000	115,000	115,000
36 Gaston	*	0	115,000	115,000	115,000
38 Graham	*	0	115,000	115,000	115,000

D3 Gran-Vance	* 0	230,000	230,000	230,000
40 Greene	* 0	115,000	115,000	115,000
41 Guilford	* 0	115,000	115,000	115,000
42 Halifax	* 0	115,000	115,000	115,000
43 Harnett	* 0	115,000	115,000	115,000
44 Haywood	* 0	115,000	115,000	115,000
45 Henderson	* 0	115,000	115,000	115,000
47 Hoke	* 0	115,000	115,000	115,000
48 Hyde	* 0	115,000	115,000	115,000
49 Iredell	* 0	115,000	115,000	115,000
50 Jackson	* 0	115,000	115,000	115,000
51 Johnston	* 0	115,000	115,000	115,000
52 Jones	* 0	115,000	115,000	115,000
53 Lee	* 0	115,000	115,000	115,000
54 Lenoir	* 0	115,000	115,000	115,000
55 Lincoln	* 0	115,000	115,000	115,000
56 Macon	* 0	115,000	115,000	115,000
57 Madison	* 0	115,000	115,000	115,000
D4 M-T-W	* 0	345,000	345,000	345,000
60 Mecklenburg	* 0	115,000	115,000	115,000
62 Montgomery	* 0	115,000	115,000	115,000
63 Moore	* 0	115,000	115,000	115,000
64 Nash	* 0	115,000	115,000	115,000
65 New Hanover	* 0	115,000	115,000	115,000
66 Northampton	* 0	115,000	115,000	115,000
67 Onslow	* 0	115,000	115,000	115,000
68 Orange	* 0	115,000	115,000	115,000
69 Pamlico	* 0	115,000	115,000	115,000
71 Pender	* 0	115,000	115,000	115,000
73 Person	* 0	115,000	115,000	115,000
74 Pitt	* 0	115,000	115,000	115,000
75 Polk	* 0	115,000	115,000	115,000
76 Randolph	* 0	115,000	115,000	115,000
77 Richmond	* 0	115,000	115,000	115,000
78 Robeson	* 0	115,000	115,000	115,000
79 Rockingham	* 0	115,000	115,000	115,000
80 Rowan	* 0	115,000	115,000	115,000
82 Sampson	* 0	115,000	115,000	115,000
83 Scotland	* 0	115,000	115,000	115,000
84 Stanly	* 0	115,000	115,000	115,000
85 Stokes	* 0	115,000	115,000	115,000

86 Surry	* 0	115,000	115,000	115,000
87 Swain	* 0	115,000	115,000	115,000
D6 Toe River	* 0	345,000	345,000	345,000
88 Transylvania	* 0	115,000	115,000	115,000
90 Union	* 0	115,000	115,000	115,000
92 Wake	* 0	115,000	115,000	115,000
93 Warren	* 0	115,000	115,000	115,000
96 Wayne	* 0	115,000	115,000	115,000
97 Wilkes	* 0	115,000	115,000	115,000
98 Wilson	* 0	115,000	115,000	115,000
99 Yadkin	* 0	115,000	115,000	115,000
Totals		11,500,000	11,500,000	11,500,000

Sign and Date - DPH Program Administrator Carol Tyson Acting Branch Head 8/3/21	Sign and Date - DPH Section Chief
Sign and Date - DPH Contracts Office Gremeko Stuart 8/5/2021	Sign and Date - DPH Budget Officer 08/05/2021

FY22 Activity: 361 School Health Center **Supplement 1**

Supplement reason: ☒ In AA+BE or AA+BE Rev –OR– ☐ –

CFDA #: 93.323	Fed awd date: 4/8/21	Is award R&D? no	FAIN: NU50CK000530	Total amount of fed awd: $ 113539687

CFDA name:	Epidemiology and Laboratory Capacity for Infectious Disease (EC)	Fed award project description:	Epidemiology and Laboratory Capacity for Infetious Disease (ELC)	
		Fed awarding agency:	DHHS, Centers for Disease Control and Prevention	Federal award indirect cost rate: n/a % %

Subrecipient	Subrecipient DUNS	Fed funds for This **Supplement**	Total of All Fed Funds for This **Activity**
Alamance	965194483	115,000	115,000
Albemarle	130537822	920,000	920,000
Alexander	030495105	115,000	115,000
Anson	847163029	115,000	115,000
Appalachian	780131541	345,000	345,000
Beaufort	091567776	115,000	115,000
Bladen	084171628	115,000	115,000
Brunswick	091571349	115,000	115,000
Buncombe	879203560	115,000	115,000
Burke	883321205	115,000	115,000
Cabarrus	143408289	115,000	115,000
Caldwell	948113402	115,000	115,000
Carteret	058735804	115,000	115,000
Caswell	077846053	115,000	115,000
Catawba	083677138	115,000	115,000
Chatham	131356607	115,000	115,000
Cherokee	130705072	115,000	115,000
Clay	145058231	115,000	115,000
Cleveland	879924850	115,000	115,000
Columbus	040040016	115,000	115,000
Craven	091564294	115,000	115,000
Cumberland	123914376	115,000	115,000
Dare	082358631	115,000	115,000
Davidson	077839744	115,000	115,000
Davie	076526651	115,000	115,000
Duplin	095124798	115,000	115,000
Durham	088564075	115,000	115,000
Edgecombe	093125375	115,000	115,000
Foothills	782359004	230,000	230,000
Forsyth	105316439	115,000	115,000
Franklin	084168632	115,000	115,000
Gaston	071062186	1115,000	115,000
Graham	020952383	115,000	115,000
Granville-Vance	063347626	230,000	230,000
Greene	091564591	115,000	115,000
Guilford	071563613	115,000	115,000
Halifax	014305957	115,000	115,000
Harnett	091565986	115,000	115,000
Haywood	070620232	115,000	115,000
Henderson	085021470	115,000	115,000
Hoke	091563643	115,000	115,000
Hyde	832526243	115,000	115,000
Iredell	074504507	115,000	115,000
Jackson	019728518	115,000	115,000
Johnston	097599104	115,000	115,000
Jones	095116935	115,000	115,000
Lee	067439703	115,000	115,000
Lenoir	042789748	115,000	115,000
Lincoln	086869336	115,000	115,000
Macon	070626825	115,000	115,000
Madison	831052873	115,000	115,000
MTW	087204173	345,000	345,000
Mecklenburg	074498353	115,000	115,000
Montgomery	025384603	115,000	115,000
Moore	050988146	115,000	115,000
Nash	050425677	115,000	115,000
New Hanover	040029563	115,000	115,000
Northampton	097594477	115,000	115,000
Onslow	172663270	115,000	115,000
Orange	139209659	115,000	115,000
Pamlico	097600456	115,000	115,000
Pender	100955413	115,000	115,000
Person	091563718	115,000	115,000
Pitt	080889694	115,000	115,000
Polk	079067930	115,000	115,000
Randolph	027873132	115,000	115,000
Richmond	070621339	115,000	115,000
Robeson	082367871	115,000	115,000
Rockingham	077847143	115,000	115,000
Rowan	074494014	115,000	115,000
Sampson	825573975	115,000	115,000
Scotland	091564146	115,000	115,000
Stanly	131060829	115,000	115,000
Stokes	085442705	115,000	115,000
Surry	077821858	115,000	115,000
Swain	146437553	115,000	115,000
Toe River	113345201	345,000	345,000
Transylvania	030494215	115,000	115,000
Union	079051637	115,000	115,000
Wake	019625961	115,000	115,000
Warren	030239953	115,000	115,000
Wayne	040036170	115,000	115,000
Wilkes	067439950	115,000	115,000
Wilson	075585695	115,000	115,000
Yadkin	089910624	115,000	115,000

Health & Human Services-Public Health Division
Breaking Through Task Force -
Public Awareness Campaign to Address Community Mental Health Grant

Description

The Public Health Division has received continued funding from the Outer Banks Hospital Grants Program for a public awareness and education campaign for the Breaking Through Task Force to reduce the stigma related to behavioral health and to improve the overall wellness of our community through better access to care, support, improved functioning and promotion of positive mental health. Funding will be used to produce additional videos for the Mental Health Champions Video Series, printing of the Adult Mental Health Workbooks and Resource Guides, and promotional materials.

Board Action Requested

Approve Budget Ammendment

Item Presenter

N/A

DARE COUNTY

BUDGET AMENDMENT

F/Y 2021-2022

ACCOUNT	CODE			INCREASE	DECREASE
	Org	Object	Project		
Department:					
Health & Human Services-Public Health					
Revenues:					
OBHDC-BTTF/MH Grant	103052	464722	56006	$7,000	
Expenses:					
Materials/Resources	104600	513323	56006	$2,350	
Advertising/Promotion	104600	525600	56006	$2,150	
Printing	104600	525723	56006	$2,500	

Explanation:
Continued funding for the Breaking Through Task Force- Public Awareness Campaign to Address Community Mental Health. Funding to be used to produce 4 additional videos, create & print adult mental health workbooks and mental health resource guides, and to purchase promotional materials.

Approved by:

Board of Commissioners:_____ Date:_____

County Manager:_____ Date:_____
(sign in red)

Finance only:

Date entered:_____ Entered by:_____ Reference number:_____

THE OUTER BANKS HOSPITAL
Development Council

April 27, 2021

Congrats!

Kelly Nettnin
Dare County Department of Health and Human Services
PO Box 669
109 Exeter St
Manteo, NC 27954

Dear Kelly,

The Outer Banks Hospital Development Council's Community Benefit Grant Committee is pleased to award funding to the Dare County Department of Health and Human Services in the amount of $7,000 to help towards a public awareness and education campaign for the Breaking Through Task Force to reduce the stigma related to behavioral health; not to be used for salary. The funding is for one year, July 1, 2021 - June 30, 2022. Your current grant continues to June 30, 2021.

As of now, we are hopeful that we can distribute grant checks as part of our Friday, August 6 Outer Banks Hospital Board meeting. Please hold that date from 9:45am-10:30am and I will be in touch in early July with more details.

We also invite you to create a short video outlining your project. I will also be in touch with more details about the video.

In the meantime, please know that we are pleased to provide support for your project, as we believe the Dare County Health Department provides much needed services to the community.

Sincerely,

Jennifer Schwartzenberg
Director, Community Outreach and Development
The Outer Banks Hospital

CC: Dr. Sheila Davies

Health & Human Services-Public Health Division
Quality Improvement Design Team Stipend

Description

The Public Health Division is one of four Health Departments chosen to work with the NC Local Health Department Accreditation Program to participate in a six-month long collaborative design team. Participation includes attending two workshops, monthly meetings/activities to develop and test quality improvement related activities. As a participant the Health Department will receive a stipend to support staff time dedication to these efforts.

Board Action Requested

Approve Budget Ammendment

Item Presenter

N/A

DARE COUNTY

BUDGET AMENDMENT

F/Y 2021-2022

ACCOUNT	CODE			INCREASE	DECREASE
	Org	Object	Project		
Department:					
Health & Human Services-Public Health					
Revenues:					
NCIPH-QI Design Team	103052	464710	41100	$1,500	
Expenses:					
Salary	104600	500200	41100	$930	
FICA	104600	500300	41100	$71	
Retirement	104600	500400	41100	$106	
Health Ins	104600	500500	41100	$393	

Explanation:
Stipend to be received for participation in 2 QI workshops, July & December 2021 for our QI Coordinator

Approved by:

Board of Commissioners:_____ Date:_____

County Manager:_____ Date:_____
(sign in red)

Finance only:

Date entered:_____ Entered by:_____ Reference number:_____

share\forms\ba\Health - BA - QI Design Team Stipend.xlsx 8/17/2021 11:53 AM

From: **Thomas, Amy Belflower** <amy.b.thomas@unc.edu>
Date: Wed, Jun 30, 2021 at 9:29 AM
Subject: QI Design Team funding
To: Jeffery Sieber <jeffery_sieber@onslowcountync.gov>, valerie.kelly@burkenc.org <valerie.kelly@burkenc.org>, Kirsten Smith <kirsten.smith@mtwdh.org>, lauraw <lauraw@darenc.com>, lcreson <lcreson@personcountync.gov>, Margaret Gibbons <margaret.gibbons@montgomerycountync.com>
Cc: NCLHDaccreditation <NCLHDaccreditation@unc.edu>, McGee, Deborah Pickett <dapicket@email.unc.edu>

Good morning,

We are excited to work with you in the coming months on the QI Design Team! As a participant, each LHD will receive $1500 in funding to support staff time dedicated to the effort. You will receive half of the funding ($750) after completion of the July 23 workshop and the other half ($750) in December.

In order to process the funding, we need a couple of things from you:

1. Completion of two vendor forms (attached).
2. Copy of agency W9 (blank attached if needed).
3. An invoice to NCIPH for $750 for "NCLHDA/IP Quality Improvement Design Team participation."

A bulk of the first payment is coming from a NACCHO grant that ends soon, so we must get this first invoice processed by the end of July. Therefore, please return these items to me ASAP. Even if your agency can't process the invoice until after the July 23 workshop has occurred, sending in the other materials earlier will allow us to get you set up as a vendor so that when you do send the invoice, it can be processed quickly (though, if allowed, please send the invoice ASAP as well!). In December, you will simply need to provide a second invoice (and I will send a reminder!).

If you have any questions, please let me know!

Amy

Amy Belflower Thomas, MHA, MSPH, CPH

Pronouns: she, her, hers
Director, *Community Assessment and Strategy* | NC Institute for Public Health
Administrator | NC Local Health Department Accreditation Program
Adjunct Assistant Professor | Public Health Leadership Program
Campus Box 8165 | Chapel Hill, NC 27599
P: 919-843-3973 | F: 919-962-0268 | amy.b.thomas@unc.edu

Connect with NCIPH: Facebook | LinkedIn | Website | Mailing List

View our 2020 Annual Report: Rising to the Occasion

APPLY TO NCLHDA'S

QUALITY IMPROVEMENT DESIGN TEAM

ABOUT THE DESIGN TEAM

WHO

The North Carolina Local Health Department Accreditation (NCLHDA) Program and Population Health Improvement Partners are recruiting four Local Health Departments to participate in a six-month long collaborative design team to develop and test quality improvement-related activities. We ask that each health department involves three of their staff members.

WHAT

Design team members will participate in a three-hour design workshop in July, followed by virtual monthly meetings and activities from August-December 2021, during which team members will receive quality improvement training and support.

WHEN

The design team will meet from July-December, with an expected average time commitment of three hours a month. This includes time for meetings and completing activities. Health departments will receive a $1,500 stipend for their participation.

WHY

NCLHDA and Improvement Partners are working together to sustainably improve quality improvement support for local health departments in North Carolina. Participating in the design team will allow you to shape what kinds of supports we provide.

HOW

Submit an application at go.unc.edu/QIdesignteam by June 4 to express your health department's interest in participating.
Candidates will be selected by June 11.

DESIGN TEAM SELECTION

CRITERIA

We are looking to select local health departments that represent diversity in size, governance structure, communities served and prior QI experience.

Additional criteria include:

1. Support from Health Director
2. Commitment to QI
3. Excitement for new ideas
4. Staff availability

NORTH CAROLINA
Local Health Department Accreditation

Health & Human Services - Johnson Controls, Inc.

Description

The Board of Commissioners will review and approve the Johnson Controls planned service proposal for Dare County Health and Human Services

Board Action Requested

Approve and authorize the County Manager to sign the Planned Service Agreement

Item Presenter

Robert Outten, County Manager

Customer
DARE COUNTY HEALTH AND SOCIAL SERVICES

Local Johnson Controls Office
4850 BROOKSIDE CT
NORFOLK, VA 23502-2052

Agreement Start Date:
09/01/2021

Proposal Date
08/30/2021

Estimate No:
1-1ATXSUCI

Partnering with you to deliver value-driven solutions

Every day, we transform the environments where people live, work, learn and play. From optimizing building performance to improving safety and enhancing comfort, we are here to power your mission.

A Planned Service Agreement with Johnson Controls provides you with a customized service strategy designed around the needs of your facility. Our approach features a combination of scheduled, predictive and preventative maintenance services that focus on your goals.

As your building technology services partner, Johnson Controls delivers an unmatched service experience delivered by factory-trained, highly skilled technicians who optimize operations of the buildings we work with, creating productive and safe environments for the people within.

By integrating our service expertise with innovative processes and technologies, our value-driven planned service solutions deliver sustainable results, minimize equipment downtime and maximize occupant comfort.

With more than a century of healthy buildings expertise, Johnson Controls leverages technologies to successfully deliver smart solutions to facilities worldwide.

FROST & SULLIVAN

2020 Award | North American Company of the Year for Innovation in Smart Connected Chillers

Johnson Controls was recognized by Frost & Sullivan as the 2020 North American Company of the Year for innovation in the Smart connected Chillers market

Executive summary

Planned service proposal for DARE COUNTY HEALTH AND SOCIAL SERVICES

Dear Keith,

We value and appreciate your interest in Johnson Controls as a service provider for your building systems and are pleased to provide a value-driven maintenance solution for your facility. The enclosed proposal outlines the Planned Service Agreement we have developed on your facility.

Details are included in the Planned Service Agreement summary (Schedule A), but highlights are as follows:

- In this proposal we are offering a service agreement for 1 Year starting 09/01/2021 and ending 08/31/2022.
- The agreement price for first year is $8,358.00; see Schedule A, Supplemental Price and Payment Terms, for pricing in subsequent years.
- The equipment options and number of visits being provided for each piece of equipment are described in Schedule A, Equipment list.

As a manufacturer of both mechanical and controls systems, Johnson Controls has the expertise and resources to provide proper maintenance and repair services for your facility.

Again, thank you for your interest in Johnson Controls and we look forward to becoming your building technology services partner.

Please contact me if you have any questions.

Sincerely,

Arlene Cole
Branch Service Manager
(866) 468-1469

The power behind **your mission**

Benefits of planned service

A Planned Service Agreement with Johnson Controls will allow you to optimize your building's facility performance, providing dependability, sustainability and energy efficiency. You'll get a value-driven solution that fits your specific goals, delivered with the attention of a local service company backed by the resources of a global organization.

With this Planned Service Agreement, Johnson Controls can help you achieve the following five objectives:

1. **Identify energy savings Opportunities**
   Since HVAC equipment accounts for a major portion of a building's energy usage, keeping your system performing at optimum levels may lead to a significant reduction in energy costs.
2. **Reduce future repair costs**
   Routine maintenance may maximize the life of your equipment and may reduce equipment breakdowns.
3. **Extend asset life**
   Through proactive, factory-recommended maintenance, the life of your HVAC assets may be extended, maximizing the return on your investment.
4. **Ensure productive environments**
   Whether creating a comfortable place where employees can be productive or controlling a space to meet specialized needs, maintenance can help you achieve an optimal environment for the work that is being accomplished
5. **Promote environmental health and safety**
   When proper indoor conditions and plant requirements are maintained, business outcomes may be improved by minimizing sick leave, reducing accidents, minimizing greenhouse gas emissions and managing refrigerant requirements.

All of the services we perform on your equipment are aligned with "The 5 Values of Planned Maintenance" and our technicians understand how the work they perform can help you accomplish your business objectives.

Our partnership

Personalized account management

A Planned Service Agreement also provides you with the support of an entire team that knows your site and can closely work with you on budget planning and asset management. Your local Johnson Controls account management team can help guide planned replacement, energy retrofits and other building improvement projects. You'll have peace of mind that an entire team of skilled professionals will be looking out for what is best for your facility and budget.

A culture of safety

Johnson Controls technicians take safety seriously and personally, and integrate it into everything they do. All of our technicians participate in regular and thorough safety training. Because of their personal commitment, we are a leader in the HVAC service industry for workplace safety performance. This means that you do not have to worry about us when we are on your site.

Commitment to customer satisfaction

Throughout the term of your Planned Service Agreement, we will periodically survey you and use your feedback to continue to make improvements to our service processes and products. Our goal is to deliver the most consistent and complete service experience possible. To meet this goal, we've developed and implemented standards and procedures to ensure you receive the ultimate service experience – every time.

Energy & sustainability

A more sustainable world one building at a time – Johnson Controls is a company that started more than 125 years ago with a product that reduced energy use in buildings. We've been saving energy for customers ever since. Today, Johnson Controls is a global leader in creating smart environments where people live, work and play, helping to create a more comfortable, safe and sustainable world.

The value of integrity

Johnson Controls has a long, proud history of integrity. We do what we say we will do and stand behind our commitments. Our good reputation builds trust and loyalty. In recognition for our commitment to ethics across our global operations, we are honored to be named one of the World's Most Ethical Companies by Ethisphere Institute, a leading think tank dedicated to business ethics and corporate social responsibility. In addition, Corporate Responsibility Magazine recognizes Johnson Controls as one of the top companies in its annual "100 Best Corporate Citizens" list.

Service delivery

As part of the delivery of this Planned Service Agreement, Johnson Controls will dedicate a local customer service agent responsible for having a clear understanding of the agreement scope, and your facility procedures and protocols.

A high-level overview around our service delivery process is outlined below including scheduling, emergency service, on-site paperwork, communication and performing repairs outside of the agreement scope.

Scheduling

Preventative maintenance service will be scheduled using our automated service management system. In advance of the scheduled service visit, our technician is sent a notice of service to a smartphone. Once the technician acknowledges the request, your customer service agent will call or e-mail your on-site contact to let you know the start date and type of service scheduled.

The technician checks in, wears personal protective equipment, performs the task(s) as assigned, checks out with you and asks for a screen capture signature on the smartphone device. A work order is then e-mailed, faxed or printed for your records.

Emergency services

Emergency service can be provided 7 days a week, 24 hours a day, 365 days a year. During normal business hours, emergency service will be coordinated by the customer service agent. After hours, weekends and holidays, the emergency service number transfers to the Johnson Controls after-hours call center and on-call technicians are dispatched as needed.

Johnson Controls is committed to dispatching a technician within hours of receiving your call through the service line. A work order is e-mailed, faxed or printed for your records. Depending on the terms of your agreement, you may incur charges for after hour services.

Communication

A detailed communication plan will be provided to you so you know how often we will provide information to you regarding your Planned Service Agreement. The communication plan will also provide you with your main contacts at Johnson Controls.

Approval process for non-covered items

Johnson Controls will adhere to your procurement process. No work will be performed outside of the agreement scope without prior approval. Johnson Controls will work with you closely to ensure your procurement process is followed before any non-covered item work is started.

Summary of services and options

Comprehensive and operational inspections

During comprehensive and operational inspections, Johnson Controls will perform routine checks of the equipment for common issues caused by normal wear and tear on the equipment. Additional tests can be run to confirm the equipment's performance.

Routine maintenance, such as lubrication, cleaning and tightening connections, can be performed depending on the type of equipment being serviced. Routine maintenance is one of the keys to the five values of maintenance – it can help identify energy saving opportunities, reduce future repair costs, extend asset life, ensure productive environments, and promote health and safety.

Summary

Thank you for considering Johnson Controls as your building technology services partner. The following agreement document includes all the details surrounding your Planned Service Agreement.

With planned service from Johnson Controls, you'll get a value-driven solution that can help optimize your building controls and equipment performance, providing dependability, sustainability and energy efficiency. You'll get a solution that fits your specific goals, delivered with the attention of a local service company backed by the resources of a global organization.

Planned Service Agreement

Customer Name :	DARE COUNTY HEALTH AND SOCIAL SERVICES
Address:	107 EXETER ST MANTEO,NC 27954-9400
Proposal Date:	08/30/2021
Estimate #:	1-1ATXSUCI

Scope of Service

Johnson Controls, Inc. ("JCI") and the Customer (collectively the "Parties") agree Preventative Maintenance Services, as defined in Schedule A ("Services"), will be provided by JCI at the Customer's facility. This Planned Service Agreement, the Equipment List, Supplemental Price and Payment Terms, Terms and Conditions, and Schedules attached hereto and incorporated by this reference as if set forth fully herein (collectively the "Agreement"), cover the rights and obligations of both the Customer and JCI.

Extended Service Options for Premium Coverage

If Premium Coverage is selected, on-site repair services to the equipment will be provided as specified in this Agreement for the equipment listed in the attached Equipment List.

Equipment List

Only the equipment listed in the Equipment List will be covered as part of this Agreement. Any changes to the Equipment List must be agreed upon in writing by both Parties.

Term / Automatic Renewal

This Agreement takes effect on 09/01/2021 and will continue until 08/31/2022 ("Original Term"). The Agreement will automatically renew and extend for successive terms equal to the Original Term unless the Customer or JCI gives the other written notice it does not want to renew prior to the end of the then-current term (each a "Renewal Term"). The notice must be delivered at least (90) days prior to the end of the Original Term or of any Renewal Term. The Original Term and any Renewal Term may be referred to herein as the "Term". Renewal price adjustments are discussed in the Terms and Conditions.

Refrigerant Charges

Refrigerant is not included under this Agreement and will be billed separately to the Customer by JCI.

Price and Payment Terms

The total Contract Price for JCI's Services during the first year of the Original Term is $8,358.00. This amount will be paid to JCI in advance in Annual installments. Pricing for each subsequent year of a multiyear Original Term is set forth in the Supplemental Price and Payment Terms. Unless otherwise agreed to by the parties, All payments will be due upon receipt. Renewal price adjustments are set forth in the Terms and Conditions.

Invoices will be sent to the following location:

COUNTY OF DARE
ADMIN BLDG ATTN: KEITH SAWYER
PO BOX 1000
MANTEO,NC 27954

☐ In lieu of paper invoices sent to the location above, invoices should be emailed to the following email address: _____

This proposal is valid for thirty days from the proposal date.

JOHNSON CONTROLS Inc.	
By:Arlene Cole	**By:**
Signature:	**Signature:**
Title:Branch Service Manager Date:	**Title: Date:**
Signature:	**Customer PO#:**
Title: Date:	

JCI Branch: JOHNSON CONTROLS NORFOLK VA CB - 0N29
Address: 4850 BROOKSIDE CT
NORFOLK,VA 23502-2052
Branch Phone: (866) 468-1469
Branch Email:

This instrument has been preaudited in the manner required by the Local Government Budget and Fiscal Control Act. 8/31/2021
Sally DeFosse

Schedule A - Equipment List

DARE COUNTY HEALTH AND SOCIAL SERVICES	107 EXETER ST MANTEO, NC 27954-9400

Product: Boiler, Gas-Fired, Water Tube, 151-300 HP

Quantity: 1
Coverage Level: Basic

Services Provided

3	Operational
1	Government/Local Jurisdiction Inspect (performed during fireside cleaning - gaskets not included)
1	Comprehensive

Customer Tag	Manufacturer	Model #	Serial #
Boiler#1	RBI Futera III Series	DBO600	011569856

Product: Boiler, Gas-Fired, Water Tube, 151-300 HP

Quantity: 1
Coverage Level: Basic

Services Provided

3	Operational
1	Government/Local Jurisdiction Inspect (performed during fireside cleaning - gaskets not included)
1	Comprehensive

Customer Tag	Manufacturer	Model #	Serial #
Boiler#2	RBI Futera III Series	DB600	081674536

Equipment tasking

Boiler, Gas-Fired, Water Tube, 151-300 HP

Government/Local Jurisdiction Inspect (performed during fireside cleaning - gaskets not included)	All work must be performed in accordance with Johnson Controls safety policies Check with appropriate customer representative for operational deficiencies Lock and tag out unit Isolate and drain boiler Open covers Conduct inspection Replace covers Fill system Prepare unit for operation
Operational	All work must be performed in accordance with Johnson Controls safety policies Check with appropriate customer representative for operational deficiencies Blow down boiler Check for proper operation of low and high gas pressure cut-out switches Check factory supplied gas piping and components for leakage Check burner for proper sequence of operation Check flame quality Visually inspect combustion chamber, draft diverter and flue for accumulation of soot Check boiler relief valves for leakage Verify proper operation of low water cut-out control Check combustion blower motor operation Check hot water/steam temperature and pressure Check proper operation of make-up water valv Check overall condition of unit Document tasks performed during visit and report any observations to appropriate customer representative
Comprehensive	All work must be performed in accordance with Johnson Controls safety policies Check with appropriate customer representative for operational deficiencies Inspect burner contactors for wear Check and tighten electrical connections Check for proper gas supply pressure Check and clean pilot assembly Clean combustion fan wheel Visually inspect combustion chamber, draft diverter and flue for accumulation of soot - clean as needed Check burner for proper sequence of operation Check operating controls Check all safety controls Lift relief valve to ensure proper operation Check boiler relief valves for leakage Check combustion blower motor operation and lubricate as needed Check factory supplied gas piping and components for leakage Drain boiler, open hand hole covers and clean as needed (if applicable) Disassemble and clean low water cut-out Fill boiler and check for proper operation of make-up water valve Verify proper operation of low water cut-out control Check overall condition of unit Record and log all operating parameters (including pressures and temperatures) Remove and dispose any debris from any maintenance activity Document tasks performed during visit and report any observations to

appropriate customer representative

Supplemental Price & Payment Terms (Applies to Multi-Year Contracts Only)

Year	Total Annual Dollar Amount	Payment Frequency
Year1	$8,358.00	Semi-Annual
Year2	$8,693.00	Semi-Annual
Year3	$9,041.00	Semi-Annual

Special Additions and Exceptions

TERMS AND CONDITIONS
DEFINITIONS

CONNECTED EQUIPMENT SERVICES means a data-analytics and monitoring Software platform that uses a cellular or network connection to gather equipment performance data to assist JCI in advising Customer on such equipment's health, performance or potential malfunction.

CONTRACT PRICE means the price that Customer shall pay to JCI for the Services.

COVERED EQUIPMENT means the equipment for which Services are to be provided under this Agreement. Covered Equipment is set forth in Schedule A - Equipment List.

EQUIPMENT FAILURE means the failure, under normal and expected working conditions, of moving parts or electric or electronic components of the Covered Equipment that are necessary for its operation.

PREMISES means those Customer premises where the Covered Equipment is located or Services performed pursuant to this Agreement.

REMOTE MONITORING SERVICES means remote monitoring of Covered Equipment and/or systems including building automation, HVAC equipment, and fire alarm, intrusion, and/or other life safety systems for alarm and event notifications using a UL Certified Central Station.

REMOTE OPERATIONS CENTER (ROC) is the department at JCI that remotely monitors alarm and industrial (HVAC) process signals.

REMOTE OPERATING SERVICES means remote interrogation, modification and/or operation of building automation, HVAC equipment, and/or other Covered Equipment.

REPAIR LABOR is the labor necessary to restore Covered Equipment to working condition following an Equipment Failure, but does not include services relating to total equipment replacement due to obsolescence or unavailability of parts.

REPAIR MATERIALS are the parts and materials necessary to restore Covered Equipment to working condition following an Equipment Failure, but excludes total equipment replacement due to obsolescence or unavailability of parts, unless excluded from the Agreement. At JCI's option, Repair Materials may be new, used, or reconditioned.

SCHEDULED SERVICE MATERIALS are the materials required to perform Scheduled Service Visits on Covered Equipment, unless excluded from the Agreement.

SCHEDULED SERVICE VISITS are the on-site labor visits required to perform JCI recommended inspections and preventive maintenance on Covered Equipment.

SERVICES are the work, materials, labor, service visits, and repairs to be provided by JCI pursuant to this Agreement except that the Services do not include the Connected Equipment Services or the provision of other software products or digital or cloud services, which are provided under separate terms and conditions referenced in Section P.

A. JCI'S SERVICES FOR COVERED EQUIPMENT

1. BASIC COVERAGE means Scheduled Service Visits, plus Scheduled Service Materials (unless excluded from this Agreement). No parts, equipment, Repair Labor or Repair Materials are provided for under BASIC COVERAGE.

2. PREMIUM COVERAGE means BASIC COVERAGE plus Repair Labor, plus Repair Materials (unless excluded from the Agreement). If Customer has ordered PREMIUM COVERAGE, JCI will inspect the Covered Equipment within forty-five (45) days of the date of this Agreement, or as seasonal or operational conditions permit. JCI will then advise Customer if JCI finds any Covered Equipment not in working order or in need of repair. With Customer's approval, JCI will perform the work necessary to put the Covered Equipment in proper working condition, subject to the terms of this Agreement. Customer will pay for such work at JCI's standard rates for parts and labor in effect at the time that the work is performed. If Customer does not want JCI to perform the work identified as necessary by JCI, any equipment thereby affected will be removed from the list of Covered Equipment, and the Contract Price will be adjusted accordingly. Should Customer not make JCI's recommended repairs or proceed with the modified PREMIUM COVERAGE, JCI reserves the right to invoice Customer for the cost of the initial equipment inspection.

3. EXTENDED SERVICE means Services performed outside JCI's normal business hours and is available only if Customer has PREMIUM COVERAGE. Extended Service is available either 24/5 or 24/7, at Customer's election. The price for Extended Service, if chosen by Customer, is part of the total Contract Price.

4. JCI CONNECTED EQUIPMENT SERVICES. Certain equipment sold hereunder includes by default JCI's Connected Equipment Services. **If Customer's equipment includes Connected Equipment Services, such services will be on by default and the remote connection will continue to connect to Customer's Equipment through the full equipment lifecycle, unless Customer specifically requests in writing that JCI disable the remote connection or JCI discontinues or removes such remote connection.** For more information on whether your particular equipment includes Connected Equipment Services, a subscription to such services and the cost, if any, of such subscription, please see your applicable order, quote, proposal, or purchase documentation or talk to your JCI sales representative. If Customer's equipment includes Connected Equipment Services, JCI will provide a cellular modem or other gateway device ("Gateway Device") owned by JCI or Customer will supply a network connection suitable to establish a remote connection with Customer's applicable equipment to permit

JCI to use Connected Equipment Services to perform first-year and extended warranty services as well as other services, including troubleshooting, quarterly health reports, remote diagnostic and monitoring and aftermarket services. For certain subscriptions, Customer will be able to access equipment information from a mobile or smart device using Connected Equipment Service's mobile or web app. Any Gateway Devices provided hereunder shall remain JCI's property, and JCI may upon reasonable notice access and remove such Gateway Device and discontinue services in accordance with the Software Terms. If Customer does not permit JCI to connect via a connection validated by JCI for the equipment or the connection is disconnected by Customer, and a service representative must therefore be dispatched to the Customer site, then the Customer will pay JCI at JCI's then-current standard applicable contract regular time and/or overtime rate for services performed by the service representative. **Customer acknowledges that, while Connected Equipment Services generally improve equipment performance and services, Connected Equipment Services does not prevent all potential malfunction, insure against all loss or guarantee a certain level of performance and that JCI shall not be responsible for any injury, loss, or damage caused by any act or omission of JCI related to or arising from the monitoring of the equipment under Connected Equipment Services**.

5. REMOTE MONITORING SERVICES OR REMOTE OPERATING SERVICES. If Remote Monitoring Services or Remote Operating Services are provided, Customer agrees to furnish JCI with a list of the names, titles, addresses, email addresses, and phone numbers of all persons authorized to be contacted by, or be able to contact the ROC to perform specific agreed upon actions with the appropriate authority. If JCI's Services include "Remote Monitoring Services with Open and Close," Customer also agrees to furnish JCI with Customer's daily and holiday opening and closing schedules. Customer agrees to maintain and update the call lists with accurate information. Customer further agrees to notify JCI of such changes as soon as possible. JCI/ROC is not responsible to find new contacts/numbers if the contacts on the call lists cannot be reached. A maximum of three contacts are allowed for any time of the day. If none of those contacts can be reached, then neither JCI nor the ROC are responsible for damages. Customer is responsible for any and all costs and expenses arising from Customer's failure to provide timely updates for any of the contact information submitted to the ROC.

6. CUSTOMER SERVICE INFORMATION PORTAL. Customer may be able to utilize JCI's Customer Service Information Portal during the term of the Agreement, pursuant to the then applicable Terms of Use Agreement.

B. OUT OF SCOPE SERVICES

If, during any Service Visit, JCI detects a defect in any of Customer's equipment that is not Covered Equipment under this Agreement (an "Out of Scope Defect"), JCI may (but shall have no obligation to) notify Customer of such Out of Scope Defect. If Customer elects for JCI to repair such Out of Scope Defect, or if JCI otherwise performs any Services or provides any materials, parts, or equipment outside the scope of the Services (collectively, "Out of Scope Services"), Customer shall direct JCI to perform such Out of Scope Services in writing, and Customer shall pay for such Out of Scope Services at JCI's standard fees or hourly rates. If, after receiving notice of an Out of Scope Defect, Customer elects not to engage JCI to repair such Out of Scope Defect, Customer shall defend and indemnify JCI from and against any and all losses, damages, claims, costs and expenses arising directly or indirectly out of such Out of Scope Defect. Any Out of Scope Services performed by JCI at the direction of Customer pursuant to this Section shall be subject to the terms of this Agreement.

C. EXCLUSIONS

JCI's Services and warranty obligations expressly exclude:

(a) the repair or replacement of ductwork, casings, cabinets, structural supports, tower fill/slats/basin, hydronic and pneumatic piping, and vessels, gaskets, and piping not normally replaced or maintained on a scheduled basis, and removal of oil from pneumatic piping;

(b) disposal of hazardous wastes (except as otherwise expressly provided herein);

(c) disinfecting of chiller condenser water systems and other components for biohazards, such as but not limited to, Legionella unless explicitly set forth in the scope of services between the parties. Unless explicitly provide for within the scope of services, this is Out of Scope Services and the Customer's exclusive responsibility to make arrangements for such services with a provider other than JCI. Mentions of chiller tube cleaning, condenser cleaning, cooling tower cleaning or boiler tube cleaning in any scope of services, only involve work to remove normal buildup of debris and scale using tube brush cleaning, pressure washing or acid flushing. Reference to such cleaning does not include chemical cleaning, disinfection or chemical water treatment required to eliminate, control or disinfect against biohazards such as but not limited to Legionella;

(d) refrigerant; supplies, accessories, or any items normally consumed during the use of Covered Equipment, such as ribbons, bulbs and paper;

(e) the furnishing of materials and supplies for painting or refinishing equipment;

(f) the repair or replacement of wire in conduit, buried cable/transmission lines, or the like, if not normally replaced or maintained on a scheduled basis;

(g) replacement of obsolete parts; and

(h) damages of any kind, including but not limited to personal injury, death, property damage, and the costs of repairs or service resulting from:

- abuse, misuse, alterations, adjustments, attachments, combinations, modifications, or repairs to Covered Equipment not performed, provided, or approved in writing by JCI;
- equipment not covered by this Agreement or attachments made to Covered Equipment;
- acts or omissions of the Customer, including but not limited to the failure of the Customer to fulfill the Customer Obligations and Commitments to JCI as described in Section F of this Agreement, operator error, Customer's failure to conduct preventive maintenance, issues resulting from Customer's previous denial of JCI access to the Covered Equipment, and Customer's failure to keep the site clean and free of dust, sand, or other particles or debris, unless such conditions are previously expressly acknowledged by JCI in writing;
- use of the Covered Equipment in a manner or environment, or for any purpose, for which it was not designed by the manufacturer;
- site-related and environmental conditions, including but not limited to power failures and fluctuations in electrical current (or "power

surges") and biohazards such as but not limited to Legionella associated with condenser water, cooling tower systems and subcomponent systems;

- the effects of erosion, corrosion, acid cleaning, or damage from unexpected or especially severe freezing weather;
- issues or failures not specifically covered by this Agreement; or
- occurrences beyond JCI's reasonable control and without JCI's fault or negligence.

D. PAYMENT TERMS; PRICE ADJUSTMENTS

Unless otherwise agreed to by the parties, fees and other amounts due hereunder are due upon receipt of the invoice. Such payment is a condition precedent to JCI's obligation to perform Services under the Agreement. Any invoice disputes must be identified in writing by Customer within 21 days of the date of invoice. Payments of any disputed amounts are due and payable upon resolution. Failure by Customer to make payments when due will give JCI, without prejudice to any other right or remedy, the right to: (i) to stop performing any Services, withhold deliveries of Equipment and other materials, terminate or suspend any software licenses provided hereunder and/or terminate this Agreement; and (ii) charge Customer interest on the amounts unpaid at a rate equal to the lesser of one and one-half (1.5) percent per month or the maximum rate permitted under applicable law, until payment is made in full. Customer will pay all of JCI's reasonable collection costs (including legal fees and expenses). In the event of Customer's default, the balance of any outstanding amounts will be immediately due and payable.

JCI may increase prices upon notice to the Customer to reflect increases in material and labor costs. If this Agreement is renewed, JCI will provide Customer with notice of any adjustments in the Contract Price applicable to any Renewal Term. Unless Customer terminates this Agreement in writing at least ninety (90) days prior to the end of the then-current Term, the adjusted Contract Price shall be the price for the Renewal Term.

E. WARRANTIES

JCI warrants its Services will be provided in a good and workmanlike manner for 90 days from the date of Services. If JCI receives written notice of a breach of this warranty prior to the end of this warranty period, JCI will re-perform any non-conforming Services at no additional charge within a commercially reasonable time of the notification.

JCI warrants that equipment manufactured or labeled by Johnson Controls, Inc. shall be free from defects in material and workmanship arising from normal usage for a period of 90 days. No warranty is provided for third-party products and equipment installed or furnished by JCI. Such products and equipment are provided with the third party manufacturer's warranty to the extent available, and JCI will transfer the benefits, together with all limitations, of that manufacturer's warranty to Customer. All transportation charges incurred in connection with the warranty for equipment and/or materials not covered under this Agreement shall be borne by Customer. Except as provided herein, if JCI receives written notice of a breach of this warranty prior to the end of this warranty period, JCI will repair or replace (at JCI's option) the defective equipment.

These warranties do not extend to any Services or equipment that have been misused, altered, or repaired by Customer or third parties without the supervision of and prior written approval of JCI, or if JCI serial numbers or warranty decals have been removed or altered. All replaced parts or equipment shall become JCI's property. This warranty is not assignable. Warranty service will be provided during normal business hours, excluding holidays. The remedies set forth herein shall be Customer's sole and exclusive remedy with regards to any warranty claim under this Agreement. Any lawsuit based upon the warranty must be brought no later than one (1) year after the expiration of the applicable warranty period. This limitation is in lieu of any other applicable statute of limitations. **CUSTOMER FURTHER ACKNOWLEDGES AND AGREES THAT THESE WARRANTIES ARE JCI'S SOLE WARRANTIES AND TO THE MAXIMUM EXTENT PERMITTED UNDER APPLICABLE LAW ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO THOSE OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.** JCI makes no and specifically disclaims all representations or warranties that the services, products, software or third party product or software will be secure from cyber threats, hacking or other similar malicious activity, or will detect the presence of, or eliminate, prevent, treat, or mitigate the spread, transmission, or outbreak of any pathogen, disease, virus or other contagion, including but not limited to COVID 19.

F. CUSTOMER OBLIGATIONS AND COMMITMENTS TO JCI

1. Customer warrants it has given JCI all information concerning the condition of the Covered Equipment. The Customer agrees and warrants that, during the Term of this Agreement, Customer will:

(1) operate the Covered Equipment according to the manufacturer's and/or JCI's recommendations;

(2) keep accurate and current work logs and information about the Covered Equipment as recommended by the manufacturer and/or JCI;

(3) provide an adequate environment for Covered Equipment as recommended by the manufacturer and/or JCI, including, but not limited to adequate space, electrical power, water supply, air conditioning, and humidity control;

(4) notify JCI immediately of any Covered Equipment malfunction, breakdown, or other condition affecting the operation of the Covered Equipment;

(5) provide JCI with safe access to its Premises and Covered Equipment at all reasonable and necessary times for the performance of the Services;

(6) allow JCI to start and stop, periodically turn off, or otherwise change or temporarily suspend equipment operations so that JCI can perform the Services required under this Agreement;

(7) as applicable, provide proper condenser, cooling tower and boiler water treatment for the proper functioning of Covered Equipment and protect against any environmental issues and instances of biohazards such as but not limited to Legionella;

(8) carefully and properly set and test the intrusion alarm system each night or at such other time as Customer shall close the Premises;

(9) obtain all necessary licenses and permits required for and pay all taxes associated with the Services;

(10) notify JCI immediately of any claimed inadequacy in, or failure of, the Covered Equipment or other condition affecting the operation of the Covered Equipment;

(11) furnish any necessary 110 volt A/C power and electrical outlets at its expense;

(12) properly maintain, repair, service, and assure the proper operation of any other property, system, equipment, or device of Customer or

others to which the Covered Equipment may be attached or connected, in accordance with manufacturer recommendations, insurance carrier requirements, or the requirements of any fire rating bureau, agency, or other authorities having jurisdiction thereof;

(13) not tamper with, alter, adjust, disturb, injure, remove, or otherwise interfere with any Covered Equipment (including any related software) and not permit the same to be done;

(14) refrain from causing false alarms, and reimburse JCI for any fine, penalty, or fee paid by or assessed against JCI by any governmental or municipal agency as a result thereof;

(15) be solely responsible for the establishment, operation, maintenance, access, security and other aspects of its computer network ("Network") and shall supply JCI secure Network access for providing its services. Products networked, connected to the internet, or otherwise connected to computers or other devices must be appropriately protected by Customer and/or end user against unauthorized access; and

(16) take appropriate measures, including performing back-ups, to protect information, including without limit data, software, or files (collectively "Data") prior to receiving the service or products.

2. Customer acknowledges and understands that unless water treatment for biohazards (such as Legionella) is explicitly included in the services JCI is providing, it is Customer's responsibility to provide such treatment. Customer also acknowledges that its failure to meet the above obligations will relieve JCI of any responsibility for any Covered Equipment breakdown, or any necessary repair or replacement of any Covered Equipment. If Customer breaches any of these obligations, JCI shall have the right, upon written notice to Customer, to suspend its Services until Customer cures such breach. In addition, Customer shall be responsible for paying or reimbursing JCI for any costs associated with corrective work required as a result of Customer's breach of these obligations.

G. INSURANCE

Customer is responsible for obtaining all insurance coverage that Customer believes is necessary to protect Customer, Customer's property, and persons in or on the Premises, including coverage for personal injury and property damage. THE PAYMENTS CUSTOMER MAKES UNDER THIS AGREEMENT ARE NOT RELATED TO THE VALUE OF THE PREMISES, CUSTOMER'S PROPERTY OR POSSESSIONS, OR THE PERSONS OCCUPYING OR AT ANY TIME PRESENT IN OR ON THE PREMISES, BUT RATHER ARE BASED ON THE COST OF THE SYSTEM AND THE SERVICES, AND TAKE INTO CONSIDERATION THE PROTECTION AFFORDED TO JCI UNDER THIS AGREEMENT. Customer hereby releases JCI from any liability for any event or condition customarily covered by commercial liability insurance. Customer understands that neither the Services nor the Covered Equipment are designed to reduce, but not eliminate, certain risks. JCI does not guaranty that neither the Services nor Covered Equipment will prevent personal injury, unauthorized entrances or fire and smoke damage to the Premises. Customer further agrees that Customer has read and understands the terms and conditions of this Agreement.

H. INDEMNITY

JCI ~~and Customer~~ shall ~~each~~ indemnify the other party and its officers, agents, directors, and employees, from any and all damages, losses, costs and expenses (including reasonable attorneys' fees) arising out of third party claims, demands, or suits for bodily injury (including death) or damage to tangible property to the extent arising out of the negligence or intentional misconduct of the indemnifying party or its employees or agents. Customer expressly agrees that JCI shall be responsible for injury, damage, or loss only to the extent caused directly by JCI's negligence or intentional misconduct. The obligations of JCI and ~~Customer~~ under this section are further subject to sections I and K below.

I. LIMITATION OF LIABILITY

TO THE MAXIMUM EXTENT PERMITTED BY LAW, IN NO EVENT SHALL JCI AND ITS AFFILIATES AND THEIR RESPECTIVE PERSONNEL, SUPPLIERS AND VENDORS ("JCI PARTIES") BE LIABLE TO YOU OR ANY THIRD PARTY UNDER ANY CAUSE OF ACTION OR THEORY OF LIABILITY EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, FOR ANY: (1) SPECIAL, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR INDIRECT DAMAGES; (2) LOST PROFITS, REVENUES, DATA, CUSTOMER OPPORTUNITIES, BUSINESS, ANTICIPATED SAVINGS, OR GOODWILL; (3) BUSINESS INTERRUPTION; OR (4) DATA LOSS OR OTHER LOSSES ARISING FROM VIRUSES, RANSOMWARE, CYBER ATTACKS OR FAILURES OR INTERRUPTIONS TO NETWORK SYSTEMS. IN ANY CASE, THE ENTIRE AGGREGATE LIABILITY OF THE JCI PARTIES UNDER THIS AGREEMENT FOR ALL DAMAGES, LOSSES, AND CAUSES OF ACTION, WHETHER IN CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE SHALL BE LIMITED TO $250,000. CUSTOMER UNDERSTANDS THAT JCI IS NOT AN INSURER REGARDING THE WORK OR THE SERVICES. JCI SHALL NOT BE RESPONSIBLE FOR ANY DAMAGE OR LOSS THAT MAY RESULT FROM FIRE SAFETY OR SECURITY EQUIPMENT THAT FAILS TO PERFORM PROPERLY OR FAILS TO PREVENT A CASUALTY OR LOSS.

J. FORCE MAJEURE

JCI shall not be liable, nor in breach or default of its obligations under this Agreement, for delays, interruption, failure to render services, or any other failure by JCI to perform an obligation under this Agreement, where such delay, interruption or failure is caused, in whole or in part, directly or indirectly, by a Force Majeure Event. A "Force Majeure Event" is a condition or event that is beyond the reasonable control of JCI, whether foreseeable or unforeseeable, including, without limitation, acts of God, severe weather (including but not limited to hurricanes, tornados, severe snowstorms or severe rainstorms), wildfires, floods, earthquakes, seismic disturbances, or other natural disasters, acts or omissions of any governmental authority (including change of any applicable law or regulation), epidemics, pandemics, disease, viruses, quarantines, or other public health risks and/or responses thereto, condemnation, strikes, lock-outs, labor disputes, an increase of 5% or more in tariffs or other excise taxes for materials to be used on the project, fires, explosions or other casualties, thefts, vandalism, civil disturbances, insurrection, mob violence, riots, war or other armed conflict (or the serious threat of same), acts of terrorism, electrical power outages, interruptions or degradations in telecommunications, computer, network, or electronic communications systems, data breach, cyber-attacks, ransomware, unavailability or shortage of parts, materials, supplies, or transportation, or any other cause or casualty beyond the reasonable control of JCI. If JCI's performance of the work is delayed, impacted, or prevented by a Force Majeure Event or its continued effects, JCI shall be excused from performance under the Agreement. Without limiting the generality of the foregoing, if JCI is delayed in achieving one or more of the scheduled milestones set forth in the Agreement due to a Force Majeure Event, JCI will be entitled to extend the relevant completion date by the amount of time that JCI was delayed as a result of the Force Majeure Event, plus such additional time as may be reasonably necessary to overcome the effect of the delay. To the extent that the Force Majeure Event directly or indirectly increases JCI's cost to perform the services, Customer is obligated to reimburse JCI for such increased costs, including, without limitation, costs incurred by JCI for additional labor, inventory storage, expedited shipping fees, trailer and equipment rental fees, subcontractor fees or other costs and expenses incurred by JCI in connection with the Force Majeure Event.

K. RESOLUTION OF DISPUTES

If a dispute arises under this Agreement, the parties shall promptly attempt in good faith to resolve such dispute by negotiation. In the event the dispute is unable to be resolved, either party shall have the right to initiate arbitration by filing with the American Arbitration Association provided no other legal action has been previously filed. Upon filing of the arbitration, the AAA shall have the exclusive jurisdiction over the Dispute. Thus, either party may decide to file an action in a court of competent jurisdiction. If that court filing is the first legal proceeding filed, that court shall have jurisdiction over the Dispute to the exclusion of any arbitration. Arbitration shall be conducted in accordance with the then current arbitration rules of the American Arbitration Association or other arbitration service mutually agreed to by the parties. Arbitration must be completed within sixty (60) days after the Dispute is submitted to arbitration unless the parties mutually agree otherwise. The award rendered by the arbitrator shall be final, and judgment issued by the Arbitrator may be entered in accordance with applicable law in any court having competent jurisdiction. The party prevailing in the arbitration or court proceeding shall be entitled to an award of its reasonable costs, including reasonable attorneys' fees, incurred as a result of the Dispute. CUSTOMER MUST BRING ANY CLAIM AGAINST JCI WITHIN ONE (1) YEAR AFTER THE CLAIM AROSE. IF CUSTOMER DOES NOT, CUSTOMER WILL HAVE IRREVOCABLY WAIVED ITS RIGHT TO SUE JCI AND/OR INSTITUTE OTHER PROCEEDINGS, AND JCI SHALL HAVE NO LIABILITY TO CUSTOMER FOR SUCH CLAIM. TIME IS OF THE ESSENCE RELATIVE TO CUSTOMER PURSUING ANY SUCH CLAIM. THE PROVISIONS OF THIS AGREEMENT WHICH APPLY TO ANY CLAIM SHALL REMAIN IN EFFECT EVEN AFTER THE AGREEMENT IS TERMINATED. JCI AND CUSTOMER EACH WAIVE THEIR RIGHT TO A JURY TRIAL.

L. TERM AND TERMINATION

1. The Original Term is as set forth herein. At the conclusion of the Original Term, ~~this Agreement shall automatically renew and extend for successive terms equal to the Original Term unless the Customer or JCI gives the other written notice it does not want to renew prior to the end of the then current term (each a "Renewal Term"). The notice must be delivered at least ninety (90) days prior to the end of the Original Term or any Renewal Term. The Original Term and any Renewal Term may be referred to herein as the "Term." Customer agrees to issue and send a Purchase Order to JCI at least thirty (30) days prior to expiration of the Original Term or any Renewal Term if necessary for payments to be processed, but failure to do so is not a pre-condition to Renewal Term payments being due to JCI~~

2. Remote Monitoring Services and Remote Operating Services may be immediately canceled by either party if JCI's Remote Operations Center, connecting wires, or monitoring systems are destroyed by fire or other catastrophe, or where the Premises are so substantially damaged that it is impractical to continue Services.

3. If either party fails to perform any of its material obligations under this Agreement, the other party shall provide written notice thereof to the party alleged to be in default. Should the party alleged to be in default fail to respond in writing or take action to cure the alleged default within ten (10) days of receiving such written notice, the notifying party may terminate this Agreement by providing written notice of such termination.

4. JCI & customer may terminate this Agreement and discontinue any Services if JCI is unable to obtain or continue to support technologies, equipment or component parts that are discontinued, become obsolete or are otherwise not commercially available, or for convenience upon forty-five (45) days written notice. JCI will not be liable for any damages or subject to any penalty as a result of any such termination. Upon termination by JCI, sums paid in advance by customer shall be prorated on a daily basis JCI shall refund to customer sums paid for services for the remainder of the contract term after termination.

5. Upon termination of this Agreement by customer for any reason, except for breach by JCI Customer shall pay to JCI all undisputed amounts owed through the date of termination within thirty (30) days of such termination. If Customer terminates this Agreement, other than in accordance with this Section L, Customer shall also pay Johnson Controls 35% of the charges for Services remaining to be paid for the unexpired Term of this Agreement as liquidated damages and not as a penalty. Customer shall provide JCI with reasonable access to the Premises to remove the Gateway Device and any other JCI property and to un-program any controls, intrusion, fire, or life safety system, as applicable. Customer shall be liable for all fees, costs, and expenses that JCI may incur in connection with the enforcement of this Agreement, including without limitation, reasonable attorney fees, collection agency fees, and court costs.

M. ASBESTOS, MOLD, BIOAHAZARDS, AND HAZARDOUS MATERIALS

"Hazardous Materials" means any material or substance that, whether by its nature or use, is now or hereafter defined or regulated as a hazardous waste, hazardous substance, pollutant, or contaminant under any local, state, or federal law, regulation, or ordinance relating to or addressing public and employee health and safety and protection of the environment, or which is toxic, explosive, corrosive, flammable, radioactive, carcinogenic or otherwise hazardous or which is or contains petroleum, gasoline, diesel, fuel, another petroleum hydrocarbon product or polychlorinated biphenyls. "Hazardous Materials" specifically includes mold, lead-based paints, biohazards such as but not limited to Legionella and asbestos-containing materials ("ACM"). Neither Customer nor JCI desires to or is licensed to undertake direct obligations relating to the identification, abatement, cleanup, control, removal or disposal of ACM.

JCI will be responsible for removing or disposing of any Hazardous Materials that it uses in providing the Services ("JCI Hazardous Materials") and for the remediation of any areas affected by the release of JCI Hazardous Materials. For other Hazardous Materials that may be present at its facilities ("Non-JCI Hazardous Materials"), Customer shall supply JCI with any information in its possession relating to the presence of Hazardous Materials if their presence may affect JCI's performance of the Services. If either Customer or JCI becomes aware of or suspects the presence of Non-JCI Hazardous Materials that may interfere with JCI's Services, it shall immediately stop the Services in the affected area and notify the other party. As between Customer and JCI, Customer shall be responsible at its sole expense for removing and disposing of Non-JCI Hazardous Materials from its facilities and for the remediation of any areas impacted by the release of the Non-JCI Hazardous Materials and must provide a certificate of abatement before JCI will be obligated to perform or continue its Services, unless JCI had actual knowledge that Non-JCI Hazardous Materials were present and acted in disregard of that knowledge, in which case (i) JCI shall be responsible at its sole expense for the remediation of any areas impacted by its release of such Hazardous Materials, and (ii) Customer shall remain responsible at its sole expense for the removal of Hazardous Materials that have not been released and for releases not resulting from JCI's performance of the Services. Customer shall defend and indemnify JCI against any losses, costs, damages, expenses, and claims arising out of its failure to comply with this Section M.

N. CUSTOMER DATA

Customer data obtained from the Services is owned by and shall belong to Customer. JCI will access and use Customer data to provide Services to Customer. Except as set forth herein, JCI will not disclose to any third party any individual Customer data acquired through performance of the Services without Customer's consent. Customer agrees that JCI and its subsidiaries, affiliates and approved third party contractors and developers may collect and use Customer data for any reason, as long as any external use of the data is on a de-identified basis that does not personally identify Customer or any individual. Customer hereby grants JCI a perpetual, worldwide, irrevocable, royalty free license to use, modify, manipulate, sublicense, and create derivative works from such data. JCI shall retain all rights to any intellectual property, data, materials and products created as a result of its performance of Services.

O. JCI'S INTELLECTUAL PROPERTY

JCI shall retain all right, title and interest in any (a) work provided to Customer, including without limitation, all software source and object code, documentation, technical information or data, specifications and designs and any changes, improvements or modifications thereto ("Deliverables"), and (b) Know-How (defined below) employed by JCI in the creation of the Deliverables or performance of the Services, whether known to JCI prior to, or developed or discovered or acquired in connection with, the performance of its obligations under this agreement. Ownership of all Deliverables and Know-How shall vest solely in JCI and no Deliverables shall be deemed "works made for hire." Without limiting the generality of the foregoing, ownership of all source files used in the course of performing the Services shall remain the exclusive property of JCI. For purposes of this Agreement, "Know-How" means any know-how, processes, techniques, concepts, methodologies, tools, analytical approaches, database models and designs, discoveries, and ideas furnished, produced by, developed, or used by JCI in the creation or provision of the Deliverables or in the performance of the Services, and any changes, improvements, or modifications thereto or derivatives thereof.

P. SOFTWARE AND DIGITAL SERVICES

Use, implementation, and deployment of the software and hosted software products ("Software") offered under these terms shall be subject to, and governed by, JCI's standard terms for such Software and Software related professional services in effect from time to time at https://www.johnsoncontrols.com/techterm (collectively, the "Software Terms"). Applicable Software Terms are incorporated herein by this reference. Other than the right to use the Software as set forth in the Software Terms, JCI and its licensors reserve all right, title, and interest (including all intellectual property rights) in and to the Software and improvements to the Software. The Software that is licensed hereunder is licensed subject to the Software Terms and not sold. If there is a conflict between the other terms herein and the Software Terms, the Software Terms shall take precedence and govern with respect to rights and responsibilities relating to the Software, its implementation and deployment and any improvements thereto.

Q. Privacy.

1. JCI as Processor: Where JCI factually acts as Processor of Personal Data on behalf of Customer (as such terms are defined in the DPA) the terms at www.johnsoncontrols.com/dpa ("DPA") shall apply.

2. JCI as Controller: JCI will collect, process and transfer certain personal data of Customer and its personnel related to the business relationship between it and Customer (for example names, email addresses, telephone numbers) as controller and in accordance with JCI's Privacy Notice at https://www.johnsoncontrols.com/privacy. Customer acknowledges JCI's Privacy Notice and strictly to the extent consent is mandatorily required under applicable law, Customer consents to such collection, processing and transfer. To the extent consent to such collection, processing and transfer by JCI is mandatorily required from Customer's personnel under applicable law, Customer warrants and represents that it has obtained such consent.

R. MISCELLANEOUS PROVISIONS

1. All notices required to be given hereunder shall be in writing and shall be considered properly given if: (a) delivered in person, (b) sent via the United States Postal Service, postage prepaid, registered or certified with return receipt requested, (c) sent by overnight delivery service (e.g., FedEx, UPS), or (d) sent by facsimile, email or other electronic means and confirmed by facsimile, return email or telephone.

2. This Agreement may not be assigned by Customer without JCI's prior written consent. JCI shall have the right to assign this Agreement to any other person, firm, or corporation without Customer's consent. JCI shall also have the right, in its sole discretion, to subcontract any portion of the Services. This Agreement inures to the benefit of and is applicable to any assignees or subcontractors of JCI, and is binding upon Customer with respect to said assignees or subcontractors with the same force and effect as it binds Customer to JCI.

3. This Agreement shall be subject to and governed by the laws of the State where the Services are performed.

4. If any provision of this Agreement is found to be invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

5. This Agreement is the entire contract between JCI and Customer and supersedes any prior oral understandings, written agreements, proposals, or other communications between the parties.

6. Customer acknowledges and agrees that any purchase order issued by Customer in connection with this Agreement is intended only to establish payment authority for Customer's internal accounting purposes and shall not be considered to be a counteroffer, amendment, modification, or other revision to the terms of this Agreement. No term or condition included or referenced in Customer's purchase order will have any force or effect and these terms and conditions shall control. Customer's acceptance of any Services shall constitute an acceptance of these terms and conditions. Any proposal for additional or different terms, whether in Customer's purchase order or any other document, unless expressly accepted in writing by JCI, is hereby objected to and rejected.

7. If there are any changes to Customer's facilities or operations, or to applicable regulations, laws, codes, taxes, or utility charges, that

materially affect JCI's performance of the Services or its pricing thereof, JCI shall have the right to an equitable and appropriate adjustment to the scope, pricing, and other affected terms of this Agreement.

8. No claim or cause of action, whether known or unknown, shall be brought against JCI more than one year after the claim first arose. Except as provided for herein, JCI's claims must also be brought within one year. Claims for unpaid contract amounts are not subject to the one-year limitation.

ADDENDUM TO PSA TERMS AND CONDITIONS FOR
MONITORING OF INTRUSION, FIRE AND OTHER SAFETY SYSTEMS

If Remote Monitoring Services explicitly includes remote fire alarm monitoring, security alarm monitoring or video monitoring in the scope of work or customer charges, the Agreement is hereby modified and amended to include the terms and provisions of this Addendum to the PSA for Monitoring of Intrusion, Fire and Safety Systems (the "Addendum"). Capitalized terms that are not defined herein, shall have the meaning given to them in the Agreement. In the event of a conflict between the terms and conditions of this Addendum and those appearing in the Agreement, the terms and conditions of this Addendum shall prevail.

1. Remote Monitoring of Alarm Signals. If JCI receives an emergency alarm signal at JCI's ROC, JCI shall endeavor to notify the appropriate police or fire department, or other emergency response agency having jurisdiction and JCI shall endeavor to notify Customer or its designated representative by email unless instructed to do otherwise by Customer in writing and/or based on standard operating procedures for the ROC. JCI, upon receipt of a non-emergency signal from the Premises, shall endeavor to notify Customer's representative pursuant to Customer's written instructions, defaulting to email or text notification. Customer acknowledges that if the signals transmitted from the Premises will be monitored in a monitoring facility not operated by JCI, the personnel in such monitoring facilities are not the agents of JCI, nor does JCI assume any responsibility for the manner in which such signals are monitored or the response to such signal.

2. Remote Monitoring Services Pricing. Remote Monitoring Services shall be provided by JCI if the Agreement includes a charge for such Service. If such Service is purchased, JCI will monitor the number of alarms for the Premises and the initial charge is based on the pricing agreed to by the parties, subject to the terms and conditions of this Addendum. If the number of alarms produced at the Premises goes beyond the contracted number of alarms in a month, Customer will be billed an overage fee.

3. Communications Media. Customer acknowledges that monitoring of Covered Equipment requires transmission of signals over standard telephone lines and/or the Internet and that these modes of transmission may be interrupted, circumvented, or compromised, in which case no signal can be transmitted from the Premises to the monitoring facility. Customer understands that to allow the monitoring facility to be aware of such a condition, additional or alternative protection can be installed, such as line security devices, at Customer's cost and expense and for transmission via telephone line only. Customer acknowledges it is aware that line security devices are available and, unless expressly identified in Schedule A - Equipment List, has declined to purchase such devices. Customer further acknowledges that such additional protection is not available for Internet transmission under this Agreement.

4. False/Unnecessary Alarms; Service Calls. At JCI's option, an additional fee may be charged for any false alarm or unnecessary Service Visit caused or necessitated by Customer. In addition, Customer shall be fully responsible and liable for fines, penalties, assessments, taxes, fees or charges imposed by a governmental body, telephone, communication, or signal transmission company as the result of any false alarm and shall reimburse JCI for any costs incurred by JCI in connection therewith. Customer shall operate the system carefully so as to avoid causing false alarms. False alarms can be caused by severe weather or other forces beyond the control of JCI. If an undue number of false alarms are received by JCI, in addition to any other available remedies available to JCI, JCI may terminate this Agreement and discontinue any Service(s) and seek to recover damages. If an agent is dispatched, by a governmental authority or otherwise, to respond to a false alarm, where the Customer, or any other party has intentionally, accidentally or negligently activated the alarm signal, Customer shall be responsible for and pay any and all fees and/or fines assessed with respect to the false alarms and pay to JCI the additional charges and costs incurred by it from a false alarm. If the Customer's system has a local audible device, Customer authorizes JCI to enter the Premises to turn off the audible device if JCI is requested or ordered to do so by governmental authorities, neighbors or anyone else and Customer will pay JCI its standard service call charge for each such visit. Police agencies require repair of systems which cause false dispatches. Customer shall maintain the equipment necessary for JCI to supply the Services and Customer shall pay all costs for such maintenance. At least monthly, Customer will test the system's protective devices and send test signals to the ROC for all monitoring equipment in accordance with instructions from JCI or the ROC. Customer agrees to test the monitoring systems, including testing any ultrasonic, microwave, infrared, capacitance or other electronic equipment prior to the end of each month and will immediately report to JCI if the equipment fails to respond to the test. Customer shall make any necessary repairs as soon after receipt of notice as is reasonably practical. Customer shall at all times be solely responsible for maintaining any sprinkler system in good working order and provide adequate heat to the Premises.

5. Remote Monitoring of Video Monitoring Services. During the Term, JCI's sole and only obligation arising from the inclusion of Video Monitoring Services in any Service offering shall be to monitor the digital signals actually received by JCI at its ROC from means of the Video System and upon receipt of a digital signal indicating that an alarm condition exists, to endeavor, as permitted by law, to notify the police or other municipal authority deemed appropriate in JCI's absolute discretion and to such persons Customer has designated in writing to JCI to receive notification of such alarm condition as set forth herein. . No alarm installation, repair, maintenance or guard responses will be provided under this Video Monitoring Services option. JCI may, without prior notice to Customer, in response to applicable law or insurance requirements, revise, replace, discontinue and/or rescind its response policies and procedures.

a. Inception and conclusion of service. Video Monitoring shall be provided by JCI if this Agreement includes a charge for Video Monitoring Services. If such Video Monitoring Service is purchased, Video Monitoring Services will begin when the Video System is installed and operational, and when the necessary communications connection is completed. No obligation for the provision of this Video Monitoring Service will commence until these requirements are met.

b. Customer Equipment. Customer shall obtain, at its own cost and expense: (a) the equipment necessary to connect to JCI's ROC; and

(b) whatever permission, permits or licenses that may be necessary from all persons, governmental authorities, utility, and any other related service providers in connection with the Services. The video system to be used by the Customer is intended to produce and transmit video images (the "Video System Images") of the Premises to the ROC (the "Video System"). JCI makes no promise, warranty or representation that the video system will operate as intended. Customer further agrees that, notwithstanding any role or participation by JCI in Video System and Video System Images, JCI shall have no responsibility or obligation with regard to Customer, the Video System or any other Customer equipment.

c. System Location. The Video System related cameras shall be located and positioned by Customer along with attendant burglary digital alarm signal(s). Customer shall ensure that the Video System related cameras will be positioned and located such that it will only produce or capture Video System Images of areas of the Premises. Customer will provide adequate illumination under all operating conditions for the proper viewing of the cameras. Customer acknowledges and agrees that JCI has exercised no control over, or participated in locating or positioning the Video System related camera including, but not limited to selecting what areas, locations, things or persons that the Video System Images may depict or capture.

d. Images. Customer shall be solely responsible for the Video System Images produced or captured by the Video System and Customer shall defend, indemnify and hold harmless JCI and its officers, agents, directors, and employees, from any and all damages, losses, costs and expenses (including reasonable attorneys' fees) arising out of third party claims, demands, or suits in connection with the use, operation, location and position of the Video System, and the Video System Images resulting there from, including, but not limited to, any claims of any person depicted in a Video System image, including but not limited to, any claim by such person that his or her privacy has been invaded or intruded upon or his or her likeness has been misappropriated. Any duty to obtain the consent or permission of any person depicted in a Video System Image to have his or her likeness to be depicted, received, transmitted or otherwise used, and the duty to determine and comply with any and all applicable laws, regulations, standards and other obligations that govern the legal, proper and ethical use of video capturing devices, such as the Video System, including, but not limited to, notification that the Video System is in use at the Premises, shall be the sole responsibility of the Customer. JCI agrees to make Video System Images available to Customer and upon their respective request. JCI makes no promise, warranty or representation as to the length of time that it retains Video Images, or the quality thereof.

e. Video System Signals. When a signal from the Video System is received, JCI reserves the right to verify all alarm signals before notifying emergency personnel, and may choose not to notify emergency personnel if it has reason to believe, in its sole discretion, that an emergency condition does not exist. JCI will first attempt to verify the nature of the emergency by using visual verification and/or the two-way voice system (if applicable) of the Video System included in Customer's system. If JCI determines that an emergency condition exists, JCI will endeavor to notify the proper police or emergency contact on a notification call list provided in writing by Customer to JCI, or its designee. When a non-emergency signal is received, JCI will attempt to contact the first available Customer representative on the notification call list but will not notify emergency authorities, this notification will be in the form of email or text and follow ROC processes. If the customer requires phone calls to the call list for any emergency or non-emergency situation, the customer will need to make this request in writing. Customer authorizes and directs JCI, as its agent, to use its full discretion in causing the arrest or detention of any person or persons on or around the premises who are not authorized by Customer. **JCI WILL NOT ARREST OR DETAIN ANY PERSON**.

f. Recordings. Customer consents to the tape recording of all telephonic communications between the Premises and JCI. JCI will have no liability arising from recording (or failure to record) or publication of any two-way voice communications, other video recordings or their quality. JCI shall have no liability in connection with Video System or the Video System Images, including, but not limited to, any failure, omission, negligence or other act by JCI, or any of its officers, employees, representatives, agents, contractors, or any other third party in connection with the receipt (or failure of receipt), transmission, reading, interpreting, or response to any Video Image.

6. Risk of Loss is Customer's. JCI does not represent or warrant that the Services will prevent any loss by burglary, holdup, fire or otherwise, or that the Services will in all cases provide the protection for which it is installed or intended, or that the Services will be uninterrupted or error-free. Customer assumes all risk of loss or damage to the Premises being monitored and to its contents, whether belonging to Customer or others; and has not relied on any representations and warranties of JCI, express or implied, except as specifically set forth in this Agreement. Further, expressly excluded from this Agreement are the warranties of merchantability or fitness or suitability for a particular purpose.

7. JCI'S RECEIPT OF ALARM SIGNALS, ELECTRONIC DATA, VOICE DATA OR IMAGES (COLLECTIVELY, "ALARM SIGNALS") FROM THE EQUIPMENT OR SYSTEM INSTALLED IN THE PREMISES IS DEPENDENT UPON PROPER TRANSMISSION OF SUCH ALARM SIGNALS. JCI'S ROC CANNOT RECEIVE ALARM SIGNALS WHEN THE CUSTOMER'S TELCO SERVICE OR OTHER TRANSMISSION MODE IS NOT OPERATING OR HAS BEEN CUT, INTERFERED WITH, OR IS OTHERWISE DAMAGED, OR IF THE ALARM SYSTEM IS UNABLE TO ACQUIRE, TRANSMIT OR MAINTAIN AN ALARM SIGNAL OVER CUSTOMER'S TELCO SERVICE OR TRANSMISSION MODE FOR ANY REASON INCLUDING BUT NOT LIMITED TO NETWORK OUTAGE OR OTHER NETWORK PROBLEMS SUCH AS CONGESTION OR DOWNTIME, ROUTING PROBLEMS, OR INSTABILITY OF SIGNAL QUALITY. CUSTOMER UNDERSTANDS THAT SIGNAL TRANSMISSION FAILURE MAY OCCUR OVER CERTAIN TYPES OF TELCO SERVICES SUCH AS SOME TYPES OF DSL, ADSL, VOIP, DIGITAL PHONE, INTERNET PROTOCOL BASED PHONE OR OTHER INTERNET INTERFACE-TYPE SERVICE OR RADIO SERVICE, INCLUDING CELLULAR, WIRELESS OR PRIVATE RADIO, OR CUSTOMER'S PROPRIETARY TELCOMMUNICATION NETWORK, INTRANET OR IP-PBX, OR OTHER THIRD-PARTY EQUIPMENT OR VOICE/DATA TRANSMISSION NETWORKS OR SYSTEMS OWNED, MAINTAINED OR SERVICED BY CUSTOMER OR THIRD PARTIES, IF: (1) THERE IS A LOSS OF NORMAL ELECTRIC POWER TO THE MONITORED PREMISES OCCURS (THE BATTERY BACK-UP FOR JCI'S ALARM PANEL DOES NOT POWER CUSTOMER'S COMMUNICATION FACILITIES OR TELCO SERVICE); OR (2) ELECTRONIC COMPONENTS SUCH AS MODEMS MALFUNCTION OR FAIL. CUSTOMER UNDERSTANDS THAT JCI WILL ONLY REVIEW THE INITIAL COMPATIBILITY OF THE ALARM SYSTEM WITH CUSTOMER'S TELCO SERVICE AT THE TIME OF INITIAL INSTALLATION OF THE ALARM SYSTEM AND THAT CHANGES IN THE TELCO SERVICE'S DATA FORMAT AFTER JCI'S INITIAL REVIEW OF COMPATIBILITY COULD MAKE THE TELCO SERVICE UNABLE TO TRANSMIT ALARM SIGNALS TO JCI'S ROC. IF JCI DETERMINES IN ITS SOLE DISCRETION THAT CUSTOMER'S TELCO SERVICE IS COMPATIBLE, JCI WILL PERMIT CUSTOMER TO USE ITS TELCO SERVICE AS THE PRIMARY METHOD OF TRANSMITTING ALARM SIGNALS, ALTHOUGH CUSTOMER UNDERSTANDS THAT JCI RECOMMENDS THAT CUSTOMER ALSO USE AN ADDITIONAL BACK-UP METHOD OF COMMUNICATION TO CONNECT CUSTOMER'S ALARM SYSTEM TO JCI'S ROC REGARDLESS OF THE TYPE OF TELCO SERVICE USED. CUSTOMER ALSO UNDERSTANDS THAT IF JCI DETERMINES IN ITS SOLE DISCRETION THAT CUSTOMER'S TELCO SERVICE IS, OR LATER BECOMES,

NON-COMPATIBLE, OR IF CUSTOMER CHANGES TO ANOTHER TELCO SERVICE THAT IS NOT COMPATIBLE, THEN JCI WILL REQUIRE THAT CUSTOMER USE AN ALTERNATE METHOD OF COMMUNICATION ACCEPTABLE TO JCI AS THE PRIMARY METHOD TO CONNECT CUSTOMER'S ALARM SYSTEM TO JCI'S ROC. JCI WILL NOT PROVIDE FIRE OR SMOKE ALARM MONITORING FOR CUSTOMER BY MEANS OTHER THAN AN APPROVED TELCO SERVICE AND CUSTOMER UNDERSTANDS THAT IT IS SOLELY RESPONSIBLE FOR ASSURING THAT IT USES APPROVED TELCO SERVICE FOR ANY SUCH MONITORING AND THAT IT COMPLIES WITH NATIONAL FIRE ALARM STANDARDS AND LOCAL FIRE CODES. CUSTOMER ALSO UNDERSTANDS THAT IF CUSTOMER'S ALARM SYSTEM HAS A LINE CUT FEATURE, IT MAY NOT BE ABLE TO DETECT ALARM SIGNALS IF THE TELCO SERVICE IS INTERRUPTED, AND THAT JCI MAY NOT BE ABLE TO DOWNLOAD SYSTEM CHANGES REMOTELY OR PROVIDE CERTAIN AUXILIARY MONITORING SERVICES THROUGH A NON-APPROVED TELCO SERVICE. CUSTOMER ACKNOWLEDGES THAT ANY DECISION TO USE A NON-APPROVED TELCO SERVICE AS THE METHOD FOR TRANSMITTING ALARM SIGNALS IS BASED ON CUSTOMER'S OWN INDEPENDENT BUSINESS JUDGMENT AND THAT ANY SUCH DECISION IS MADE WITHOUT ANY ASSISTANCE, INVOLVEMENT, INPUT, RECOMMENDATION, OR ENDORSEMENT ON THE PART OF JCI. CUSTOMER ASSUMES SOLE AND COMPLETE RESPONSIBILITY FOR ESTABLISHING AND MAINTAINING ACCESS TO AND USE OF THE NON-APPROVED TELCO SERVICE FOR CONNECTION TO THE ALARM MONITORING EQUIPMENT. CUSTOMER FURTHER UNDERSTANDS THAT THE ALARM SYSTEM MAY BE UNABLE TO SEIZE THE TELCO SERVICE TO TRANSMIT AN ALARM SIGNAL IF ANOTHER CONNECTION HAS DISABLED, IS INTERFERING WITH, OR BLOCKING THE CONNECTION.

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Upcoming Board Appointments

Description

The Dare County Board of Commissioners welcomes citizen participation on its many Boards and Committees.

Following is a list of the Boards and Committees that have terms expiring during the next 3 months. The list indicates when the item will be presented to the County Commissioners and any requirements that may pertain to the appointment.

Instructions on how to obtain and submit an application are attached along with additional information about each of the Boards and Committees with upcoming term appointments.

Board Action Requested

None

Item Presenter

Robert Outten, County Manager

Upcoming Board & Committee Appointments

The Dare County Board of Commissioners welcomes citizen participation on Advisory Boards and Committees. This type of grassroots public involvement is the foundation of democracy and a vital part of maintaining Dare County as a quality place to live.

Following is a list of Boards and Committees that have terms expiring during the next three months.

Information on how to obtain and submit applications follows the list.

October, 2021

Juvenile Crime Prevention Council --2 terms expiring

November, 2021

Older Adult Services Advisory Council --3 terms expiring

Rodanthe, Waves, Salvo Community Center Board **--**2 terms expiring

Stumpy Point Community Center Board **--**1 term expiring

December, 2021

Equalization and Review Board **--**5 terms expiring

Special Motor Vehicle Valuation Review Committee **--**3 terms expiring

~~~~~~Instructions for Obtaining and Submitting Applications~~~~~~~~

An application must be submitted in order for your name to be considered for a Board or Committee appointment. The form is available on the Dare County website, or by calling:

Cheryl C. Anby, Clerk to the Board at 475-5800

Commissioners' Business & Manager's/Attorney's Business

Description

Remarks and items to be presented by Commissioners and the County Manager.

Board Action Requested

Consider items presented

Item Presenter

Robert Outten, County Manager