CONTRACT #6
RFS # 317.01-300
FA # 07-17170-00

Finance & Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of Tennessee, Inc.
(CoverTN – Plan A)

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Laurie Lee

Date: January 29, 2009

RE: Amendments # 2 to CoverTN Plan A and B contracts

Please find attached Non-Competitive Amendment requests to add language to each of the existing contracts with BlueCross BlueShield of Tennessee (BCBST) for Plans A and B signed by Commissioner Goetz. The original procurement sought two vendors with different benefit plans and BCBST was awarded both contracts under their Plan A and Plan B proposal submissions. The two plans differ only in the benefits package contained in Attachment A, Part B of both documents.

The modification to both of the CoverTN contracts through this basically identical amendment to both plans clarifies existing contract language, updates the summary of benefits coverage in Attachment A, Part B for both documents and details eligibility requirements for those individuals participating in the VBP for CoverTN coverage.

The base contract and amendment # 1 with BCBST for both Plan A and B are included for review as is the proposed amendment to each document.

Thank you for your consideration of this request to amend both contracts with a start date for the amendment of April 1, 2009.

NON-COMPETITIVE AMENDMENT REQUEST:

APPROVED
Commissioner of Finance & Administration

1) **RFS #**	31701-30002
2) **Procuring Agency :**	Department of Finance and Administration
EXISTING CONTRACT INFORMATON	
3) **Service Caption :**	Provides statewide administrative services for the CoverTN program under Plan A
4) **Contractor :**	BlueCross BlueShield of Tennessee, Inc.
5) **Contract #**	FA-17170-00
6) **Contract Start Date :**	January 12, 2007
7) **CURRENT Contract End Date :** (if ALL options to extend the contract are exercised)	December 31, 2009
8) **CURRENT Maximum Cost :** (if ALL options to extend the contract are exercised)	$ 50,000,000
PROPOSED AMENDMENT INFORMATON	
9) **Amendment #**	Two
10) **Amendment Effective Date :** (attached explanation required if < 60 days after F&A receipt)	April 1, 2009
11) **PROPOSED Contract End Date :** (if ALL options to extend the contract are exercised)	December 31, 2009
12) **PROPOSED Maximum Cost :** (if ALL options to extend the contract are exercised)	$ 50,000,000
13) **Approval Criteria :** (select one)	☒ **use of Non-Competitive Negotiation is in the best interest of the state**
	☐ **only one uniquely qualified service provider able to provide the service**

14) Description of the Proposed Amendment Effects & Any Additional Service :

This amendment:

- Defines special eligibility category for former State employees who participated in the State's Voluntary Buyout Program(VBP) and enrollment procedures for this group
- Clarifies administrative procedures around employer participation and participation of Tennesseans Between Jobs and VBP participants
- Authorizes programming for certain eligibility changes, program integrity activities and reporting for program evaluation
- Authorizes ongoing data match activities to support program integrity
- Expands member benefits within the program's fixed payment

15) Explanation of Need for the Proposed Amendment :

This amendment benefits the state by expanding member benefits without increasing the per member per month charge,

expanding eligibility criteria and cleaning up contract language to clarify administrative procedures.

16) Name & Address of Contractor's Current Principal Owner(s) : (not required for a TN state education institution)

BlueCross BlueShield of Tennessee, Inc., 801 Pine Street-4G, Chattanooga, TN., 37402

17) Office for Information Resources Endorsement : (required for information technology service; n/a to THDA)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

18) eHealth Initiative Endorsement : (required for health-related professional, pharmaceutical, laboratory, or imaging service)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

19) Department of Human Resources Endorsement : (required for state employees training service)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

This contract is in the second year of the term and the State is satisfied with the performance of the Contractor. The benefit and eligibility changes permitted by this amendment enhance the benefits of the core contract without adding cost. The programming changes enable the State to perform critical program integrity functions. It is therefore in the best interest of the State to continue this business commitment and to implement this amendment. The agency did not attempt to identify competitive procurement alternatives.

21) Justification for the Proposed Non-Competitive Amendment :

The amendment language adds some responsibilities to the Contractor that will benefit the State and plan members. Specifically, the Amendment expands the member's benefits within the fixed per member per month rate and enables the State's Voluntary Buyout participants to enroll in CoverTN. The administrative changes in the amendment either clarify contract language or make the language consistent for the new eligibility categories.

AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

1/30/09

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Marlene Alvarez	*Contact Phone:	615.253.8358
*Contract Number:	FA-07-17170-00	*RFS Number:	31701-30002
*Original Contract Begin Date:	Jan. 12, 2007	*Current End Date:	Dec. 31, 2009
Current Request Amendment Number: (*if applicable*)	# 2		
Proposed Amendment Effective Date: (*if applicable*)	April 1, 2009		
*Department Submitting:	Finance and Administration		
*Division:	Benefits Administration		
*Date Submitted:	Jan. 30, 2009		
*Submitted Within Sixty (60) days:	Yes		
If not, explain:			
*Contract Vendor Name:	BlueCross BlueShield of Tennessee, Inc.		
*Current Maximum Liability:	$50,000,000		

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Contract Summary Sheet)

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY	FY
$2,000,000.00	$13,000,000.00	$23,000,000.00	$12,000,000.00	$	$

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS or FDAS report)

FY: 2007	FY: 2008	FY: 2009	FY: 2010	FY	FY
$344,137.71	**$5,263,299.27**	**$3,447,664.81**			

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	**Contract Per Member Per Month (PMPM) expenditures are based on estimates of annual plan membership for the term of the contract. Actual membership may vary from the original estimates during the term of each contract, and therefore funding needs may vary. Surplus funds were not spent.**
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:	**Surplus funds for the CoverTN program were carried forward to ensure adequate funding to sustain program growth. Carry forward authority is PC 1203, Section 35, item 11.**
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	

*Contract Funding Source/Amount:	State:	$50,000,000	Federal:	
Interdepartmental:			*Other:*	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment # 1 - August, 2008	Clarifies contract language, expands member methods of payment, requires more frequent updates to member handbook, allows county governments to become "participating employers", allows the State to waive the six month "go bare requirement" in certain situations such as an individual's employment termination
Method of Original Award: (*if applicable*)	RFP in calendar year 2006

CoverTN BCBST Payments Contract FA0717170

As of January 29, 2009

Contract Number	Effective Month	Total		
FA0717170	APRIL 2007	534.99		
FA0717170	MAY 2007	33,108.85		
FA0717170	JUNE 2007	117,728.01		
FA0717170	JUNE 2007	192,765.86	**Total FY 07**	**344,137.71**
FA0717170	JULY 2007	251,978.87		
FA0717170	AUGUST 2007	312,898.89		
FA0717170	OCTOBER 2007	357,283.31		
FA0717170	OCTOBER 2007	382,875.03		
FA0717170	NOVEMBER 2007	405,941.10		
FA0717170	JANUARY 2008	470,699.12		
FA0717170	FEBRUARY 2008	462,383.02		
FA0717170	FEBRUARY 2008	479,877.17		
FA0717170	MARCH 2008	439,850.12		
FA0717170	MARCH 2008	67,012.48		
FA0717170	MAY 2008	537,535.39		
FA0717170	MAY 2008	529,071.67		
FA0717170	JUNE 2008	565,893.10	**Total FY 08**	**5,263,299.27**
FA0717170	JULY 2008	568,762.78		
FA0717170	SEPTEMBER 2008	565,465.03		
FA0717170	SEPTEMBER 2008	550,337.67		
FA0717170	OCTOBER 2008	554,731.67		
FA0717170	DECEMBER 2008	566,147.97		
Edison Contract # 2891	JANUARY 2009	642,219.69	**Total FY 09**	**3,447,664.81**
	Grand Total	**9,055,101.79**		

CONTRACT AMENDMENT COVER

RFS Tracking #	Edison Contract ID #	Amendment #
31701-30002	0000000000000000000002891	2

Amendment Purpose	Delegated Authority Requisition ID # (ONLY if applicable)
Provides statewide administrative services for the CoverTN program under Plan A. Amendment clarifies existing contract language, updates the summary of benefits and coverage and details eligibility requirements for those individuals participating in the VBP for CoverTN coverage.	

Contractor/Grantee	Contractor/Grantee FEIN or SSN
BlueCross BlueShield of Tennessee, Inc.	☐ C- or ☒ V- 62 – 0427913

Begin Date	End Date	Subrecipient or Vendor	CFDA #(s)
January 12, 2007	December 31, 2009	☐ Subrecipient ☒ Vendor	

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$2,000,000.00				$2,000,000.00
2008	$13,000,000.00				$13,000,000.00
2009	$23,000,000.00				$23,000,000.00
2010	$12,000,000.00				$12,000,000.00
TOTAL:	$50,000,000.00				$50,000,000.00

— COMPLETE FOR AMENDMENTS —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$2,000,000.00	
2008	$13,000,000.00	
2009	$23,000,000.00	
2010	$12,000,000.00	
2011		
TOTAL:	$50,000,000.00	

Procuring Agency Contact & Telephone #

Maureen Abbey, Director – Office of Business & Finance
312 Rosa L Parks Avenue, Suite 2000
Nashville, Tennessee 37243
615.741.6070

Procuring Agency Budget Officer Approval (there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.)

Speed Code	Account Code
	70804000

— OCR Use —

Procurement Process Summary (FA or ED-type only)

The original contract (FA0717170) was procured through the RFP process.

AMENDMENT TWO
TO FA-07-17170-00

This Contract Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject Contract is hereby amended as follows:

1. The following provisions are added to Contract Section A Definitions:

   "Voluntary Buyout Program (VBP)" includes former State employees who signed an agreement with the State to terminate their employment during 2008 or 2009 in exchange for an established package of benefits and who were eligible for continuation of health coverage under the Public Health Service Act (codified at 42 USC § 300bb-1 *et seq.*). For purposes of the non-eligibility components of this Contract, the Contractor shall treat VBP enrollees as employees of non-participating employers unless the State and the Contractor agree to a different protocol.

2. The text of Contract Section A Definitions, "$41,000 a year" is deleted in its entirety and replaced with the following:

   "$41,000 a year" means the income level that the State updates each year with the release of the Census Bureau's federal poverty guidelines. This income level is approximately 300 percent of the federal poverty level for a household of four.

3. The text of Contract Section A.2.1.2 is deleted in its entirety and replaced with the following:

   A.2.1.2 The Contractor shall not modify the services or benefits provided to members during the term of this contract without the consent of the State. Any modification to services or benefits shall be implemented through a contract amendment (see Section D.2). If, in any calendar year after year one and when membership reaches 100,000 member months, the Contractor's average PMPM for claims incurred during the contract year and paid through the sixth month following the end of the contract year plus an estimate of incurred but not reported claims costs is $20 above or below the average premium amount PMPM, minus (x) the administrative component and (y) the broker commissions, the Contractor shall cooperate with the State in restructuring the Contractor's benefits so that the benefit cost is within $20 of the average premium amount PMPM minus the administrative component.

4. The following provision is added as Contract Section A.4.7; renumber existing Section A.4.7 and subsequent sections as necessary:

   A.4.7 The Contractor shall determine eligibility for applicants for VBP participants (and their spouses, as applicable). In order to determine eligibility for VBP participants and their spouses, the Contractor shall:
   A.4.7.1 Verify that the applicant is a VBP participant based on information provided by the State;
   A.4.7.2 Confirm that the application for the applicant (and spouse, if applicable) includes a residential street address in Tennessee; and
   A.4.7.3 Screen the VBP participant's application and approve eligibility unless the applicant self-attests on the application that he/she:
   A.4.7.3.1 Is under age nineteen (19);
   A.4.7.3.2 Is not a U.S. citizen or qualified alien;
   A.4.7.3.3 Earns more than $41,000 a year;
   A.4.7.3.4 Has health benefits coverage other than coverage offered as part of the VBP package; or
   A.4.7.3.5 Has had health benefits coverage within the last six (6) months (unless Contractor is directed by the State in writing to waive this requirement for such applicant, or any group of applicants, in accordance with TCA § 56-7-3005(c), as amended).
   A.4.7.4 If the applicant is determined to be eligible, approve eligibility for the applicant's spouse (as applicable) unless the spouse self-attests on the application that he/she:
   A.4.7.4.1 Is under age nineteen (19);

A.4.7.4.2 Is not a U.S. citizen or qualified alien; or

A.4.7.4.3 Has health benefits coverage other than coverage offered as part of the VBP package; or

A.4.7.4.4 Has had health benefits coverage within the last six (6) months (unless Contractor is directed by the State in writing to waive this requirement for such applicant, or any group of applicants, in accordance with TCA § 56-7-3005(c), as amended).

5. The text of renumbered Contract Section A.4.8 is deleted in its entirety and replaced with the following:

A.4.8 The Contractor shall not request any verification documents for the self-attested eligibility elements listed in Sections A.4.3.3, A.4.3.4., A.4.5.2, A.4.5.3, A.4.6.2, A.4.6.3, A.4.7.3 or A.4.7.4. If the Contractor has good cause to doubt the veracity of any of the attestations, then the Contractor shall refer the application to the State. While awaiting the State's response, the Contractor shall presume the truthfulness of the applicant's representations and approve or deny eligibility accordingly.

6. The text of renumbered Contract Section A.4.8.1 is deleted in its entirety and replaced with the following:

A.4.8.1 If an employee, Tennessean Between Jobs, VBP participant, or a self-employed individual is ineligible for any of the reasons listed in Sections A.4.3, A.4.5, A.4.6 or A.4.7, then the spouse is not eligible unless he or she qualifies independent of his or her status as a spouse.

7. The text of renumbered Contract Section A.4.11 is deleted in its entirety and replaced with the following:

A.4.11 Individuals may apply for CoverTN within the following timeframes:

A.4.11.1 Current employees of participating employers (and their spouses) shall have ninety (90) days from when the Contractor receives the necessary forms to activate the participating employer, provided that the participating employer shall have one (1) year from when it receives confirmation from the State/its vendor that the employer is a participating employer (or one (1) year after CoverTN begins operations, whichever is later) to submit such necessary activation forms to the Contractor.

A.4.11.2 New employees of participating employers (and their spouses) shall have 30 calendar days from the employee's start date of employment to submit an application to a CoverTN plan.

A.4.11.3 Employees of participating employers may also apply for CoverTN during open enrollment (see Section A.5.3.1) or if the employee involuntarily loses other health insurance coverage (e.g., the employee involuntarily loses coverage under his/her spouse's plan).

A.4.11.4 Self-employed individuals (and their spouses) shall have ninety (90) days from when the Contractor receives the necessary forms to activate the self-employed individual, provided that the self-employed individual shall have one (1) year from when it receives confirmation from the State/its vendor that it is a qualified self-employed individual (or one (1) year after CoverTN begins operations, whichever is later) to submit such necessary activation forms to the Contractor.

A.4.11.5 Employees of non-participating employers (during Phase 2) may enroll at any time. There is no time limit for applying.

A.4.11.6 New and current employees of participating employers (and their spouses) shall have thirty (30) calendar days from the date of a qualifying event to submit an application to a CoverTN plan.

A.4.11.7 Applicants eligible as Tennesseans Between Jobs (and their eligible spouses) shall have ninety (90) calendar days from the date on which the State notifies the applicant that he or she is a qualified Tennessean Between Jobs to submit an application to the CoverTN plan.

A.4.11.8 Applicants eligible as VBPs (and their eligible spouses) must submit an application to enroll in the CoverTN plan within ninety (90) calendar days of April 1, 2009, which is the first date that VBPs may be effective with the CoverTN plan.

8. The following provision is added as Contract Section A.4.21:

A.4.21 Contractor shall perform a daily match of the participating employers, self-employed individuals, and employees of non-participating employers provided by the State against the Contractor's enrollment files to confirm that such applicant does not have current health benefits coverage with the Contractor or has not had health benefits coverage with the Contractor in the past six (6)

months. The Contractor shall provide the State with a report of the results of such daily data match on a weekly basis.

9. The text of Contract Sections A.4.3.3.5, A.4.3.4.4, A.4.5.2.6, A.4.5.3.4, A.4.6.2.6 and A.4.6.3.4 are deleted in their entirety and replaced with the following in each instance:

   Has had health benefits coverage within the last six (6) months (unless Contractor is directed by the State in writing to waive this requirement for such applicant, or any group of applicants, in accordance with TCA § 56-7-3005(c), as amended).

10. The text of Contract Section E.2 is deleted in its entirety and replaced with the following:

    E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

    The State:

    Marlene D. Alvarez, Manager of Procurements and Contracting
    Tennessee Department of Finance and Administration,
    Benefits Administration Division
    312 Rosa L Parks Avenue, Suite 2600
    Nashville, TN 37243
    marlene.alvarez@state.tn.us
    Telephone: 615.253.8358
    FAX: 615.253.8556

    The Contractor:

    Amy Bercher, Senior Product Manager
    BlueCross BlueShield of Tennessee, Inc.
    One Cameron Hill
    Chattanooga, Tennessee 37402
    Amy_Bercher@VSHPTN.com
    Telephone: 423.535.5983
    FAX: 423.535.7601

    All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

11. The following is added as Contract Section C.11:

    C.11 Data Match Process Reimbursement. The State shall reimburse Contractor the one-time sum of $74,492 for the development and implementation of the data match and report provided by Contractor pursuant to Section A.4.21, and $4,886 per month, for the continued provision of this data match and report during the initial term of the Contract. The State further agrees to pay $1,768 per month for this data match and report during any extension of the term of this Contract. The Contractor shall include the one-time amount in the invoice to the State next following the execution of this Amendment and the monthly amount in its standard monthly invoice to the State beginning with the invoice next following the execution of this Amendment.

12. The following is added as Contract Section C.12:

C.12 Go-Bare Programming Expense Reimbursement. The State shall reimburse Contractor the one-time sum of $76,840 for expenses associated with the reprogramming of certain aspects of the enrollment process, enrollment form and other services provided by the Contractor in connection with changes by the State to the administration of the "go-bare" criteria. The Contractor shall include this one-time amount in the invoice to the State next following the execution date of this Amendment.

13. The following is added as Contract Section C.13:

C.13 Reporting Package Reimbursement. The State shall reimburse Contractor the one-time sum of $5,000 for a portion of the development, implementation and provision of a monthly reporting package provided by the Contractor. The Contractor shall include this one-time amount in the invoice to the State next following the execution date of this Amendment.

14. The following provision is added as Contract Section E.13.:

E.13. Voluntary Buyout Program. The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.

b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.

c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

15. Contract Attachment A, Plan A: "Benefits and Cost Sharing", Part B: "Summary of Benefits and Coverage." attached hereto.

16. Contract Attachment D is deleted in its entirety and replaced with updated Contract Attachment D attached hereto.

The revisions set forth herein shall be effective as of April 1, 2009. All other terms and conditions not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

CONTRACTOR SIGNATURE DATE

SONYA K. NELSON, VICE PRESIDENT, STATE GOVERNMENT PROGRAMS

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. GOETZ, JR., COMMISSIONER DATE

APPROVED:

COMMISSIONER OF FINANCE & ADMINISTRATION DATE

COMPTROLLER OF THE TREASURY DATE

Plan A
Benefits and Cost-Sharing

Part B: Summary of Benefits and Coverage					
Service Description	**Required?** (Yes/No)	**Included in your CoverTN plan?** (Yes/No)	**CoverTN Cost-Sharing Requirements** (No deductibles or coinsurance permitted)	**Service Limitations/Exclusions**	**Copayment** (if any)
Hospital Inpatient					
Medical	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	$100 copayment per admission
Surgical	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	$100 copayment per admission
Psychiatric	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Inpatient psychiatric and substance abuse services limited to 5 days per year. Note 1	$100 copayment per admission

	Substance Abuse	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Inpatient psychiatric and substance abuse services limited to 5 days per year. Inpatient substance abuse services limited to medical detox only at a medical facility. Note 1	$100 copayment per admission
	Dialysis Clinic	No	No			$
	Skilled Nursing Facility	No	No			$
	Other (specify)	No	No			$
Hospital Outpatient						
	Emergency Room	**YES**	**YES**	Maximum $100 copay per visit for non-emergency conditions.	Limited to 2 ER visits per calendar year	$100 copayment for non-emergent services
	Medical	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit
	Surgery/Procedures	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	$25 copayment per visit
	Radiology	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit

	Pathology	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit
	Other (specify)	No	No			$
Outpatient Behavioral Health						
	OP Mental Health Services	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to behavioral health visit limit of 10 visits per calendar year for mental health and substance abuse services	$25 copayment per visit
	OP Substance Abuse Services	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to behavioral health visit limit of 10 visits per calendar year for mental health and substance abuse services	$25 copayment per visit
Physician Services						
	Inpatient Surgery					
	Primary Surgeon	**YES**	**YES**	Maximum $25 copay per encounter.	Inpatient stay must be covered	No copayment
	Anesthesia	**YES**	**YES**	Maximum $25 copay per encounter.	Inpatient stay must be covered	No copayment
	Outpatient Surgery					
	OP Hospital	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	No copayment
	Surgical Center	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	No copayment

		Office	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 12 visits to a Primary Care Physician (PCP) or 5 visits to a specialist per calendar year for medical, surgical or preventive services performed in an office setting Note 1	$15 copayment per visit
	Inpatient Visits		**YES**	**YES**	Maximum $25 copay per visit.	Inpatient stay must be covered	No copayment
	Preventive Services						
		Adult preventive physical exams, including lab tests	**YES**	**YES**	Maximum $25 copay per encounter.	One adult physical exam per calendar year, subject to office visit limit of 12 visits to a PCP per calendar year for medical, surgical or preventive services performed in an office setting One well woman exam per calendar year, subject to office visit limit of 12 visits to a PCP per calendar year for medical, surgical or preventive services performed in an office setting	No copayment No copayment
		Pap smears	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one well woman visit per calendar year	No copayment
		PSA	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one adult physical exam per calendar year	No copayment

		Mammography	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one well woman visit per calendar year Mammograms performed in an outpatient setting will be subject to the outpatient visit limit of 2 non-surgical visits per calendar year	No copayment
		Immunizations/Vaccinations	**YES**	**YES**	No copay.	Included with one adult physical exam per calendar year	No copayment
		Other (specify)	No	No			$
	Services related to ER visit		**YES**	**YES**	Maximum $25 copay per encounter.	Limited to 2 ER visits per calendar year	$25 copayment per encounter for both emergent and non-emergent services
	Diagnostic and Therapeutic Services						
		PCP visits	**YES**	**YES**	Maximum $25 copay per visit; also, one visit without charge for health assessment every three years.	Subject to office visit limit of 12 visits per calendar year for medical, surgical or preventive services performed in an office setting	$15 copayment per visit
		Specialist visits	**YES**	**YES**	Maximum $25 copay per visit.	Subject to office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting	$15 copayment per visit
		Lab	**YES**	**YES**	Maximum $10 copay per test.	Office visit must be covered for related lab work to be covered Does not count toward visit limit when performed separately from an office visit Office lab services are not covered after the office visit limit is met	No copayment

		Chemotherapy	No	**YES**		Subject to office visit limit of 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting, regardless of whether an office visit is filed with the services	No copayment
		Radiation	No	**YES**		Subject to office visit limit of 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting, regardless of whether an office visit is filed with the services	No copayment
		Allergy tests, injections, and sera	No	No			$
		Other (specify)	No	No			$
Other Provider Services							
	PT, OT, and speech therapists		No	No			$
	Audiology		No	No			$
	Vision		No	**YES**		Subject to office visit limit of 12 visits to a PCP and 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting Medical benefit only Glasses or contacts following cataract surgery limited to $200 per year	$15 copayment per visit
	Chiropractic		No	No			$

	Podiatry	No	No			$
	Dental Services	No	No			$
	Urgent Care	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 12 visits to a PCP or 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting Subject to outpatient visit limit of 2 non-surgical visits and 1 surgical visit per calendar year	Office Visit - $15 copayment per visit Outpatient - $25 copayment per visit
	Other (specify)	No	No			$
Radiology						
	IP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	Included in $100 copayment per admission No additional copayment per encounter
	OP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year and 1 surgical visit per calendar year Note 1	Included in $25 copayment per visit No additional copayment per encounter

	Office (Combined)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 12 visits to a PCP or 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services when performed in conjunction with an office visit Does not count toward visit limit when performed separately from an office visit Office x-ray services are not covered after the office visit limit is met	Included in $15 copayment per visit No additional copayment per encounter
	Other (specify)	No	No			$
Pathology						
	IP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	Included in $100 copayment per admission No additional copayment per encounter
	OP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year and 1 surgical visit per calendar year Note 1	Included in $25 copayment per visit No additional copayment per encounter

	Office (Combined)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 12 visits to a PCP or 5 visits to a specialist per calendar year for medical, surgical, diagnostic, preventive or other services when performed in conjunction with an office visit Does not count toward visit limit when performed separately from an office visit Office x-ray services are not covered after the office visit limit is met	Included in $15 copayment per visit No additional copayment per encounter
	Other (specify)	No	No			$
Miscellaneous Services						
	PDN/Home Health Care	No	**YES**		Subject to annual payment limit of $500	No copayment
	Hospice Care	No	**YES**		Subject to annual payment limit of $5,000 for inpatient and/or outpatient services	No copayment
	Air Ambulance	No	No			
	Ground and other ambulance	**YES**	**YES**	Maximum $25 copay per emergent encounter; maximum $50 copay for non-emergency.	Limited to 2 trips per calendar year	No copayment
	Non-Emergency Transportation	No	No			
	Durable Medical Equipment	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Prosthetics	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Corrective Appliance	No	No			

	Medical Supplies	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Diabetic supplies and injectibles	No	**YES**		Diabetic supplies must be purchased through the pharmacy benefit to be covered	No copayment for meters Strips subject to $10 copayment Supplies subject to $5 copayment
	Organ/Tissue Transplants and Donor Services	No	No			
	Reconstructive Breast Surgery	No	**YES**		Inpatient - Subject to $10,000 annual payment limit for inpatient medical and behavioral health services Outpatient - Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	Included in $100 copayment per admission Included in $25 copayment per outpatient visit
	Other (specify)	No	No			$
Pharmacy						
	Generic	**YES**	**YES**	Maximum $10 copay per prescription.	Subject to quarterly payment limit of $250	$10 copayment per 30 day supply

	Name-Brand	No	**YES**	Please see Attachment 6.3, Section A, item A.12 for limitations; maximum $25 copay per prescription.	Limited to insulin and brand name test strips	$10 copayment per 30 day supply
Other (specify)		No	**YES**		**All services subject to a payment maximum of $25,000 per calendar year**	varies

Note 1: All services subject to an overall payment maximum of $25,000 per calendar year

Contract Attachment D
Premium Amounts for CY 2007

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 103.00	$ 113.00	$ 123.00	$ 133.00
30-39	$ 126.00	$ 139.00	$ 146.00	$ 159.00
40-49	$ 155.00	$ 170.00	$ 175.00	$ 190.00
50-59	$ 189.00	$ 208.00	$ 209.00	$ 228.00
60-64	$ 216.00	$ 238.00	$ 236.00	$ 258.00
65+	$ 253.00	$ 278.00	$ 273.00	$ 298.00

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 34.33	$ 37.67	$ 41.00	$ 44.33
30-39	$ 42.00	$ 46.33	$ 48.67	$ 53.00
40-49	$ 51.67	$ 56.67	$ 58.33	$ 63.33
50-59	$ 63.00	$ 69.33	$ 69.67	$ 76.00
60-64	$ 72.00	$ 79.33	$ 78.67	$ 86.00
65+	$ 84.33	$ 92.67	$ 91.00	$ 99.33

Contractor's administrative component of the premium amounts: $9.50 per member per month

Premium Amounts for CY 2008

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 112.58	$ 123.58	$ 134.58	$ 145.58
30-39	$ 137.88	$ 152.18	$ 159.88	$ 174.18
40-49	$ 169.78	$ 186.28	$ 191.78	$ 208.28
50-59	$ 207.18	$ 228.08	$ 229.18	$ 250.08
60-64	$ 236.88	$ 261.08	$ 258.88	$ 283.08
65+	$ 277.58	$ 305.08	$ 299.58	$ 327.08

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 37.53	$ 41.19	$ 44.86	$ 48.53
30-39	$ 45.96	$ 50.73	$ 53.29	$ 58.06
40-49	$ 56.59	$ 62.09	$ 63.93	$ 69.43
50-59	$ 69.06	$ 76.03	$ 76.39	$ 83.36
60-64	$ 78.96	$ 87.03	$ 86.29	$ 94.36
65+	$ 92.53	$ 101.69	$ 99.86	$ 109.03

Contractor's administrative component of the premium amounts: $9.73 per member per month

Premium Amounts for CY 2009

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 112.58	$ 123.58	$ 134.58	$ 145.58
30-39	$ 137.88	$ 152.18	$ 159.88	$ 174.18
40-49	$ 169.78	$ 186.28	$ 191.78	$ 208.28
50-59	$ 207.18	$ 228.08	$ 229.18	$ 250.08
60-64	$ 236.88	$ 261.08	$ 258.88	$ 283.08
65+	$ 277.58	$ 305.08	$ 299.58	$ 327.08

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 37.53	$ 41.19	$ 44.86	$ 48.53
30-39	$ 45.96	$ 50.73	$ 53.29	$ 58.06
40-49	$ 56.59	$ 62.09	$ 63.93	$ 69.43
50-59	$ 69.06	$ 76.03	$ 76.39	$ 83.36
60-64	$ 78.96	$ 87.03	$ 86.29	$ 94.36
65+	$ 92.53	$ 101.69	$ 99.86	$ 109.03

Contractor's administrative component of the premium amounts: $10.07 per member per month

GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

320 Sixth Avenue, North – 8th Floor
NASHVILLE, TENNESSEE 37243-0057
615-741-2564

Rep. Charles Curtiss, Chairman
Representatives
Curt Cobb
Curtis Johnson
Gerald McCormick
Mary Pruitt
Craig Fitzhugh, *ex officio*
Speaker Jimmy Naifeh, *ex officio*
Donna Rowland
David Shepard
Curry Todd
Eddie Yokley

Sen. Douglas Henry, Vice-Chairman
Senators
Doug Jackson
Bill Ketron
Paul Stanley
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*
Reginald Tate
Jamie Woodson

MEMORANDUM

TO: The Honorable Dave Goetz, Commissioner
Department of Finance and Administration

FROM: Charles Curtiss, Chairman, Fiscal Review Committee
Bill Ketron, Chairman, Contract Services Subcommittee

CC
BK

DATE: June 25, 2008

SUBJECT: **Contract Comments**
(Contract Services Subcommittee Meetings 6/24)

RFS# 317.30-041
Department: Finance & Administration/Benefits Administration
Contractor: BlueCross BlueShield of Tennessee (BCBST)
Summary: The vendor currently provides statewide administrative services for the CoverTN program under Plan A. These services include, but are not limited to, marketing, eligibility determination, enrollment and disenrollment processing, premium collection, and delivery of benefits. The proposed amendment clarifies contract language, adds additional responsibilities for the vendor, and allows county governments to participate in CoverTN after meeting certain requirements. The term of the contract remains the same, effective through December 31, 2009, with the option to extend in one-year increments for a total of five years.
Maximum liability: $50,000,000
Maximum liability w/amendment: $50,000,000

After review, the Fiscal Review Committee voted to recommend approval of the contract amendment.

cc: The Honorable Mike Morrow, Deputy Commissioner
Mr. Robert Barlow, Director, Office of Contracts Review

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MAY 30 2008
FISCAL REVIEW

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Brian Haile, Deputy Director, Benefits Administration BH

Date: May 29, 2008

RE: Amendments to CoverTN Plan A and B contracts

Please find attached Non-Competitive Amendment requests to add language to each of the existing contracts with BlueCross BlueShield of Tennessee (BCBST) for Plans A and B signed by Commissioner Goetz. The original procurement sought two vendors with different benefit plans and BCBST was awarded both contracts under their Plan A and Plan B proposal submissions. The modification to both of the CoverTN contracts through this identical amendment to both plans clarifies some contractual language, corrects a reference to a contract attachment and adds additional responsibilities that the Contractor is willing to accept. Additionally, the amendments facilitate the implementation of SB 4076/HB 4025, which the General Assembly passed on May 15, 2008. The amendments to both contracts are slated to take effect August 1, 2008.

The base contract with BCBST for Plan A and B are included for review as is a draft of the amendment to both documents to address the inclusion of additional responsibilities, the reference correction and clarifications to the original contract with BCBST for the CoverTN program.

Thank you for your consideration of this request to amend both contracts.

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	317.30-041-07
2) State Agency Name :	Department of Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Provides statewide administrative services for the CoverTN program under Plan A.
4) Contractor :	BlueCross BlueShield of Tennessee, Inc.
5) Contract #	FA-07-17170-00
6) Contract Start Date :	January 12, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2009
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$50,000,000.00
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	One
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	August 1, 2008
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2009
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$50,000,000.00
13) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service

14) Description of the Proposed Amendment Effects & Any Additional Service :

The amendment:

- Clarifies that the Contractor shall provide written notices to applicants regarding its eligibility determinations;
- Requires Contractor to provide more frequent updates to the Member Handbook if annual updates are insufficient;
- Expands methods of payments that members may use to remit premiums to the Contractor;
- Provides CoverTN members with access to the BlueCard PPO Program card program;
- Allows the carrier to increase broker fees in order to induce insurance brokers to more actively market the product; and

- Corrects ambiguities in definitions, policies and procedures and several scrivener's errors in the original contract.

Pursuant to SB 4076/HB 4025, which the General Assembly passed on May 15, 2008, the amendment also:

- Allows county governments to become "participating employers" in CoverTN if these county governments do not offer health insurance to their employees;
- Clarifies that any CoverTN member may have catastrophic coverage in addition to CoverTN as long as that coverage has a deductible of at least $15,000 annually; and
- Allows the state to waive the six-month "go-bare requirement" in certain situations (e.g., employer goes out of business, carrier no longer offers group products, carrier no longer covers the business, or individual's employment is terminated).

15) Explanation of Need for the Proposed Amendment :

This amendment clarifies some contractual language, corrects a reference to a contract attachment and adds additional responsibilities that the Contractor is willing to accept. Additionally, the amendment facilitates the implementation of SB 4076/HB 4025, which the General Assembly passed on May 15, 2008.

16) Name & Address of Contractor's Current Principal Owner(s) :
(not required if proposed contractor is a state education institution)

BlueCross BlueShield of Tennessee, Inc., 801 Pine Street-4G, Chattanooga, TN., 37402

17) Documentation of Office for Information Resources Endorsement :
(required only if the subject service involves information technology)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

18) Documentation of Department of Personnel Endorsement :
(required only if the subject service involves training for state employees)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

19) Documentation of State Architect Endorsement :
(required only if the subject service involves construction or real property related services)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

This contract is in the second year of the term and the State is satisfied with the performance of the Contractor. In addition, the provisions of SB 4076/HB 4025, which was enacted on May 15, 2008, become effective on July 1, 2008. Timely implementation of this new law requires an immediate change to the current contract, the program's policies, and its operating procedures. It is therefore in the best interest of the State to continue this business commitment. The agency did not attempt to identify competitive procurement alternatives.

21) Justification for the Proposed Non-Competitive Amendment :

The amendment language adds some responsibilities to the Contractor that will benefit the State and the recipients. The clarifications included in this document also provide access to the BlueCard Program which to date has not been included under the terms of the contract, and it implements recently-enacted legislation that modified the CoverTN program.

REQUESTING AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

Agency Head Signature	5/28/08 **Date**

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
317.30-041-07	FA-07-17170-01
State Agency	**State Agency Division**
Dept. of Finance and Administration	Benefits Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

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Service Description

To provide statewide administrative services for the CoverTN program under Plan A. **Amendment complies with new statute.**

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
January 12, 2007	December 31, 2009	Vendor	

Mark Each TRUE Statement

☒ Contractor is on STARS ☒ Contractor's Form W-9 is on file in Accounts

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.30	100	08	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$2,000,000				$2,000,000
2008	$13,000,000				$13,000,000
2009	$23,000,000				$23,000,000
2010	$12,000,000				$12,000,000
TOTAL:	$50,000,000				$50,000,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$2,000,000	
2008	$13,000,000	
2009	$23,000,000	
2010	$12,000,000	
TOTAL:	$50,000,000	
End Date:	December 31, 2009	December 31, 2009

State Agency Fiscal Contact & Telephone #

Maureen Abbey
20th Floor, Tennessee Tower
615-741-6070

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A. § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

RECEIVED AUG -6 2008 COMPTROLLER OF THE TREASURY OFFICE OF MANAGEMENT SERVICES

Contractor Ownership (complete for ALL base contracts — N/A to amendments or delegated authorities)

☐ African American ☐ Person w/ Disability ☐ Hispanic ☐ Small Business ☐ Government
☐ Asian ☐ Female ☐ Native American ☐ NOT Minority/Disadvantaged ☐ Other

Contractor Selection Method (complete for ALL base contracts — N/A to amendments or delegated authorities)

☐ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☐ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU) ☐ Other *

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)

OCR RECEIVED

OIR/PCM 7/24/

AMENDMENT ONE
TO FA-07-17170-00

This Contract Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject Contract is hereby amended as follows:

1. The following provisions are added to Contract Section A Definitions:

"Health Benefits Coverage" includes medical insurance in force currently or in force during the past six (6) months that would make a participating employer or enrollee ineligible pursuant to § 56-7-3005. Health benefits coverage shall include but not be limited to basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies; limited-benefit plans, mini-medical plans, and high deductible health plans with health savings accounts. Health benefits coverage shall not include catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of fifteen thousand dollars ($15,000). Additionally, health benefits coverage shall not include medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (Pub. L. No. 99-272, codified at 29 U.S.C. § 1161 *et seq.*) and which the individual declined, or to § 56-7-2312 *et seq.* and which the individual declined.

"Involuntary Loss of Coverage" means the loss of health benefits coverage arising from, but not limited to the following circumstances: (i) A separation from employment, voluntary or involuntary; (ii) A health insurance carrier's cancellation of group or individual health benefits coverage for reasons other than premium non-payment, fraud, or misrepresentation; (iii) A health insurance carrier's decision to no longer sell small group health benefits coverage; or (iv) The loss of eligibility for TennCare or CoverKids. Involuntary loss of coverage shall not include situations in which the primary insured dropped dependent spouse or dependent child(ren) from the health benefits coverage policy.

"Participating Local County Government" is defined as county government enumerated in § 5-1-101 and established under title 5 or as a metropolitan government under title 7 who has been determined by the State or its vendor to be eligible to participate in CoverTN and has enrolled in the CoverTN program. Participating local county governments include those who meet the eligibility criteria and guidelines established by the department for county governments to enroll in the program. The criteria shall include but not be limited to: (1) only county governments who have not offered health benefits coverage to their employees for at least the previous twelve (12) months shall be eligible to participate in the program, except that coverage under a group insurance plan offered by counties to eligible local education employees defined in 8-27-02(e)(2) will not preclude the county government's participation; (2) all of a participating county government's employees eligible for the program operated pursuant to this part shall be limited to citizens of the United States; except that individuals satisfying the federally defined exceptions contained in 8 U.S.C. § 1622(b) shall also be eligible to apply; (3) a minimum employee participation of fifty percent (50%) of county government employees eligible to participate in the program shall be required; (4) a participating local county government shall contribute a minimum of sixty-six percent (66%) toward the premiums of its eligible, participating employees on a uniform basis.

"Qualifying Event" is defined as marriage, death of spouse, divorce or annulment, involuntary loss of health insurance coverage, spouse becoming entitled to Medicare, or meeting the six- (6) month go-bare requirement in cases of a voluntary loss of coverage.

"Tennessean Between Jobs" means an individual who is a U.S. citizen or qualified alien adult (age 19 or older), who is domiciled in Tennessee and (i) who has been determined by the State through its online eligibility verification process to be currently unemployed and who has worked at least one (1) week for a minimum of twenty (20) hours during the preceding six (6) months; or (ii) who has been determined by the State through its online eligibility verification process to be currently employed, and who is not working more than twenty (20) hours per week (on average) but has worked at least one (1) week for a minimum of twenty (20) hours during the preceding six (6) months. For purposes of the non-eligibility components of this Contract, the Contractor shall treat Tennesseans Between Jobs as employees of non-participating employers unless the State and the Contractor agree to a different protocol.

"**$41,000 a year**" means the income level that the State updates each year with the release of the Census Bureau's federal poverty guidelines. This income level is approximately 200 percent of the federal poverty level for a household of four.

2. The text of Contract Section A Definitions, "Non-Participating Employer" is deleted in its entirety and replaced with the following:

   "Non-Participating Employer" is defined as an employer who is not eligible to participate in CoverTN, or who is eligible but chooses not to participate.

3. The text of Contract Section A Definitions, "Participating Employer" is deleted in its entirety and replaced with the following:

   "Participating Employer" is defined as an employer who has been determined by the State or its vendor to be eligible to participate in CoverTN and has enrolled in the CoverTN program. This may include churches, private schools, associations, and other non-profit organizations that meet the employer eligibility criteria established by the State. In phase 1, participating employer will include employers with fewer than twenty-five (25) full-time equivalent employees who meet the other criteria established by the State, which are: (a) being incorporated in Tennessee and operating in Tennessee as its principal place of business; (b) having half or more of its employees receiving wages less than $41,000; and (c) not having offered health insurance for at least the preceding six months for which the employer paid at least fifty (50) percent of the premium. In phase 2, participating employer will include employers with fewer than fifty (50) full-time equivalent employees. Pursuant to SB 4076/HB 4025 and beginning July 1, 2008, participating employer will also include participating local county governments.

4. The text of Contract Section A.2.9.2 is deleted in its entirety and replaced with the following:

   A.2.9.2. If the Contractor has a service limit for a particular service that is expressed other than in terms of units (e.g., an expenditure limit) or has a combination of service limits, and allowed charges are greater than the limit, the provider may bill the member the difference between the amount paid by the Contractor for the service and the amount allowed by the Contractor's CoverTN plan for the service.

5. The text of Contract Section A.4.3 is deleted in its entirety and replaced with the following:

   A.4.3 In order to determine eligibility for employees of participating employers (and their spouses, as applicable) or for self-employed individuals (and their spouses, as applicable), the Contractor shall:

   A.4.3.1 Verify that the employer is a participating employer of that the applicant is a qualified self-employed individual (as applicable) based on information provided by the State;

   A.4.3.2 Confirm that the application for the applicant (and spouse, if applicable) includes a residential street address in Tennessee; and

A.4.3.3 Screen the application and approve eligibility for the applicant unless the applicant self-attests on the application that he/she:

A.4.3.3.1 Is under age nineteen (19);
A.4.3.3.2 Is not a U.S. citizen or qualified alien;
A.4.3.3.3 Does not work more than twenty (20) hours per week (on average);
A.4.3.3.4 Has health benefits coverage; or
A.4.3.3.5 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

A.4.3.4 If the applicant is determined to be eligible, approve eligibility for the applicant's spouse (as applicable) unless the spouse self-attests on the application that he/she:

A.4.3.4.1 Is under age nineteen (19);
A.4.3.4.2 Is not a U.S. citizen or qualified alien;
A.4.3.4.3 Has health benefits coverage;
A.4.3.4.4 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

6. The text of Contract Section A.4.5.1 is deleted in its entirety and replaced with the following:

A.4.5.1 Confirm that the application for the applicant (and spouse, if applicable) includes a residential street address in Tennessee; and

7. The text of Contract Section A.4.5.2 is deleted in its entirety and replaced with the following:

A.4.5.2 Screen the application and approve eligibility for the applicant unless the applicant self-attests on the application that he/she:

A.4.5.2.1 Is under age nineteen (19);
A.4.5.2.2 Is not a U.S. citizen or qualified alien;
A.4.5.2.3 Does not work more than twenty (20) hours per week (on average);
A.4.5.2.4 Earns more than $41,000 a year;
A.4.5.2.5 Has health benefits coverage; or
A.4.5.2.6 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

8. The following provision is added as Contract Section A.4.5.3:

A.4.5.3 If the applicant is determined to be eligible, approve eligibility for the applicant's spouse (as applicable) unless the spouse self-attests on the application that he/she:

A.4.5.3.1 Is under age nineteen (19);
A.4.5.3.2 Is not a U.S. citizen or qualified alien;
A.4.5.3.3 Has health benefits coverage;
A.4.5.3.4 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

9. The text of Contract Section A.4.6 is deleted in its entirety and replaced with the following:

A.4.6 The Contractor shall determine eligibility for applicants for Tennesseans Between Jobs (and their spouses, as applicable). In order to determine eligibility for applicants for Tennesseans Between Jobs and their spouses, the Contractor shall:

A.4.6.1 Confirm that the application for the applicant (and spouse, if applicable) includes a residential street address in Tennessee; and

A.4.6.2 Screen the application and approve eligibility for the applicant unless the applicant self-attests on the application that he/she:

A.4.6.2.1 Is under age nineteen (19);
A.4.6.2.2 Is not a U.S. citizen or qualified alien;
A.4.6.2.3 Has not worked at least twenty (20) hours in any one week within the last six (6) months;
A.4.6.2.4 Earns more than $41,000 a year;
A.4.6.2.5 Has health benefits coverage; or
A.4.6.2.6 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

A.4.6.3 If the applicant is determined to be eligible, approve eligibility for the applicant's spouse (as applicable) unless the spouse self-attests on the application that he/she:

A.4.6.3.1 Is under age nineteen (19);
A.4.6.3.2 Is not a U.S. citizen or qualified alien;
A.4.6.3.3 Has health benefits coverage; or
A.4.6.3.4 Voluntarily stopped health benefits coverage within the last six (6) months (unless in TennCare, in armed forces, or employer did not pay at least fifty (50) percent).

10. The following provision is added as Contract Section A.4.7.1:

A.4.7.1 If an employee, Tennessean Between Jobs, or self-employed individual is ineligible for any of the reasons listed in Sections A.4.3, A.4.5, or A.4.6, then the spouse is not eligible unless he or she qualifies independent of his or her status as a spouse.

11. The following provision is added as Contract Section A.4.10.6:

A.4.10.6 New and current employees of participating employers (and their spouses) shall have thirty (30) calendar days from the date of a qualifying event to submit an application to a CoverTN plan.

12. The following provision is added as Contract Section A.4.10.7:

A.4.10.7 Applicants eligible as Tennesseans Between Jobs (and their eligible spouses) shall have ninety (90) calendar days from the date on which the State notifies the applicant that he or she is a qualified Tennessean Between Jobs to submit an application to the CoverTN plan.

13. The text of Contract Section A.4.11. is deleted in its entirety and replaced with the following:

A.4.11. An application from a potential member should include an identifier to the participating employer or self-employed individual so that the Contractor may draft the participating employer's bank account or the self-employed individual's bank account.

14. The text of Contract Section A.4.12. is deleted in its entirety and replaced with the following:

A.4.12. The Contractor shall determine eligibility for potential members and send a notice to each applicant notifying him/her of the disposition of his/her application within the timeframes specified in Contract Attachment B, Performance Guarantee #1 (Eligibility Determination).

15. The text of Contract Section A.5.1.1. is deleted in its entirety and replaced with the following:

A.5.1.1 The Contractor shall enroll eligible applicants and their eligible spouses into the Contractor's plan. A spouse may only enroll (a) when his/her spouse who is an eligible

employee or self-employed individual enrolls; (b) during open enrollment; (c) within thirty (30) calendar days from the date of a qualifying event. In order to enroll, the spouse shall complete and submit a change form to the Contractor. In all instances, the Contractor shall ask the prospective member spouse to self-attest that he or she is a U.S. citizen or qualified alien.

16. The text of Contract Section A.5.2.7. is deleted in its entirety and replaced with the following:

A.5.2.7. The Contractor shall bill the employer for the first month of enrollment. The Contractor shall require pre-payment of subsequent premiums. For example, payment for August coverage shall be required in July.

17. The text of Contract Section A.5.2.10. is deleted in its entirety and replaced with the following:

A.5.2.10. In phase 2, once an employee of a non-participating employer is enrolled, the Contractor shall notify the member (and the employer, if the employer will contribute or otherwise make payment on behalf of the member) of the applicable premium for each employee and spouse (if applicable), the amount due from the employer (if applicable) and member, and the due date. If the employer contributes to the employer's premium, conducts withholding on behalf of the employee, or otherwise makes payment on behalf of the member, the Contractor shall send a monthly statement to the employer that details the premium amounts due and notifies the employer that these amounts will be paid through bank draft. The Contractor shall draft the employer's banking account for applicable premium amounts on the due date.

18. The text of Contract Section A.5.2.11. is deleted in its entirety and replaced with the following:

A.5.2.11. If the member is responsible for payment of all or part of the premium due, the Contractor shall send a statement to the member at least quarterly that details the premium amounts due. The member may pay these amounts through bank draft, credit card, debit card or check. The Contractor shall draft the member's banking account for applicable premium amounts (employer and member share) or charge the designated credit or debit card on the due date.

19. The text of Contract Section A.5.3.4. is deleted in its entirety and replaced with the following:

A.5.3.4. The Contractor shall disenroll a member from its plan for non-payment of premiums (see Sections A.5.2.13 through A.5.2.15). If a member is disenrolled for non-payment of premiums, he/she is terminated from the CoverTN program and shall not be able to enroll in a CoverTN plan for a period of six (6) months from the date of disenrollment. However, if an employee was disenrolled as a result of non-payment by the employer, the employee may re-enroll if he/she applies as an employee of another qualifying employer or pays the entire non-state share. The Contractor shall not require these individuals to pay past due premiums that were not paid by the employer. If these individuals re-enroll within 63 calendar days of disenrollment, then the employee will receive credit for any of the pre-existing condition waiting period satisfied during the initial coverage period (see Section A.2.4).

20. The following provision is added as Contract Section A.6.10:

A.6.10. The State shall have access to Contractor's BlueCard PPO Program in accordance with Contract Attachment G, BlueCard PPO Program.

21. The text of Contract Section A.9.12. is deleted in its entirety and replaced with the following:

A.9.12. The State may assist the Contractor in identifying fraud and performing fraud investigations of members and providers for the purpose of recovery of overpayments

due to fraud. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall inform Benefits Administration who will notify the Office of the Inspector General.

22. The text of Contract Section A.11.9. is deleted in its entirety and replaced with the following:

A.11.9. The Contractor, following review and approval by the State, shall update, print, and distribute to members' homes a Member Handbook. The Member Handbook shall be specific to the CoverTN plan and shall describe and outline plan benefits, limitations and exclusions, co-payments, how to access services, and other information helpful to members. The Member Handbook shall be at least at a sixth grade reading level and shall be available in Spanish.

A.11.9.1 The number of member handbooks to be printed shall be in sufficient quantities for the members and shall be mailed to members' homes with the provider directory (see Section A.6.4). The Contractor shall send a member handbook and provider directory to new members as specified in Section A.5.1.3 and Contract Attachment B, Performance Guarantee #3 (Member Handbooks and Provider Network Directories Distributed). The Contractor shall also provide member handbooks and provider directories to members after open enrollment, as specified in Contract Attachment B, Performance Guarantee #3 (Member Handbooks and Provider Network Directories Distributed).

A.11.9.2 Failure to have the member handbook approved by the State before release shall result in an assessment of $1,000 per occurrence. The State shall notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State.

23. The text of Contract Section D.8. is deleted in its entirety and replaced with the following:

D.8. Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document included as Contract Attachment E, hereto, semi-annually during the period of this contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this contract, and semi-annually thereafter, during the period of this contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

e. For purposes of this contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the contract.

24. The text of Contract Section D.13. is deleted in its entirety and replaced with the following:

D.13. Independent Contractor. The parties hereto, in the performance of this contract, shall not act as employees, partners, joint ventures, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this contract.

The State acknowledges its understanding that this Contract constitutes a contract solely between the State and Contractor, which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting Contractor to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that Contractor is not contracting as the agent of the Association. The State further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Association nor any other Blue Cross Blue Shield licensee shall be considered to be a party to this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

25. The text of Contract Section E.2. is deleted in its entirety and replaced with the following:

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:

Marlene D. Alvarez, Manager of Procurement and Contracting

Tennessee Department of Finance and Administration
Benefits Administration
312 Rosa L. Parks Avenue
26th Floor, WRS Tennessee Tower
Nashville, Tennessee 37243-1102
Phone: 615-253-8358
Fax: 615-253-8556
marlene.alvarez@state.tn.us

The Contractor:

Ms. Amy Bercher, Senior Product Manager
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402
Phone: 423-535-5983
Fax: 423-535-7601
amy_bercher@bcbst.com

with a copy to:

Ms. Tena Roberson,
Director, Legal Services & Deputy General Counsel
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 8P
Chattanooga, TN 37402
Phone: 423-535-5158
Fax: 423-535-4576
tena_roberson@bcbst.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

26. The following is added as Contract Section E.12.:

E.12. Definitional Terms. All references to "sole proprietor" shall be deleted and replaced with "self-employed individual."

27. Contract Attachment D is deleted in its entirety and replaced with the new Contract Attachment D attached hereto.

28. Contract Attachment G attached hereto is added as a new Contract Attachment.

The revisions set forth herein shall be effective August 1, 2008. All other terms and conditions not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

8/4/08

CONTRACTOR SIGNATURE **DATE**

Dr. Steven Coulter, President, Gov't Business & Emerging Markets

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. 8-5-08

M. D. GOETZ, JR., COMMISSIONER DATE

APPROVED:

M.D. Goetz, Jr. IKW AUG 06 2008

M. D. GOETZ, JR., COMMISSIONER DATE
DEPARTMENT OF FINANCE AND ADMINISTRATION

John G. Morgan 8/7/08

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

Contract Attachment D
Premium Amounts for CY 2007

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 103.00	$ 113.00	$ 123.00	$ 133.00
30-39	$ 126.00	$ 139.00	$ 146.00	$ 159.00
40-49	$ 155.00	$ 170.00	$ 175.00	$ 190.00
50-59	$ 189.00	$ 208.00	$ 209.00	$ 228.00
60-64	$ 216.00	$ 238.00	$ 236.00	$ 258.00
65+	$ 253.00	$ 278.00	$ 273.00	$ 298.00

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 34.33	$ 37.67	$ 41.00	$ 44.33
30-39	$ 42.00	$ 46.33	$ 48.67	$ 53.00
40-49	$ 51.67	$ 56.67	$ 58.33	$ 63.33
50-59	$ 63.00	$ 69.33	$ 69.67	$ 76.00
60-64	$ 72.00	$ 79.33	$ 78.67	$ 86.00
65+	$ 84.33	$ 92.67	$ 91.00	$ 99.33

Contractor's administrative component of the premium amounts: $9.50 per member per month

Premium Amounts for CY 2008

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 112.58	$ 123.58	$ 134.58	$ 145.58
30-39	$ 137.88	$ 152.18	$ 159.88	$ 174.18
40-49	$ 169.78	$ 186.28	$ 191.78	$ 208.28
50-59	$ 207.18	$ 228.08	$ 229.18	$ 250.08
60-64	$ 236.88	$ 261.08	$ 258.88	$ 283.08
65+	$ 277.58	$ 305.08	$ 299.58	$ 327.08

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 37.53	$ 41.19	$ 44.86	$ 48.53
30-39	$ 45.96	$ 50.73	$ 53.29	$ 58.06
40-49	$ 56.59	$ 62.09	$ 63.93	$ 69.43
50-59	$ 69.06	$ 76.03	$ 76.39	$ 83.36
60-64	$ 78.96	$ 87.03	$ 86.29	$ 94.36
65+	$ 92.53	$ 101.69	$ 99.86	$ 109.03

Contractor's administrative component of the premium amounts: $9.73 per member per month

Contract Attachment G
BLUECARD PPO PROGRAM

Like all Licensees of the BlueCross BlueShield Association, the Contractor participates in a program called BlueCard. Whenever members access health care services outside Tennessee, the claim for those services may be processed through BlueCard and presented to Contractor for payment in conformity with network access rules of the BlueCard policies then in effect. Under BlueCard, when members receive Covered Services within the geographic area served by an on-site BlueCross and/or BlueShield Licensee ("Host Plan"), the Plan will remain responsible to the Group for fulfilling the Plan's contract obligations. However, the Host Plan will only be responsible, in accordance with applicable BlueCard policies, if any, for providing such services as contracting with its Participating Providers and handling all interactions with its Participating Providers. The financial terms of BlueCard are described below.

The calculation of the member's liability for Covered Services claims incurred outside the Plan's service area which are processed through the BlueCard PPO Program will typically be at the lower of the provider's Billed Charges or the negotiated price Contractor pays the Host Plan.

The methods employed by the Host Plan to determine a negotiated price will vary among Host Plans based on the terms of each Host Plan's provider contracts. The negotiated price paid to a Host Plan by Contractor on a claim for health care services processed through BlueCard may represent:

1. the actual price paid by the Host Plan on such a claim; or
2. an estimated price determined by the Host Plan in accordance with BlueCard policies, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or
3. an average price, determined by the Host Plan in accordance with BlueCard policies, based on a billed charges discount representing the Host Plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers. An average price may result in greater variation to the member and the Group from the actual price than would an estimated price.

Host Plans using either the estimated price or average price methods may, in accordance with BlueCard policies, prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount the member pays is considered a final price and will not be affected by such prospective adjustment.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if the member receives Covered Services in these states, the member's liability for Covered Services will be calculated using these states' statutory methods.

Under BlueCard, recoveries from a Host Plan or from Participating Providers of a Host Plan can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization-review refunds, and unsolicited refunds. In some cases, the Host Plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
317.30-041-07	FA-07- 17170-00
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the CoverTN program under Plan A.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
January 12, 2007	December 31, 2009	Vendor	

Mark, if Statement is TRUE

☒ Contractor is on STARS as required ☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.30	~~100~~ 200	08 4	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$2,000,000				$2,000,000
2008	$13,000,000				$13,000,000
2009	$23,000,000				$23,000,000
2010	$12,000,000				$12,000,000
TOTAL:	$50,000,000				$50,000,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007		
FY: 2008		
FY: 2009		
TOTAL:		
End Date:		

State Agency Fiscal Contact & Telephone #

Maureen Abbey
20th Floor, Tennessee Tower
615-741-6070

State Agency Budget Officer Approval

Maureen Abbey

Funding Certification (certification, required by T.C.A. § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged
☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method
☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

RECEIVED
2007 JAN 19 PM 2:00
COMPTROLLER'S OFFICE
OFFICE OF
MANAGEMENT SERVICES

CONTRACT
BETWEEN THE STATE OF TENNESSEE,

DEPARTMENT OF FINANCE AND ADMINISTRATION
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the administration and management of CoverTN, including marketing, eligibility determination, enrollment and disenrollment processing, premium collection, delivery of benefits, development and maintenance of a statewide provider network, medical management, claims adjudication, customer service, administrative services, and reporting; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a corporation.

The Contractor's address is:

BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402

The Contractor's place of incorporation or organization is Tennessee.

The Contractor's Federal Employee Tax Identification Number is 62-0427913.

A SCOPE OF SERVICES

The Contractor agrees to provide services for the State's CoverTN program for eligible individuals who elect to participate in the CoverTN plan offered by the Contractor, hereinafter referred to as "members," in accordance with this contract.

Definitions:

- **"Member"** is defined as an eligible individual or eligible spouse who is enrolled in the Contractor's CoverTN plan. Member may include, but is not limited to, an employee, owner, or officer of a participating employer; a qualified sole proprietor; a spouse of an employee, owner, or officer of a participating employer; and a spouse of a qualified sole proprietor. In phase 2 of CoverTN, which shall begin on a date to be determined by the State but no later than December 2008, member shall include an eligible individual who is working for an employer that is not a participating employer and the individual's spouse.
- **"Non-Participating Employer"** is defined as an employer who is not a participating employer.
- **"Participating Employer"** is defined as an employer who has been determined by the State or its vendor to be eligible to participate in CoverTN and has enrolled in the CoverTN program. This may include churches, private schools, associations, and other non-profit organizations that meet the employer eligibility criteria established by the State. In phase 1, participating employer will include employers with fewer than 25 full-time equivalent employees who meet the other criteria established by the State, which are: (a) being incorporated in Tennessee and operating in Tennessee as its principal place of business; (b) having half or more of its employees receiving wages less than $41,000; and (c) not having offered health insurance for at least the preceding six months for which the employer paid at least fifty percent (50%)of the premium. In phase 2, participating employer will include employers with fewer than 50 full-time equivalent employees.
- **"Qualified Sole Proprietor"** is defined as a sole proprietor who has been determined by the State or its vendor to be eligible to participate in CoverTN.

A.1 READINESS REVIEW

A.1.1 Prior to the start date of operations, as determined by the State, the Contractor shall demonstrate to the State's satisfaction that it is able to meet the requirements of the contract.

A.1.2 The Contractor shall cooperate in a "readiness review" conducted by the State to review the Contractor's readiness to begin operations. This review may include, but is not limited to, desk and onsite review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations, and interviews with the Contractor's staff. The scope of the review may include any and all requirements of this contract as determined by the State.

A.1.3 Based on the results of the review activities, the State will notify the Contractor, in writing, of its findings, including, if applicable, requests for corrective action.

A.1.4 If the Contractor is unable to demonstrate its ability to meet the requirements of the contract, as determined by the State, within the timeframes specified by the State, the State may terminate this contract and shall have no liability for payment to the Contractor.

A.2 BENEFITS AND CO-PAYMENTS

A.2.1 The Contractor shall provide the benefits developed through the RFP process and detailed in Attachment A.

A.2.1.1 At the State's request, and by mutual agreement, the Contractor shall reconfigure the benefit package as defined by the State. The benefit reconfiguration shall be equal to but not less than the actuarial value (relative value) of the medical services originally proposed and shall coincide with the open enrollment period.

A.2.1.2 The Contractor shall not modify the services or benefits provided to members during the term of this contract without the consent of the State. Any modification to services or benefits shall be implemented through a contract amendment (see Section D.2). If, in any calendar year after year one and when membership reaches 100,000 member months, the Contractor's average PMPM for claims incurred during the contract year and paid through the sixth month following the end of the contract year plus an estimate of incurred but not reported claims costs is $20 above or below the average premium amount PMPM, minus the administrative component, the Contractor shall cooperate with the State in restructuring the Contractor's benefits so that the benefit cost is within $20 of the average premium amount PMPM minus the administrative component.

A.2.2 Except as provided in Section A.2.3 below, the Contractor shall not categorically exclude coverage for any health or behavioral health condition.

A.2.3 <u>Maternity and Pregnancy-Related Services</u>

A.2.3.1 Through CoverKids (the State's Title XXI program), Tennessee will provide health insurance to eligible children under age 19, including unborn children from conception to birth.

A.2.3.2 Subject to the disenrollment provisions in Section A.5.3, CoverTN members who become pregnant will remain enrolled in CoverTN but will receive maternity benefits and pregnancy-related services through CoverKids (or TennCare, if the member is eligible for TennCare).

A.2.3.3 The Contractor shall not cover prenatal care, services that are related to the pregnancy or to conditions that could complicate pregnancy, or labor and delivery. Instead, the CoverKids (or TennCare) program will provide these maternity and pregnancy-related services for all pregnant women in CoverTN.

A.2.3.4 The Contractor shall provide pregnant members any services that are covered by the Contractor but are not covered through CoverKids (or TennCare), subject to the Contractor's service limitations.

A.2.3.5 Within the Contractor's service limitations, the Contractor shall cover one office visit to confirm pregnancy.

A.2.3.6 The Contractor shall provide covered services (as defined by the Contractor and subject to the Contractor's service limitations) to female members after delivery unless these services are provided through CoverKids or TennCare.

A.2.3.7 The Contractor's benefit package, including co-payments and service limitations, may not discriminate against members because of or on the basis of pregnancy, childbirth, or related medical conditions.

A.2.4 The Contractor may impose a pre-existing condition exclusion if:

A.2.4.1 Such exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, or treatment was recommended or received within the six-month period ending on the enrollment date;

A.2.4.2 Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information;

A.2.4.3 Such exclusion extends for a period of up to 12 months after the enrollment date;

A.2.4.4 The Contractor provides written general notice to members (e.g., in the member handbook) regarding the existence and terms of any pre-existing condition exclusion; and

A.2.4.5 The Contractor provides written individualized notice to members regarding the member's pre-existing condition exclusion.

A.2.5 The benefits covered by the Contractor's plan, including any service limitations, must be clearly described in the member handbook (see Section A.11.9). In addition, the member handbook must explain that the member will be responsible for paying for any service that is not covered by the plan or exceeds a service limit.

A.2.6 The Contractor shall not require any cost-sharing responsibilities for covered benefits except applicable premiums and the co-payments established through the RFP process and detailed in Attachment A. The Contractor shall not require deductibles, coinsurance, etc.

A.2.7 The Contractor shall not charge employers or members any fees or other costs except applicable premiums and co-payments. This includes, but is not limited to, administrative fees, late fees, surcharges, etc. However, if a bank charges the Contractor a fee as a result of a bank draft that is returned, the Contractor may pass that fee onto the employer or member, as applicable.

A.2.8 The Contractor shall ensure that providers do not charge members or third parties for health care services covered by the Contractor's plan in excess of the amount allowed by the plan, except for any applicable co-payments. Providers shall not be required to provide services to members who refuse or fail to meet their co-payment responsibilities.

A.2.9 Providers may bill members for covered services provided in excess of service limits only if one of the following exceptions applies:

A.2.9.1 If the Contractor has a service limit for a particular service that is only expressed in terms of units (e.g., 12 days, 14 visits), the provider may bill the member for any service provided beyond the service limit, up the Contractor's allowed amount for that service.

A.2.9.2 If the Contractor has a service limit for a particular service that is expressed other than in terms of units (e.g., an expenditure limit) or has a combination of service limits, and allowed charges are greater than the limit, the provider may bill the member the difference between the amount paid by the Contractor for the service and the amount allowed by the Contractor's CoverTN plan for the service only if: (a) prior to performing the service the provider gives the member an individualized notice that clearly states that the member will soon exceed his/her service limit, provides the estimated cost that will not be covered by the Contractor, and gives the member the option to continue or discontinue care; and (b) is signed and dated by the member prior to receiving the service but no more than one week prior to the date of service for which the provider is seeking payment. The Contractor shall develop a notice template, which shall be prior approved by the State, and shall provide copies of the notice template to providers.

A.3 MARKETING

A.3.1 The Contractor shall be responsible for marketing its CoverTN plan to potentially eligible employers and sole proprietors, participating employers, qualified sole proprietors, potentially eligible employees (including, in Phase 2, employees of non-participating employers), and employees of participating employers. Subject to the requirements below, such marketing may include, but is not limited to, television ads, radio ads, banner/banner-like ads, print ads, internet advertising, direct mail, presentations, and sales calls.

A.3.2 The Contractor may use insurance agents or brokers ("brokers") to help market its plan to employers and potential members. The Contractor shall ensure that any insurance agents comply with applicable contract requirements regarding marketing. The State reserves the right to review and approve (a) broker fee arrangements including any incentives; (b) broker training materials; (c) and any promotional materials regarding the CoverTN program that brokers may develop or distribute.

A.3.3 The Contractor may conduct direct marketing, including direct mailing to potentially eligible employees at work. However, the Contractor may not otherwise directly contact potentially eligible employees (e.g., phone calls, faxes, emails, sales calls) at work unless authorized by the employer.

A.3.4 The Contractor may conduct outbound telemarketing. As provided in Section A.3.3 above, the Contractor may only conduct outbound telemarketing to employees at work if authorized by the person's employer. If the Contractor conducts outbound telemarketing, it shall have a systematic method for recording and tracking "do not call again" requests and shall honor such requests.

A.3.5 The Contractor may conduct promotional activities (e.g., gift for attending a marketing presentation) directed at eligible employees and sole proprietors. However, unless otherwise approved by the State, any activities or items offered by the Contractor shall be of nominal value, offered to all eligible employees, and not be in the form of cash or monetary rebates. The Contractor shall not offer or provide incentives to employers other than incentives for pre-payment of premiums.

A.3.6 The Contractor shall not distribute any marketing materials that are materially inaccurate, misleading, or confusing.

A.3.7 All marketing materials, including any promotional activities (see Section A.3.5), shall be prior approved by the State. (See Section A.14.2.)

A.3.8 The Contractor shall provide marketing materials upon request from any participating employer.

A.3.9 The Contractor shall notify the State in advance of any direct to consumer marketing of any product or service, other than its CoverTN plan, to members, employees of participating employers, or qualified sole proprietors. The State reserves the right to approve or disapprove the direct to consumer marketing of any product or service to CoverTN members, employees of participating employers, or qualified sole proprietors.

A.4 ELIGIBILITY DETERMINATION

A.4.1 The Contractor shall determine eligibility for employees of participating employers (and their spouses, as applicable), for qualified sole proprietors (and their spouses, as applicable), and, in Phase 2 of CoverTN, for employees of employers that are not participating employers (and their spouses, as applicable), in accordance with the State's requirements.

A.4.2 The Contractor shall receive, process, and load participating employer and qualified sole proprietor eligibility and enrollment files from the State or its vendor within 24 hours of transmission from the State or its vendor. The Contractor shall have the capability to utilize the information provided in the files to determine member eligibility.

A.4.3 In order to determine eligibility for employees of participating employers or for sole proprietors, the Contractor shall:

A.4.3.1 Verify that the employer is a participating employer or that the applicant is a qualified sole proprietor (as applicable) based on information from the State or its vendor;

A.4.3.2 Confirm that the employee's application includes a residential street address in Tennessee; and

A.4.3.3 Screen the individual's application (see Appendix 7.1 [of RFP #317.30-014] for a draft application) and approve eligibility for the individual and his/her spouse (as applicable) unless the applicant self-attests on the application that he/she:

A.4.3.3.1 Is under age 19;
A.4.3.3.2 Is not a U.S. citizen or qualified alien;
A.4.3.3.3 Does not work more than 20 hours a week (on average);
A.4.3.3.4 Has health insurance; or
A.4.3.3.5 Voluntarily stopped health benefits coverage within the last six months (unless in TennCare, in armed forces, or employer did not pay at least 50%).

A.4.4 If a State that borders Tennessee permits Tennessee to offer CoverTN plans to its residents who work for a participating employer, then residents of that state who meet other eligibility factors may enroll in the Contractor's plan, but Tennessee will not pay the State share. Therefore, if an application from an employee of a participating employer does not include a residential street address in Tennessee, but the employee is a resident of a border state that permits Tennessee to offer CoverTN to its residents, the Contractor shall determine the employee and his/her spouse eligible for enrollment in its plan if the other eligibility factors are met. However, the State will not make a premium payment for the member. The amount of the premium that would be paid by the State if the member were a resident of Tennessee must be paid by the employer and/or the member. In these situations, the Contractor shall notify the member and the participating employer that the employee (and his/her spouse) is not eligible for premium payment from the State and that the entire premium must be paid by the employer and/or the member.

A.4.5 In Phase 2, the Contractor shall determine eligibility for employees of employers who are not participating employers (and their spouses, as applicable). In order to determine eligibility for these individuals, the Contractor shall:

A.4.5.1 Confirm that the employee's application includes a residential street address in Tennessee and employer information; and

A.4.5.2 Screen the employee's application and approve eligibility for the employee and/or spouse unless the applicant self-attests on the application that he/she:

A.4.5.2.1 Is under age 19;
A.4.5.2.2 Is not a U.S. citizen or qualified alien;
A.4.5.2.3 Does not work more than 20 hours a week (on average);
A.4.5.2.4 Earns more than $41,000 a year;
A.4.5.2.5 Has health insurance; or
A.4.5.2.6 Voluntarily stopped health benefits coverage within the last six months (unless in TennCare, in armed forces, or employer did not pay at least 50%).

A.4.6 If an employee or sole proprietor is ineligible for any of the reasons listed in Section A.4.3 or Section A.4.5 above, then the spouse is not eligible.

A.4.7 The Contractor shall not request any verification documents for the self-attested eligibility elements listed in Section A.4.3.3 or Section A.4.5.2. If the Contractor has good cause to doubt the veracity of any of the attestations, then the Contractor shall refer the application to the State. While awaiting the State's response, the Contractor shall presume the truthfulness of the applicant's representations and approve or deny eligibility accordingly.

A.4.8 The Contractor shall cooperate with the State and any other contractor providing CoverTN services to finalize the application form included in RFP Appendix 7.1 [of RFP #317.30-041]. The application form shall include information necessary for both eligibility determination and enrollment into a CoverTN plan.

A.4.9 The Contractor may pre-complete certain sections of the application form and mail/fax/email it to the applicant to complete and sign. The Contractor may accept faxed or electronic signatures. The Contractor may also allow members to create personal identification numbers (PINs), and members may use these PINs as an acceptable form of electronic signature for application purposes to satisfy TCA 56-7-3023.

A.4.10 Individuals may apply for CoverTN within the following timeframes:

A.4.10.1 Current employees of participating employers (and their spouses) shall have 90 calendar days from when the participating employer receives confirmation from the State/its vendor that the employer is a participating employer (or 90 days after CoverTN begins operations, whichever is later) to submit an application to a CoverTN plan.

A.4.10.2 New employees of participating employers (and their spouses) shall have 30 calendar days from the employee's start date of employment to submit an application to a CoverTN plan.

A.4.10.3 Employees of participating employers may also apply for CoverTN during open enrollment (see Section A.5.3.1) or if the employee involuntarily loses other health insurance coverage (e.g., the employee involuntarily loses coverage under his/her spouse's plan).

A.4.10.4 Sole proprietors (and their spouses) shall have 90 calendar days from when the sole proprietor receives confirmation from the State/its vendor that it is a qualified sole proprietor (or 90 days after CoverTN begins operations, whichever is later) to submit an application to a CoverTN plan.

A.4.10.5 Employees of non-participating employers (during Phase 2) may enroll at any time. There is no time limit for applying.

A.4.11 As provided in Section A.5.2.7, the Contractor shall require pre-payment of the non-state premium obligation for the first month of enrollment prior to enrollment. An application from a potential member should include a bank draft (electronic funds transfer) authorization form so that the Contractor may draft the participating employer's bank account, the sole proprietor's account, or, in Phase 2, for members who are employees of a non-participating employer (or the spouse of such an employee), the member's and/or employer's account as applicable for the purpose of paying premiums on behalf of the member, including pre-payment of the premium for the first month.

A.4.12 The Contractor shall determine eligibility for potential members within the timeframes specified in Contract Attachment B, Performance Guarantee #1 (Eligibility Determination).

A.4.13 If the Contractor uses an automated eligibility algorithm, decision rules, or integrity checks to determine eligibility, then the Contractor shall also allow for manual overrides (e.g., by first-line supervisors) to the system.

A.4.14 As part of the eligibility determination process, using the information provided in the member's application, the Contractor shall determine the appropriate premium amount for each member (see Section C.4).

A.4.15 Within the timeframes specified in Contract Attachment B, Performance Guarantee #1 (Eligibility Determination), the Contractor shall send a notice to each applicant notifying him/her of the disposition of his/her application.

A.4.15.1 If the applicant is determined eligible, the notice shall state that the person is eligible, the effective date of coverage, the applicable premium amount, if the State will not make a premium payment (see Section A.4.4), the Contractor's toll-free telephone number (see Section A.11.3), and that additional materials, e.g., member handbook and ID card (see Section A.5.1.3) will be sent under separate cover.

A.4.15.2 If the applicant is determined ineligible, the notice shall state that the applicant is ineligible, the reason that the applicant is ineligible, that the applicant may appeal the decision, information about the appeals process, and the Contractor's toll-free telephone number (see Section A.11.3).

A.4.16 The Contractor shall have an appeals process for applicants to appeal a determination by the Contractor that the individual and/or his/her spouse is not eligible. At contract implementation, the Contractor shall provide to the State two written copies describing in detail the Contractor's eligibility appeal procedures. The Contractor shall maintain files on all appeals and provide a semi-annual report summarizing the

number of appeals, the number and types of resolution, and the average timeframes for resolving appeals.

A.4.17 The Contractor shall maintain an electronic eligibility and enrollment file (see Section A.12.1) and shall provide a copy to the State upon request and as specified in Section A.12.5. This file shall include every application form that is submitted to the Contractor and includes a name, address, and signature. Thus, the Contractor shall enter all applications, including "incomplete" application forms, and their disposition.

A.4.18 Once determined eligible, an employer or a member shall continue to be eligible throughout the term of the contract. Therefore, except as provided in Section A.4.19 and A.5.1.6, the Contractor shall not redetermine eligibility of members on a regular basis.

A.4.19 Notwithstanding Section A.4.18, if a member continues enrollment in the Contractor's plan pursuant to Section A.5.1.6, the Contractor shall confirm that the member (and spouse as applicable) is a resident of Tennessee and does not have Medicare or other health insurance coverage. Also, regardless of this continuation of eligibility, a member's premium amounts will change as provided in Section C.4.

A.5 ENROLLMENT AND DISENROLLMENT

A.5.1 Enrollment

A.5.1.1 The Contractor shall enroll eligible applicants and their eligible spouses into the Contractor's plan. A spouse may only enroll (a) when his/her spouse who is an eligible employee or sole proprietor enrolls; (b) during open enrollment; (c) upon the spouse's loss of eligibility for other health insurance coverage; and (d) upon marriage. In order to enroll, the spouse shall complete and submit a change form to the Contractor. In all instances, the Contractor shall ask the prospective member spouse to self-attest that he or she is a U.S. citizen or qualified alien.

A.5.1.2 A member's coverage/enrollment shall be effective on the first day of the calendar month following the month in which a determination of eligibility is made. However, if eligibility is determined after a date specified by the Contractor and approved by the State, which shall be no earlier than the 15th of the month, then enrollment shall be effective the first day of the second calendar month following the month in which a determination of eligibility is made. For example, if the Contractor determines on May 14th that a person is eligible, that person's coverage/enrollment effective date shall be June 1. If the Contractor determines on May 16th that a person is eligible, then enrollment shall be effective on July 1st. A member's effective date of coverage/enrollment start date shall be included in the notice of eligibility (see Section A.4.15.1).

A.5.1.3 The Contractor shall provide each new member a member identification card (see Section A.9.6), a member handbook (see Section A.11.9), and a provider directory (see Section A.6.4). The Contractor shall send the member identification card within the timeframes specified in Contact Attachment B, Performance Guarantee #2 (Member ID Card Distribution). The member handbook and provider directories should also be sent within 14 calendar days after eligibility determination but shall be sent within the timeframes specified in Contract Attachment B, Performance Guarantee #3 (Member Handbooks and Provider Network Directories Distributed).

A.5.1.4 The Contractor shall provide each new member with a "personal health covenant" to be completed by the member and signed by the member and his/her physician. The form for the personal health covenant shall be designed by the Contractor and prior approved by the State. It shall identify activities that the member will undertake to improve his/her health, e.g., take his/her medications, keep his/her appointments, and avoid unnecessary emergency room visits, and shall be signed by the member and his/her physician. The personal health covenant should be sent at the time of PCP selection/assignment (if applicable) or within 20 calendar days of the date of eligibility determination.

A.5.1.5 A member's enrollment shall continue until he/she is disenrolled or terminated as provided in Section A.5.3.

A.5.1.6 Subject to the conditions in A.5.1.6.1 and A.5.1.6.2, the Contractor shall allow a member (including a spouse) to continue enrollment if the employer stops paying the employer's share or the employee

stops work or reduces his/her hours. Additionally, the Contractor shall allow a member who is a spouse to continue enrollment if he/she legally separates from or divorces the enrolled employee/sole proprietor, the enrolled employee/sole proprietor becomes incapacitated or disabled or dies, or the enrolled employee/sole proprietor qualifies for Medicare or other health insurance.

A.5.1.6.1 The Contractor shall only be contractually obliged to continue enrollment in CoverTN if the continuing member (including a spouse):

A.5.1.6.1.1 Is a resident of Tennessee;

A.5.1.6.1.2 The continuing member does not have Medicare or other health insurance coverage; and

A.5.1.6.1.3 The non-state share of the continuing member's premium is paid as required in Section A.5.2.

A.5.1.6.2 Confirmation of residency and health insurance status in Section A.5.1.6.1.1 and Section A.5.1.6.1.2 shall be based on the member's self-attestation, provided that the member signs a form under penalty of perjury. The Contractor shall develop policies and procedures, to be prior approved by the State, to ensure that members can continue coverage as provided in this Section A.5.1.6.

A.5.2 **Premium Collection**

A.5.2.1 The Contractor shall be responsible for the collection of premium payments from the State, participating employers (if applicable), non-participating employers (in Phase 2, if they elect to contribute or make payment on behalf of an employee), and members. Participating employers will be required to withhold their employees' share through a payroll deduction and make payment on behalf of their employees.

A.5.2.2 Premium amounts will be determined pursuant to Section C.4. During open enrollment the Contractor shall notify members and employers who are making premium payments (including non-participating employers in Phase 2) of the premium amounts effective January 1st of the following calendar year.

A.5.2.3 Premium obligations shall be established in accordance with the following:

A.5.2.3.1 For employees of participating employers who are residents of Tennessee:

A.5.2.3.1.1 The State pays one-third of the total premium;

A.5.2.3.1.2 The employer pays at least one-third of the total premium; and

A.5.2.3.1.3 The employee (through a payroll deduction) pays the remaining portion of the premium.

A.5.2.3.2 For spouses of employees of participating employers who are residents of Tennessee:

A.5.2.3.2.1 The State pays one-third of the total premium;

A.5.2.3.2.2 The employer may pay a portion of the spouse's premium; and

A.5.2.3.2.3 The employee (through a payroll deduction) pays the remaining portion of the premium.

A.5.2.3.3 For employees of participating employers who are not residents of Tennessee (and their spouses) (see Section A.4.4), the State will not pay one-third of the total premium. The employer and/or the member shall be responsible for payment of the total premium.

A.5.2.3.4 For qualified sole proprietors and their spouses:

A.5.2.3.4.1 The State pays one-third of the total premium; and

A.5.2.3.4.2 The sole proprietor pays the remaining portion of the premium.

A.5.2.3.5 For former employees of participating employers and their spouses:

A.5.2.3.5.1 The State pays one-third of the total premium; and

A.5.2.3.5.2 The former employee pays the remaining portion of the premium.

A.5.2.3.6 For employees of non-participating employers and their spouses (in Phase 2):

A.5.2.3.6.1 The State pays one-third of the total premium;

A.5.2.3.6.2 The employer may pay a portion of the premium; and

A.5.2.3.6.3 The member (either directly or through a payroll deduction) pays the remaining portion of the premium.

A.5.2.4 Based on available appropriations, the State may limit the number of members for whom the State will provide a premium contribution (see TCA 56-7-3013(c)). In such case, the member would be responsible for the State share.

A.5.2.5 The Contractor shall inform employers (including in Phase 2 any non-participating employers who make premium payments for members) and members in writing about the potential opportunity to withhold premiums from pre-tax earnings.

A.5.2.6 Except as otherwise provided in the contract (see, e.g., Section A.5.2.12), the Contractor shall require that all premium payments be made electronically through bank drafts (electronic funds transfer).

A.5.2.7 The Contractor shall require pre-payment of the average non-state premium obligation for the first month of enrollment ($100). The Contractor shall only collect pre-payment of the first month's premium for individuals found eligible for CoverTN. The Contractor shall adjust subsequent payments as necessary to reflect the member's actual premium amount. The Contractor shall require pre-payment of subsequent premiums. For example, payment for August coverage shall be required in July.

A.5.2.8 Once an employee of a participating employer is enrolled, the Contractor shall notify the employer of the applicable premium for each employee and spouse (if applicable), the amount due from the employer and employee, and the due date. The Contractor shall send a monthly statement to the participating employer that details the premium amounts due and notifies the employer that these amounts will be paid through bank draft. The Contractor shall draft the participating employer's banking account for applicable premium amounts (employer and employee share) on the due date.

A.5.2.9 Once a sole proprietor is enrolled as a member, the Contractor shall notify the sole proprietor of the premium amount for the sole proprietor (and his/her spouse, if applicable) and specify the amount due from the sole proprietor and the due date. The Contractor shall send a statement to the sole proprietor at least quarterly that details the premium amounts due and notifies the sole proprietor that these amounts are being paid through bank draft. The Contractor shall draft the sole proprietor's banking account for applicable premium amounts (employer and employee share) on the due date.

A.5.2.10 In phase 2, once an employee of a non-participating employer is enrolled, the Contractor shall notify the member (and the employer, if the employer will contribute or otherwise make payment on behalf of the member) of the applicable premium for each employee and spouse (if applicable), the amount due from the employer (if applicable) and member, and the due date. If the employer contributes to the employer's premium, conducts withholding on behalf of the employee, or otherwise makes payment on behalf of the member, the Contractor shall send a monthly statement to the employer that details the premium amounts due and notifies the employer that these amounts will be paid through bank draft. The Contractor shall draft the employer's banking account for applicable premium amounts on the due date. If the member is responsible for payment of all or part of the premium due, the Contractor shall send a statement to the member at least quarterly that details the premium amounts due and notifies the member that these amounts are being paid through bank draft. The Contractor shall draft the member's banking account for applicable premium amounts (employer and employee share) on the due date.

A.5.2.11 If the member is responsible for payment of all or part of the premium due, the Contractor shall send a statement to the member at least quarterly that details the premium amounts due and notifies the member that these amounts are being paid through bank draft. The Contractor shall draft the member's banking account for applicable premium amounts (employer and member share) on the due date.

A.5.2.12 The Contractor shall establish a process, prior approved by the State, to ensure that members who are no longer employed by a participating employer or a non-participating employer that makes payment on behalf of the member, as well as their spouses, may continue enrollment in the Contractor's plan if the member pays both the employer and employee share and meets the conditions in Section A.5.1.6.

A.5.2.13 <u>Non-Payment by Participating Employers or Non-Participating Employers who Make Payment on Behalf of their Employees.</u> If an employer does not pay the premium due (e.g., employer and employee share) by the due date specified by the Contractor, the Contractor shall immediately issue a notice of failure to pay to the employer and the employee giving each of them until the end of the

month for which payment is due to bring payment current. The notice to the employer shall notify the employer that a notice was also sent to the member. The notice to the member shall inform the member that the employer did not pay the premium on time, that in order to retain coverage the member may elect to submit the payment due (employer and member share) by the end of the month, and explain the options for making payment (which shall include credit card and debit card). For example, if the Contractor requires payment of August premiums July 15th, the Contractor shall send a notice to the employer and the employee requiring payment of the August premium by the end of July.

A.5.2.13.1 If payment is not current by the end of the month (i.e., by July 31st), the Contractor shall notify the employer and employee that if payment is not made by the end of the next month (i.e., by August 31st), the member shall be disenrolled from the Contractor's plan effective midnight on August 31st and terminated from the CoverTN program (see Section A.5.3). The notice to the employer shall say that payment must include the premium (employer and member share) for two months. The notice to the member shall give the member the option of making payment (employer and member share) for only one month (see Section A.5.2.13). The notice to the member shall also explain the methods the member may use to make payment, which shall include credit card and debit card.

A.5.2.13.2 If premium payment (both the employer and member share) is made by the end of that second month (i.e., by August 31st), coverage shall continue. Using the example above, if the employer pays the August premium and September premium (employer and member share) by the end of August, then coverage continues through September.

A.5.2.13.3 If the employer pays one month's premium (employer and member share) by the end of the second month, then the member is terminated effective the end of the second month (August 31st in the example above).

A.5.2.13.4 If the member pays one month's premium (employer and member share) by the end of the second month (August 31st in the example above), then the member's coverage continues through the following month (September 30th in the example above) (see Section A.5.2.15).

A.5.2.13.5 If no payment is received by the end of the second month (August 31st in the example above), the member is terminated effective the end of the second month (August 31st in the example above).

A.5.2.13.6 The Contractor shall permit employers to make payments by the end of the coverage month two times in a rolling 12 month period before disenrolling employees of the participating employer. On the third late payment, the Contractor shall disenroll the employees effective the end of the applicable month. If this occurs for a participating employer, the Contractor shall: (a) notify the other contractor providing statewide health plan administrative service for CoverTN; and (b) ensure that the employer does not participate in its plan for a period of six months from the date of disenrollment.

A.5.2.14 As provided in Section A.5.2.13 above, if a member is subject to termination because of his/her employer's non-payment, the member shall have the option to pay the member and employer's share for one month by the end of the month for which payment is due and retain prospective coverage. In all cases of employer non-payment (as specified in Section A.5.2.13), the Contractor shall concurrently send a notice to the employee to inform him/her of the employer's non-payment and the member's option to pay the employer's share, including the methods (which shall include credit card and debit card), and the timeframe. If both the employer and member tender payment, the Contractor shall promptly refund the member's duplicate payment.

A.5.2.15 Non-Payment by Members. If a member is responsible for payment of his/her premium (e.g., sole proprietor, member who no longer works for a participating employer, or, in Phase 2, an employee of a non-participating employer or spouse of such an employee), and the member's premium is not paid by the due date, the Contractor shall continue coverage for two months. If one month's premium payment is not made before the end of the second month, the Contractor shall terminate the member effective the end of that second month. However, if one month's premium payment is received before the end of the second month, coverage shall continue. Nonetheless, the Contractor may require the member to set up and follow a payment plan to bring payments current.

A.5.2.15.1 If a member's premium is not paid by the due date, the Contractor shall immediately issue a notice of failure to pay to the member giving the member until the end of the month for which payment is due to bring payment current. For example, if the Contractor requires payment of August premiums July 15th, the Contractor shall send a notice requiring payment of the August premium by the end of July.

A.5.2.15.2 If payment is not current by the end of the month, the Contractor shall notify the member that if payment is not made by the end of the next month, the member shall be disenrolled from the Contractor's plan and terminated from the CoverTN program (see Section A.5.3). If premium payment is made by the end of that second month, regardless of whether payment is made current, coverage shall continue. Using the example above, if the August premium is paid by the end of August, then coverage continues through September. If no payment is received by the end of August, the member is terminated effective August 31st.

A.5.2.15.3 The Contractor shall not require members to make payments for coverage during the time period when payment was not made (e.g., in the example above, if the August premium is paid by the end of August, the member may pay the September premium in September, the October premium in October, etc.). The Contractor shall not refer these payments for collection.

A.5.2.16 The Contractor shall develop policies and procedures, to be prior approved by the State, to address the issue of non-payment of an employee's share of the premium when the employee's pay is insufficient to withhold the employer's share of the premium (e.g., employee is on leave without pay). This could include, for example, authorizing a bank draft on the member's bank account or payment by credit or debit card.

A.5.2.17 The Contractor shall accept premium payments from individuals or organizations that are made electronically on behalf of members (with the consent of the member).

A.5.2.18 The Contractor shall not refer debts of less than $500 for collection or seek judgment on debts of less than $500.

A.5.3 Disenrollment and Termination

A.5.3.1 Members may only change plans or contractors during the open enrollment period, which shall be in October, unless otherwise specified by the State.

A.5.3.2 Members may provide notice of disenrollment from the Contractor's plan at any time. However, if a member voluntarily disenrolls from the Contractor's plan, he/she is terminated from the CoverTN program and shall not be eligible to enroll in a CoverTN plan for six months. The Contractor shall only accept disenrollment requests (excluding termination due to death) from members in writing.

A.5.3.3 The Contractor shall disenroll a member from its plan, and terminate the member from the CoverTN program, if the member moves out of state but does not work for a participating employer, is a non-resident but no longer works for a participating employer, or dies. If the Contractor becomes aware that a member has moved out of state or died, the Contractor shall issue a disenrollment notice and disenroll the member unless the Contractor receives an attestation from the member refuting the basis for disenrollment.

A.5.3.4 The Contractor shall disenroll a member from its plan for non-payment of premiums (see Sections A.5.2.13 through A.5.2.15). If a member is disenrolled for non-payment of premiums, he/she is terminated from the CoverTN program and shall not be able to enroll in a CoverTN plan until the anniversary of his/her initial enrollment or six months, if the anniversary date is less than six months from the date of disenrollment. However, if an employee was disenrolled as a result of non-payment by the employer, the employee may re-enroll if he/she applies as an employee of another qualifying employer or pays the entire non-state share. The Contractor shall not require these individuals to pay past due premiums that were not paid by the employer. If these individuals re-enroll within 63 calendar days of disenrollment, then the pre-existing condition exclusion (see Section A.2.4) shall not apply.

A.5.3.5 The Contractor shall notify the other contractor providing statewide health plan administrative service for CoverTN regarding members who have been disenrolled for non-payment of premiums, and the Contractor shall ensure that, except as provided in Section A.5.3.4, members disenrolled for non-payment of premium do not enroll in the Contractor's plan for the period specified in Section A.5.3.4.

A.5.3.6 The Contractor may disenroll a member for fraud, misrepresentation, or noncompliance with plan provisions.

A.5.3.7 Except in cases of disenrollment due to death, before disenrolling a member from its plan, the Contractor shall provide the member with 30 calendar days prior notice.

A.5.3.8 Disenrollment of members from the Contractor's plan shall be effective on the last day of the calendar month after the month of notice but no later than the first day of the second month after the month of notice.

A.5.3.9 The Contractor shall track and report all member disenrollments to the State.

A.6 PROVIDER NETWORK

A.6.1 The Contractor shall maintain and administer a provider network covering the entire State of Tennessee service area, for members, in accordance with this contract. The Contractor further agrees to maintain under contract, participation by health care providers including but not limited to, primary care physicians, specialist physicians, hospitals, pharmacies, and all other health care facilities, services, and providers necessary to provide high quality, cost effective services, adequate distribution, and reasonable access from a geographic and service standpoint throughout the service area(s).

A.6.1.1 As required by Contract Attachment B, Performance Guarantee #4 (Provider/Facility Network Accessibility), the Contractor shall ensure network access. When requested by the State, the Contractor shall, within ten business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by network reports or otherwise identified by the State.

A.6.2 The Contractor shall report to the State within five business days of the end of each contract quarter any changes in the designation of network hospitals, physicians, and other health care providers, but no less than 30 calendar days prior to the removal of a hospital, clinic, or ambulatory surgery center from the network. See also Section A.13.2.

A.6.3 The Contractor shall not take action to disenroll network primary care providers or hospital providers except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/re-credentialing process; non-compliance with contract requirements; provider request for disenrollment; member complaints; suspicion of provider impairment; loss of license; or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act.

A.6.4 The Contractor shall annually update, print, and distribute provider directories to members' homes. The provider directory shall include provider name, specialty, address, and phone number, and be organized by county. Distribution shall be made to every member at his/her home address. Upon mutual agreement of the State and the Contractor, electronic means may be utilized to inform members of the network of providers.

A.6.5 The Contractor shall maintain the capability to respond to inquiries from members concerning participation by providers in the network, by specialty and by county. Such capabilities shall be by toll-free telephone and an up-to-date internet-based directory of providers that includes provider search capability. This directory shall accurately reflect network providers who have joined the network in the past 15 calendar days.

A.6.6 The Contractor shall contract only with providers who are duly licensed to provide such medical services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The Contractor shall perform, on a continuous basis, appropriate provider credentialing as

described in the Contractor's Proposal that assures the quality of network providers. Re-credentialing of network providers shall be performed at least every three years.

A.6.7 The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management and other services as required for participation in the provider network.

A.6.8 As provided in TCA 56-7-3010(a)(ii), the Contractor shall ensure that network providers do not refuse to provide services to a member on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, gender, sexual orientation, disability, or marital status. This requirement shall not be construed to require a provider to furnish medical services that are not within the scope of the provider's license.

A.6.9 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of members.

A.7 MEDICAL MANAGEMENT SERVICES

A.7.1 The Contractor shall provide a medical management system designed to help members secure the most appropriate level of care consistent with their health status within the benefit package specified in Section A.2. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness of hospital inpatient care and other levels of care as necessary. The Contractor shall have in place an effective process that identifies and manages those members in need of inpatient care. The following services shall be provided:

A.7.1.1 Identification of patients in need of inpatient care for the purpose of reviewing the level of care requested and determining extent of care required and available through the Contractor's plan; and the identification of appropriate additional or alternative services as needed. Process shall include admission review, or the pre-certification/ authorization of inpatient stay.

A.7.1.2 Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and patients' physicians. Process will review the continued hospitalization of patients and identify medical necessity for stays, as well as available alternatives.

A.7.1.3 Discharge planning, providing a process by which medical management staff work with the hospital, patients' physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient. Prevention of readmission is also a goal of the discharge planning process.

A.7.1.4 Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

A.7.2 The Contractor shall submit to the State, at contract implementation, two written copies describing its medical management procedures and evaluation methodology. Additionally, the Contractor shall notify the State, in writing, within 30 calendar days of any significant changes to these procedures during the course of the contract.

A.7.3 The Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of services relative to benefit limits and the demonstrated effectiveness of its medical management activities.

A.7.4 The aforementioned services should be included as required and appropriate for hospital admissions. Prospective review procedures may also include criteria for pre-admission testing and for same-day surgery procedures. If inpatient hospital pre-admission certification is utilized, authorization or denial shall occur within one business day for urgent requests upon receipt by the Contractor of all necessary information regarding the admission. Any appeals of requests for continued hospitalization denials shall be promptly processed and involve physician-to-physician consultation.

A.7.5 As part of its medical management activities, the Contractor shall notify members and providers regarding the extent of available benefits.

A.7.6 The Contractor shall maintain an internal quality assurance program. The Contractor shall submit to the State, at contract implementation, a summary of the plan indicating areas addressed and methodology employed.

A.8 **PHARMACY**

The Contractor shall provide its pharmacy benefit through a retail network and may also provide pharmacy services through a mail order service. If the Contractor has a mail order pharmacy benefit, it shall comply with Tennessee law regarding mail order pharmacy (Refer to TCA 56-7-117 and TCA 56-7-2359). The Contractor shall provide the following required programs and service components for the retail and mail order pharmacy benefits.

A.8.1 The Contractor shall perform quarterly reviews of pharmacy network adequacy, performance, service levels, and other factors that focus on managing pharmacy benefit cost.

A.8.2 Retail and Mail Order Claims Adjudication. The Contractor shall:

A.8.2.1 Adjudicate and process all electronic point of sale and paper retail and mail order pharmacy claims incurred during the term of the contract in accordance with the benefit package (see Section A.2).

A.8.2.2 Maintain an integrated retail and mail order electronic point-of-sale claims system that shall have edits to verify eligibility, covered drug benefits, and claim accuracy. Mail order facilities shall have the capacity to process the volume of member prescriptions.

A.8.3 The Contractor shall provide a website for members providing access to pharmacy plan benefits, retail pharmacy network, formulary/Preferred Drug List (PDL), drugs requiring prior authorization, drugs dispensed with limitations, and link to mail-order.

A.8.4 Retail Network. The Contractor shall:

A.8.4.1 Provide a comprehensive network with member access to retail pharmacies, which contractually agree through point-of-sale electronic transmission to verify eligibility, submit member claims electronically, agree not to waive co-payments, and agree to accept the Contractor's reimbursement as payment in full for covered prescription drugs allowing no balance billing.

A.8.4.2 Provide participating pharmacies with a toll-free telephone service number.

A.8.4.3 Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.

A.8.5 Formulary/Preferred Drug List (PDL) and Utilization Review. The Contractor shall:

A.8.5.1 Implement and maintain a formulary/ PDL for the retail and mail order program that includes the minimum number of generic drugs in each of the drug categories specified in Appendix 7.3 [to RFP #317.30-041]. Changes in the formulary/PDL shall be approved and communicated to the State and affected members no less than 30 calendar days prior to change implementation date, unless a shorter notification time is mutually agreed to by the Contractor and State.

A.8.5.2 Provide a Prospective Utilization Review program for the retail and mail order programs allowing pharmacists access to patient prescription drug profile and history in order to identify potentially adverse events, including but not limited to the following:

A.8.5.2.1 Drug to drug interaction
A.8.5.2.2 Duplicate therapy
A.8.5.2.3 Known drug sensitivity
A.8.5.2.4 Over utilization
A.8.5.2.5 Maximum daily dosage

A.8.5.2.6 Early refill indicators
A.8.5.2.7 Suspected fraud

A.8.5.3 Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.

A.8.5.4 Provide a Retrospective Utilization Review program to track provider prescribing habits and identify those who practice outside of their peer norms as well as identify patients who may be abusing prescription drugs or visiting multiple providers.

A.8.5.5 Have the ability to lock a member suspected of abusing the system into just one network pharmacy.

A.8.5.6 Pharmacy Rebates and Audits. When the Contractor is at full risk, the Contractor shall provide a quarterly report to the State detailing rebates obtained due to the use of pharmaceuticals by members for the rebates accrued during the claim period ending six months prior to the report date.

A.9 CLAIMS PROCESSING

A.9.1 The Contractor shall process all medical claims in accordance with the plan benefits, as detailed in Attachment A. The Contractor may not modify these benefits during the term of this contract without the approval of the State.

A.9.2 The Contractor shall ensure that the majority of all claims will be paperless. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.

A.9.3 The Contractor shall ensure that the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Said standards shall include the requirements specified under each of the following HIPAA subsections:

- Electronic Transactions and Code Sets
- Privacy
- Security
- National Provider Identifier
- National Employer Identifier
- National Individual Identifier
- Claims attachments
- National Health Plan Identifier
- Enforcement

A.9.4 The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this contract and meets the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996. The Contractor shall have a disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.

A.9.5 The Contractor shall confirm eligibility of each member as claims are submitted for the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, filed by provider(s), including in accordance with Performance Guarantees #5 and #6 contained in Contract Attachment B.

A.9.6 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide members with identification cards. Identification cards shall contain unique identifiers for each member; such identifier shall NOT be the member's Federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review any claim forms and identification cards prior to issuance for use.

A.9.7 The Contractor shall institute subrogation based on a mutually agreeable process between the Contractor and the State. Such process shall include:

A.9.7.1 A defined process for the recovery of monies received through subrogation;

A.9.7.2 Notification, upon request by the State, of the status of cases under review for subrogation; and
A.9.7.3 Identification to the State of all subrogation subcontractors and, upon request by the State, copies of said subcontracts.

A.9.8 The Contractor may retain any subrogation recoveries. The Contractor shall understand that recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

A.9.9 The Contractor shall determine eligible expenses that are medically necessary and within the benefit limits (see Section A.2). The Contractor shall have on staff qualified and licensed medical personnel whose primary duties are to determine both prospectively and retroactively the medical necessity of treatments and their associated claims.

A.9.10 The Contractor shall generate and mail an explanation of benefits (EOB) to the member each time the Contractor processes a claim. The Contractor shall mail the EOB within five business days of processing the claim. The EOB format shall be approved by the State and shall include but not be limited to customer service information, member information, the type of service, the service date, the provider's name, the amount billed, the amount the Contractor paid, and the amount not covered by the Contractor's plan. In addition, if the service is subject to a service limit, then the EOB must include information on the service limit, including the adjusted service limit (e.g., the number of visits remaining).

A.9.11 Upon conclusion of this contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered or medical supplies purchased during the period of this contract with no additional administrative cost to the State. The claims run out period shall extend through the final day of the 13th month following contract termination.

A.9.12 The Contractor shall assist the State in identifying fraud and perform fraud investigations of members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews shall include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the Division of Insurance Administration and the Office of the Inspector General, both in the Department of Finance and Administration, and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

A.9.12.1 discontinue further investigation if there is insufficient justification;
A.9.12.2 continue the investigation and report back to the State;
A.9.12.3 continue the investigation with the assistance of the State; or
A.9.12.4 discontinue the investigation and turn the Contractor's findings over to the State for its investigation.

A.9.13 The Contractor shall allow for periodic audits to be performed by the State of Tennessee's Division of State Audit, Office of the Comptroller of the Treasury, other State agencies, or other qualified entity(ies) designated by the State. For the purpose of this requirement, the Contractor shall include its parent organization, affiliates, subsidiaries, and subcontractors only as their work relates to their performance of the work under this contract. The selected auditor shall be qualified to conduct such audits and shall not present any conflict of interest with the Contractor that would compromise any Contractor proprietary information. The Contractor shall provide the auditor access to all information necessary to perform the examination, and the State will work with the Contractor in defining the scope of the audit, requirements, and time frame for conducting the audit. The State shall provide reasonable notice to Contractor of not less than 30 calendar days. Contractor agrees to be fully prepared for any on-site audit on the mutually agreed upon date. To the extent allowed by applicable law, the State agrees that persons or organizations conducting audits of the Contractor shall be prohibited from disclosing confidential patient records or proprietary or confidential information reasonably designated as such by the Contractor.

For the purpose of conducting these audits, the Contractor agrees to the following:

A.9.13.1 Audits may be conducted by the State to ensure that all rebates, discounts, special pricing considerations, and financial incentives have accrued to the State and that all costs incurred are in accordance with the contract terms and plan benefits. In addition, risk sharing arrangements, performance guarantees, and administrative processes as specified in this contract may be audited by the State or its qualified representative(s).

A.9.13.2 Audits may commence at any time within the three year period following the period being audited. However, the State will not request an audit for the same purpose more than two times in any one contract year.

A.9.13.3 State shall not be required to pay for any Contractor data, reporting, time, expenses, or other related costs incurred by Contractor for the preparation of, or participation in, such audits.

A.9.13.4 The Contractor shall not restrict the State audit sample size or sample selection methodology. The State retains the right to select a random sampling process, whereby a statistically valid sample of transactions completed during the audit period are analyzed, or an electronic audit process, whereby one hundred percent (100%) of transactions completed during the audit period are analyzed. In the event that the random sampling process is selected, audit results/error rates may be extrapolated for purposes of financial penalties and/or recoveries in accordance with generally accepted auditing principles. For any audit performed for purposes other than performance guarantee validation, State retains the right to choose the sampling method.

A.9.13.5 Such audits are permissible and required pursuant to the Sarbanes-Oxley Act of 2002; the American Institute of Certified Public Accounts standards; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and the fiduciary obligations of the State. Accordingly, the Contractor shall not restrict State access to Protected Health Information (PHI) as that term is defined in HIPAA, provided the appropriate Business Associate Agreement and confidentiality agreements are in place and all applicable federal and state laws are followed.

A.9.13.6 The Contractor agrees to provide all requested data and documents, access to the Contractor's computer system, and assistance in using the computer system.

A.10 CLAIMS PAYMENT AND RECONCILIATION PROCESS

A.10.1 For the payment of all claims under this contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House (ACH) electronic funds transfer against the Contractor's own bank account. Unless otherwise mutually agreed to in writing by the parties, the check mailing/delivery process, including the location and timing for the printing and mailing of the checks, shall be in the manner described in the Contractor's Proposal. The Contractor shall maintain security and quality controls over the design, printing, and mailing of checks, as well as any fraud prevention feature of check stock in the manner described in the Contractor's Proposal.

A.10.2 As provided in Section C.4, the State shall make monthly premium payments to the Contractor based on the Contractor's membership.

A.10.3 The Contractor shall issue all related Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting.

A.10.4 Overpayments resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents, or employees shall be the responsibility of the Contractor, regardless of whether or not such overpayments can be recovered by the Contractor.

A.11 CUSTOMER AND ADMINISTRATIVE SERVICES

A.11.1 The Contractor shall respond to inquiries, correspondence, complaints, and problems from members and providers. The Contractor shall answer, in writing, within ten business days of receipt, ninety percent (90%) of all written inquiries from members concerning requested information, including benefits available.

A.11.2 The Contractor shall maintain a formal grievance and appeal procedure, by which members and providers may appeal: eligibility decisions (see Section A.4.16), claims disputes, decisions regarding benefits administration, medical necessity determinations within benefit limits, determinations that the member has reached a benefit limit, and disputes arising from the utilization management program. At contract implementation, the Contractor shall provide to the State two written copies describing in detail the Contractor's grievance and appeal procedures. The State reserves the right to review the procedure and make recommendations, where appropriate.

A.11.3 The Contractor shall maintain statewide, toll-free phone lines manned by qualified member services staff and for the exclusive purpose of applicant and member inquiries and operate at a minimum of 8:00 a.m. until 6:00 p.m. Eastern Standard Time. These phone lines shall be operated in accordance with details provided in the Contractor's proposal and perform consistent with Performance Guarantee #7 in Contract Attachment B. These phone lines shall handle calls from non-English speaking members.

A.11.4 If the Contractor knows that a member is pregnant, the Contractor shall immediately refer the member to the State so that she can receive maternity and pregnancy-related services through CoverKids or TennCare (see Section A.2.3 and Section A.14.4). If a pregnant member contacts the Contractor during normal business hours by phone, then the Contractor shall refer the member to the State via warm transfer.

A.11.5 The Contractor shall refer any calls from potentially eligible employers regarding the CoverTN program to 1-866-COVER-TN or to http://covertn.gov/. In addition, the Contractor shall refer potentially eligible employers and sole proprietors to the State/the State's vendor for eligibility determination.

A.11.6 Unless otherwise stipulated by the State in writing, the Contractor shall refer (via warm transfer) any calls from members or potential members regarding coverage of dependents or seeking social services (e.g., unemployment, food stamps, energy assistance) to 1-866-COVER-TN. The Contractor shall refer any calls from members or potential members seeking Medicare assistance to 1-800-MEDICARE.

A.11.7 The Contractor shall designate an individual with overall responsibility for administration of this contract. This person shall designate qualified additional staff as necessary.

A.11.8 The Contractor, at the request of either party, shall meet with representatives of the State periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by the State. The Contractor shall have in attendance, when requested by the State, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide information to the State concerning its efforts to develop cost containment mechanisms and improve administrative activities. The Contractor shall provide information to the State regarding the administration of the benefit, internal procedures for billing and reconciliation of transactions and the provision of health care treatment, and other administrative matters.

A.11.9 The Contractor, following review and approval by the State, shall annually update, print, and distribute to members' homes a member handbook. The handbook shall be specific to the CoverTN plan and shall describe and outline plan benefits, limitations and exclusions, co-payments, how to access services, and other information helpful to members. The handbook shall be at least at a sixth grade reading level and shall be available in Spanish.

A.11.9.1 The number of member handbooks to be printed shall be in sufficient quantities for the members and shall be mailed to members' homes with the provider directory (see Section A.6.4). The Contractor shall send a member handbook and provider directory to new members as specified in Section A.5.1.3 and Contract Attachment B, Performance Guarantee #3 (Member Handbooks and Provider Network Directories Distributed). The Contractor shall also provide member handbooks and provider directories to members after open enrollment, as specified in Contract Attachment B, Performance Guarantee #3 (Member Handbooks and Provider Network Directories Distributed).

A.11.9.2 Failure to have the member handbook approved by the State before release shall result in an assessment of $1,000 per occurrence. The State shall notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State.

A.11.10 The Contractor, following review and approval by the State, shall annually prepare, print and distribute to member's homes a summary of changes to the Contractor's plan, including but not limited to changes to benefits, provider network, and medical management procedures. This summary of changes shall be mailed to members two weeks prior to the start of open enrollment.

A.11.11 The Contractor shall, in consultation with the State, print and distribute all identification cards, member handbooks, provider directories, personal health covenants, primary care physician selection cards (if applicable), summaries of changes, letters, administrative forms, and manuals pertaining to or sent to members. If the materials address eligibility or benefits, they shall be prior approved by the State. The State reserves the right to review and comment on any materials sent to members. The cost of printing and distributing these materials shall be the responsibility of the Contractor.

A.11.12 If the Contractor maintains State-dedicated internet pages, it shall provide up-to-date information.

A.11.13 The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefit levels, service limitations, remaining benefit levels (for services with service limits), premiums, and cessation of coverage as requested by the State, members, employers, and providers.

A.11.14 The Contractor and the State shall jointly develop an action plan to correct problems or deficiencies by the State.

A.12 DATA AND SPECIFIC REPORTING REQUIREMENTS

A.12.1 Eligibility and Enrollment Data

A.12.1.1 The Contractor shall maintain, in its computer system, in-force eligibility and enrollment records of all participating employers and all members.

A.12.1.2 The Contractor shall maintain all of the eligibility elements included in the employer/sole proprietor file provided by the State.

A.12.1.3 For applicants/members the Contractor shall collect and maintain, at minimum, the elements listed in Appendix 7.4 [of RFP #317.30-041].

A.12.1.4 The Contractor shall ensure that member eligibility and enrollment records remain accurate and complete and include historical information (at least three years).

A.12.2 The Contractor shall maintain a duplicate set of all records relating to the benefit payments in an electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of 60 calendar days from the date of creation. Upon notice of termination or cancellation of this contract, the original and the duplicate data processing records medium, and the information they contain, shall be conveyed to the State on or before the effective date of termination or cancellation.

A.12.3 The Contractor shall reconcile, within ten business days of receipt, payments from the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.12.4 Semi-annually the first year and annually thereafter, the Contractor shall provide the State with a GeoNetworks® report showing service and geographic access (see Contract Attachment B, Performance Guarantee #4). The State shall review the network structure and shall inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within 60 calendar days.

A.12.5 The Contractor is required to transmit member eligibility and enrollment data and medical, behavioral health, and prescription drug claims to the State's health care decision support system (DSS) vendor (currently Medstat) until all claims incurred during the term of this contract have been paid. The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ICD-9 and CPT4 codes (and when applicable, updated versions).

A.12.5.1 For each quarter of the contract term, and any extensions thereof, data shall meet the quality standards detailed in Contract Attachment B, Performance Guarantee #8, as determined by the State's health care DSS vendor (currently Medstat).

A.12.5.2 The Contractor shall work with the State's DSS vendor to identify a mutually-agreeable data format for claims transmission similar to the format detailed in Appendix 7.5 [of RFP #317.30-041] as well as a format to collect member eligibility and enrollment data that includes elements similar to those detailed in Appendix 7.4 [of RFP #317.30-041]. The Contractor is responsible for the cost incurred by the State's DSS vendor to develop, test, and implement conversion programs for the Contractor's data. The State's DSS vendor currently charges a maximum of $30,000 per new contractor. Furthermore, the Contractor shall pay during the full term of this contract all applicable fees as assessed by the State's DSS vendor related to any data formats changes that are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any efforts by the State's DSS vendor to correct Contractor data quality errors that occur during the term of this contract.

A.12.5.3 Member eligibility and enrollment data are to be submitted to the State's DSS vendor no later than the last day of the month following the end of each calendar month.

A.12.5.4 Claims data is to be submitted to the State's DSS vendor no later than the last day of the month following the end of each calendar quarter (see Contract Attachment B, Performance Guarantee #9).

A.12.5.5 The Contractor shall participate and cooperate with the State to implement a secure, web-accessible community health record (CHR) for CoverTN members. Cooperation shall include, but may not be limited to, the provision of encounter/results data directly to an authorized CHR vendor in a time and manner approved by the State and consistent with the requirements of the CHR vendor and an executed Business Associates Agreement between the Contractor and the CHR vendor. The Contractor shall require subcontractors and providers to participate and cooperate with the State and/or a CHR vendor.

A.13 SUBMIT MANAGEMENT REPORTS

A.13.1 The Contractor shall submit Management Reports in a mutually agreeable electronic format (MS Word, MS Excel, etc.), of the type, at the frequency, and containing the detail described in Contract Attachment B. Quarterly reports shall be due to the State not later than 45 calendar days after the end of each reporting period. Reporting shall continue for the 13 month period following termination of the contract.

A.13.2 The Contractor shall also generate and submit to the State, within five business days of the end of each contract quarter, a Quarterly Network Changes Report, also in electronic format.

A.14 **SERVICES PROVIDED BY THE STATE**

A.14.1 The State shall conduct general marketing activities to inform potential participating employers, sole proprietors, and members about CoverTN and how to enroll.

A.14.2 The State shall review the Contractor's marketing materials to ensure that materials are not materially inaccurate, misleading, or confusing. The State shall review materials with information about eligibility or benefits to ensure that this information is clear and accurate.

A.14.3 The State or its vendor shall determine eligibility for participating employers and sole proprietors and provide enrollment records for employers and sole proprietors who are eligible to participate in CoverTN. The Contractor's computer system shall have the capability to utilize the enrollment information provided by the State.

A.14.4 The State shall facilitate the enrollment of pregnant CoverTN members into other state programs, including CoverKids, so that they can receive maternity and pregnancy-related services. Additionally, the State will help these members resolve any concerns about enrollment in or claims payments by the other health plan. The State will also advise women to continue their enrollment in CoverTN and to pay their monthly premiums throughout their pregnancy and following their delivery.

B CONTRACT TERM

B.1 Contract Term. This contract shall be effective for the period commencing on January 12, 2007 and ending on December 31, 2009. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2 Term Extension. The State reserves the right to extend the contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, provided that such an extension of the contract term is effected prior to the current contract expiration date by means of an amendment to the contract.

C PAYMENT TERMS AND CONDITIONS

C.1 Maximum Liability. In no event shall the maximum liability of the State under this contract exceed Fifty Million Dollars ($50,000,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials, or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the contract or any extensions of the contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this contract.

C.2 Compensation Firm. The Service Rates and the Maximum Liability of the State under this contract are firm for the duration of the contract and are not subject to escalation for any reason unless amended.

C.3 Premium Payments

C.3.1 The State has established the premium amounts for CoverTN members for calendar year 2007 (see Contract Attachment D). The premium amount for a member will be adjusted depending on the member's age, whether or not he/she is a tobacco user, and his/her body mass index (BMI), and each member shall be assigned to a premium group based on these factors (see Contract Attachment D). As provided in Section A.5.2, the premium amount for a member may be paid by the State, an employer, and/or the member. This premium amount is payment for all services under this contract, including administrative

costs. The Contractor's administrative component of premiums in calendar year 2007, as established through the procurement process in response to RFP #317.30-041, is included in Contract Attachment D.

C.3.2 For each member enrolled in the Contractor's plan, except for those who are ineligible for State payment (see Section A.4.4), the State will pay the Contractor, on a monthly basis, the amount of the "State Share" of the monthly premium amount established by the State. (See Contract Attachment D for the premium amounts and State share of such premium amounts for calendar year 2007.)

C.3.3 The State's payment of its premium obligation (State share) shall be based upon the number of members, by premium group, as certified by the Contractor and included in a monthly invoice with accompanying enrollment file provided to the State. The monthly invoice and enrollment file shall be sent electronically to the State two business days before the end of the month and shall include information specified by the State for members who will be enrolled for the following month. The State shall remit payment of its premium obligation to the Contractor based on the invoice and enrollment file within three business days of receipt of a clean file. Each month's payment to the Contractor by the State shall be equal to the number of members in each premium group times the State's share of the premium for that premium group (except as provided in Section A.4.4).

C.3.4 The Contractor shall assign a member to a premium group based on the information provided on the member's application regarding age, tobacco use, and BMI. During open enrollment the Contractor shall collect information to assess if there has been a change in any of these factors. If any of these factors changes (based on information collected during open enrollment or otherwise known to the Contractor) in a manner that impacts a member's premium group, then the Contractor shall adjust the member's premium. Premium adjustments shall be made as follows:

C.3.4.1 Premium adjustments for age shall be effective January 1st of each year unless age was incorrectly reported or entered at the time of application. For example, if a member turns 50 in May of 2007, the premium adjustment shall be effective January of 2008. If age was incorrectly reported or entered at the time of application, then the Contractor may adjust the premium after providing 30 calendar days notice to the member and employer (as applicable).

C.3.4.2 Premium adjustments for tobacco use shall be made if a member without the tobacco use surcharge begins to use tobacco or a member with a tobacco use surcharge certifies that he/she has not used tobacco in the previous six months. The Contractor may require physician certification (through the personal health covenant or other means) for removal of the surcharge. Except as provided in Section C.3.4.4 and Section C.3.4.5, premium adjustments for tobacco use shall be effective January 1st of each year.

C.3.4.3 Premium adjustments for BMI shall be made if a member with the premium discount has a BMI of 30 or more or if a member without the premium discount certifies that he/she has sustained a BMI of less than 30 for at least six months. The Contractor may require physician confirmation (through the personal health covenant or other means) for a premium reduction. Except as provided in Section C.3.4.4 and Section C.3.4.5, premium adjustments for change in BMI shall be effective January 1st of each year.

C.3.4.4 The Contractor shall provide members who enroll in the Contractor's plan fewer than six months prior to open enrollment one opportunity at the one year anniversary of their enrollment to reduce their premiums based on tobacco use or BMI. Any such premium reductions shall be effective through the end of that year. Any future adjustments shall be made effective January 1st of each year.

C.3.4.5 For premium adjustments related to tobacco use and BMI, the Contractor shall comply with any federal regulations regarding "wellness programs." Until final regulations are issued, the Contractor shall comply with the provisions of the proposed regulations (see 66 Federal Register 1421), including any revisions.

C.3.4.5.1 In order to comply with federal requirements regarding wellness program, the Contractor shall (a) establish a reasonable alternative standard to obtain the premium reduction for members for whom it is unreasonably difficult to meet the standard for the premium reductions (i.e., cease tobacco use or achieve a BMI below 30), and (b) disclose in all member materials describing the premium amounts

the availability of a reasonable standard to both remove the surcharge for tobacco use and receive the discount for having a BMI under 30. The following language, or substantially similar language, shall be used to meet the requirement in (b): "If it is unreasonably difficult due to a medical condition for you to stop using tobacco (or if it is medically inadvisable for you to attempt to meet this standard), then your CoverTN plan will make available a reasonable alternative standard for you to receive this discount. Similarly, if it is unreasonably difficult due to a medical condition for you to achieve a BMI under 30 (or if it is medically inadvisable for you to attempt to meet this standard), then your CoverTN plan will make available a reasonable alternative standard for you to avoid this surcharge. Please call your CoverTN plan for more information."

C.3.4.5.2 During open enrollment and, for members who enroll fewer than six months prior to open enrollment, at the one year anniversary of the member's enrollment, the Contractor shall make the premium reductions available to members who meet the reasonable alternative standard. These premium reductions shall be effective January 1 or the 13th month of enrollment, as applicable, through December of that year. If, after receiving a premium reduction for meeting an alternative standard, the member fails to comply with the alternative standard, the Contractor may adjust the premium to remove the discount for meeting the BMI standard or reinstate the surcharge for tobacco use (as applicable). If the Contractor increases the premium as a result of member's failure to comply with the alternative standard, the higher premium amount shall remain in effect through December of that year. During open enrollment, the Contractor shall provide the member with an opportunity to qualify for a premium reduction, including compliance with an alternative standard, for premiums effective the following January.

C.3.5 For coverage provided in calendar year 2008 and 2009 the State shall increase the premium amounts in Contract Attachment D. In calendar year 2008, the State shall increase the non-administrative component of the premium amounts by ten percent (10%) from calendar year 2007. For calendar year 2009 the increase shall be based on the State's analysis of claims experience for the CoverTN program and shall not exceed ten percent (10%). In each year the administrative component of the premium amount shall be adjusted by the percent increase, if any, between the Consumer Price Index (CPI): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100 published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in the August of the year prior to the calendar year that the adjustment will take effect and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5%).

C.3.6 If this contract is extended pursuant to Section B.2, the State shall increase the premium amounts in Contract Attachment D for each extension year, as applicable. This increase shall be based on the State's analysis of claims experience for the CoverTN program and shall not exceed ten percent (10%) per year for the non-administrative component of the premium amount. The administrative component of the premium amount shall be adjusted by the percent increase, if any, between the Consumer Price Index (CPI): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100 published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in the August of the year prior to the calendar year that the adjustment will take effect and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5%).

C.4 Marketing Payments

C.4.1 Payments for Enrollment of Employees of Participating Employers and of Sole Proprietors

C.4.1.1 New Members. The State shall pay ten percent (10%) of the average monthly premium (e.g., $15.00 in CY 2007) to the Contractor for enrollment of "new members" following the first month of enrollment. For purposes of Section C.4, "new members" shall be defined as persons who (a) enroll in the Contractor's CoverTN plan and (b) have not previously been members of the Contractor's CoverTN plan at any time during the last 90 days. The State shall make monthly payments based on a monthly report of new members submitted by the Contractor.

C.4.1.2 Continuing Enrollees. Following the month for which the State made a payment pursuant to Section C.4.1.1, the State shall pay five percent (5%) of the average monthly premium (e.g., $7.50 in CY 2007) to the Contractor for each of the next 11 months for which a continuing enrollee remains a member in the Contractor's plan. For purposes of this Section C.4, "continuing enrollees" shall be defined as persons who were "new members" in the preceding 12 months. The State shall make monthly payments based on a monthly report of continuing enrollees submitted by the Contractor.

C.4.2 Retention Incentive Payments

C.4.2.1 The State shall pay twenty percent (20%) of the average monthly premium to the Contractor following the twelfth month of continuous enrollment for each continuing enrollee who is still enrolled in the Contractor's plan. The State shall make payments based on a monthly report submitted by the Contractor.

C.4.2.2 The Contractor shall have the right to use the retention incentive payment described in Section C.4.2.1 in order to offer rebates, discounts, waivers or payment, hardship assistance, and related promotions to incentivize members to maintain their enrollment in the CoverTN program. The State reserves the right to review and approve the terms of these incentives prior to the distribution of any related promotional materials.

C.4.3 Enrollment Target Incentive Payments

C.4.3.1 The State shall make a total one-time payment of $500,000 to the Contractor if the Contractor is the first contractor to enroll 10,000 new members within the first six months (e.g., 180 calendar days) after coverage under this contract begins. If the Contractor is the second contractor to enroll 10,000 new members during this period, then the State shall pay the Contractor a total one-time payment of $250,000. If the Contractor does not enroll 10,000 new members during this period, the State shall not make any payment under this section. "New members" are defined in Section C.4.1.1 above.

C.4.3.2 The State shall make a total one-time payment of $500,000 to the Contractor if the Contractor is the first contractor to enroll 10,000 new members within the second six-month period after coverage under this contract begins. If the Contractor is the second contractor to enroll 10,000 new members during this period, then the State shall pay the Contractor a total one-time payment of $250,000. If the Contractor does not enroll 10,000 new members during this period, the State shall not make any payment under this section. "New members" are defined in Section C.4.1.1 above. Payments under this Section C.4.3.2 are subject to the geographic limitations of Section C.4.4.1 below.

C.4.3.3 The State shall make a total one-time payment of $1,000,000 to the Contractor if the Contractor is the first contractor to enroll 20,000 new members, including 8,000 new individual members, between months 13 and 24 after coverage under this contract begins. If the Contractor is the second contractor to enroll 20,000 new members, including 8,000 new individual members, during this period, then the State shall pay the Contractor a total one-time payment of $600,000. If the Contractor does not enroll 20,000 new members during this period, including 8,000 new individual members, the State shall not make any payment under this section. Payments under this Section C.4.3.3 are subject to the geographic limitations of Section C.4.4.2 below.

C.4.3.3.1 For purposes of Section C.4.3.3, "new members" are defined in Section C.4.1.1 above. Additionally, "new individual members" shall be defined as persons who work for a non-participating employer and their spouses who (a) enroll in the Contractor's CoverTN plan and (b) have not previously been members of the Contractor's CoverTN plan at any time during the last 90 days.

C.4.3.4 The State reserves the right to review and approve incentive programs that the Contractor intends to implement with its employees, sales staff, contractors, brokers, and other marketing agents.

C.4.4 Geographic Limitation for Enrollment Target Incentive Payments

C.4.4.1 The State shall not pay any incentive payment to a Contractor under Section C.4.3.2 if, at the end of the first 12 months from the date the Contractor began providing coverage under this contract, more than one-half of the Contractor's total CoverTN plan members reside within the same region of Tennessee. "Regions" are East, Middle, and West Tennessee as defined in Part E of RFP Attachment 6.4 [of RFP #317.30-041].

C.4.4.2 The State shall not pay any incentive payment to a Contractor under Section C.4.3.3 if, at the end of the first 24 months from the date the Contractor began providing coverage under this contract, the Contractor does not meet the geographic distribution of members as established by the State, which shall be designed to ensure that residents of suburban and rural Tennessee have adequate access to and opportunity to enroll in CoverTN. If the State does not specify a standard within 12 months after coverage under this contract begins, then the geographic limitation in Section C.4.4.1 shall apply.

C.5 Performance Guarantees. The Contractor agrees to be bound by the provisions contained in Contract Attachment B, Performance Guarantees, and to pay amounts due upon notification of Contractor non-compliance by the State.

C.5.1 Performance Guarantees under Contract Extension. If this contract is extended, per Section B.2, the Performance Guarantees shall remain unchanged for the years extended.

C.6 Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.7 Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.8 Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

C.9 Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.10 Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

D STANDARD TERMS AND CONDITIONS

D.1 Required Approvals. The State is not bound by this contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2 Modification and Amendment. This contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D.3 Termination for Convenience. The contract may be terminated by either party by giving written notice to the other, provided that the State shall give said notice to the Contractor at least ninety (90) calendar days before the effective date of termination, and the Contractor shall give said notice to the State at least two hundred seventy (270) calendar days before the effective date of termination. Should the State

exercise this provision, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Should the Contractor exercise this provision, the State shall have no liability to the Contractor except for those units of service which can be effectively used by the State. The final decision as to what these units of service are shall be determined by the State. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.

D.4 Termination for Cause. If the Contractor fails to properly perform its obligations under this contract in a timely or proper manner, or if the Contractor violates any terms of this contract, the State shall have the right to immediately terminate the contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this contract by the Contractor.

D.5 Subcontracting. The Contractor shall not assign this contract or enter into a subcontract for any of the services performed under this contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this contract pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (sections D.6, D.7, and D.9.). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6 Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this contract.

D.7 Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document included as Contract Attachment F, hereto, semi-annually during the period of this contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this contract, and semi-annually thereafter, during the period of this contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

e. For purposes of this contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the contract.

D.9 Records. The Contractor shall maintain documentation for all charges against the State under this contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10 Monitoring. The Contractor's activities conducted and records maintained pursuant to this contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11 Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12 Strict Performance. Failure by any party to this contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.13 Independent Contractor. The parties hereto, in the performance of this contract, shall not act as employees, partners, joint ventures, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this contract.

D.14 State Liability. The State shall have no liability except as specifically provided in this contract.

D.15 Force Majeure. The obligations of the parties to this contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D.16 State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this contract.

D.17 Governing Law. This contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under ***Tennessee Code Annotated***, Sections 9-8-101 through 9-8-407.

D.18 Completeness. This contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19 Severability. If any terms and conditions of this contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this contract are declared severable.

D.20 Headings. Section headings of this contract are for reference purposes only and shall not be construed as part of this contract.

E SPECIAL TERMS AND CONDITIONS

E.1 Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this contract, these special terms and conditions shall control.

E.2 Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:

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Division of Insurance Administration
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The Contractor:

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All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the telefax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

E.3 Subject to Funds Availability. The contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the contract upon written notice to the Contractor. Said termination shall not be deemed a breach of contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4 Breach. A party shall be deemed to have breached the contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the contract;
— partial performance of any term or provision of the contract;
— any act prohibited or restricted by the contract; or
— violation of any warranty.

For purposes of this contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages (hereinafter referenced as "Assessments," as contained in Contract Attachment B, Performance Guarantees) — In the event of a Breach, the State may assess Performance Guarantee Assessments. The State shall notify the Contractor of amounts to be assessed as Performance Guarantee Assessments. The parties agree that due to the complicated nature of the Contractor's obligations under this contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Performance Guarantee Assessments contained in the above referenced Contract Attachment B and agrees that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Performance Guarantee Assessments represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Performance Guarantee Assessment amounts are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this contract.

The State may continue to assess Performance Guarantee Assessments or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the contract. The State is not obligated to assess Performance Guarantee Assessments before availing itself of any other remedy. The State may choose to discontinue Performance Guarantee Assessments and avail itself of any other remedy available under this contract or at law or equity; provided, however, Contractor shall receive a credit for said Performance Guarantee Assessments previously assessed except in the event of a Partial Default.

(3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the

greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Performance Guarantee amounts, as applicable, against the Contractor for any failure to perform which ultimately results in a Partial Default with said Performance Guarantee amounts to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.

(4) Contract Termination— In the event of a Breach, the State may terminate the contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within 30 days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.5 Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.6 Incorporation of Additional Documents. Included in this contract by reference are the following documents:

a. The contract document and its attachments
b. The Contractor's Best and Final Offer (BAFO) Proposal as may be Clarified by the State
c. All Clarifications and addenda made to the Contractor's Proposal
d. The Request for Proposal and its associated amendments
e. Technical Specifications provided to the Contractor
f. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this contract, these documents shall govern in order of precedence detailed above.

E.7 Confidentiality of Records. Strict standards of confidentiality of records shall be maintained in accordance with the law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this contract.

E.8 HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the contract so that both parties will be in compliance with HIPAA.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.9 Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to ***Tennessee Code Annotated***, Title 8, Chapter 35, Part 3 accepts state employment, the

member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this contract is that of "employee/employer" and not that of an independent contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this contract.

E.10 Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;

b. have not within a three (3) year period preceding this contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining attempting to obtain, or performing a public (Federal, State, or Local) transaction or grant under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this contract had one or more public transactions (Federal, State, or Local) terminated for cause or default.

E.11. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP #317.30-041 (Attachment 6.3, Section B, Item B.13) and resulting in this contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the State of Tennessee Governor's Office of Business Diversity Enterprise in form and substance as required by said office.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — Jan. 11, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT — DATE

Ronald E Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. — 1-12-07

M.D. GOETZ, JR., COMMISSIONER — DATE

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. — 1-12-07

M. D. GOETZ, JR., COMMISSIONER — DATE

COMPTROLLER OF THE TREASURY:

John G. Morgan — 1/23/07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY — DATE

Contract Attachment A
Benefits and Cost-Sharing

Part B: Summary of Benefits and Coverage					
Service Description	**Required?** (Yes/No)	**Included in your CoverTN plan?** (Yes/No)	**CoverTN Cost-Sharing Requirements** (No deductibles or coinsurance permitted)	**Service Limitations/Exclusions**	**Copayment** (if any)
Hospital Inpatient					
Medical	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	$100 copayment per admission
Surgical	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	$100 copayment per admission
Psychiatric	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Inpatient psychiatric and substance abuse services limited to 5 days per year. Note 1	$100 copayment per admission

	Substance Abuse	**YES**	**YES**	Maximum $100 copay per admission.	Subject to $10,000 annual payment limit for medical and behavioral health services Inpatient psychiatric and substance abuse services limited to 5 days per year. Inpatient substance abuse services limited to medical detox only at a medical facility. Note 1	$100 copayment per admission
	Dialysis Clinic	No	No			$
	Skilled Nursing Facility	No	No			$
	Other (specify)	No	No			$
Hospital Outpatient						
	Emergency Room	**YES**	**YES**	Maximum $100 copay per visit for non-emergency conditions.	Limited to 2 ER visits per calendar year	$100 copayment for non-emergent services
	Medical	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit
	Surgery/Procedures	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	$25 copayment per visit
	Radiology	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit

	Pathology	**YES**	**YES**	Maximum $25 copay per visit.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year Note 1	$25 copayment per visit
	Other (specify)	No	No			$
Outpatient Behavioral Health						
	OP Mental Health Services	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to behavioral health visit limit of 10 visits per calendar year for mental health and substance abuse services	$25 copayment per visit
	OP Substance Abuse Services	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to behavioral health visit limit of 10 visits per calendar year for mental health and substance abuse services	$25 copayment per visit
Physician Services						
	Inpatient Surgery					
	Primary Surgeon	**YES**	**YES**	Maximum $25 copay per encounter.	Inpatient stay must be covered	No copayment
	Anesthesia	**YES**	**YES**	Maximum $25 copay per encounter.	Inpatient stay must be covered	No copayment
	Outpatient Surgery					
	OP Hospital	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	No copayment
	Surgical Center	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	No copayment

		Office	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting Note 1	$15 copayment per visit
	Inpatient Visits		**YES**	**YES**	Maximum $25 copay per visit.	Inpatient stay must be covered	No copayment
	Preventive Services						
		Adult preventive physical exams, including lab tests	**YES**	**YES**	Maximum $25 copay per encounter.	One adult physical exam per calendar year, subject to office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting One well woman exam per calendar year, subject office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting	No copayment No copayment
		Pap smears	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one well woman visit per calendar year	No copayment
		PSA	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one adult physical exam per calendar year	No copayment

		Mammography	**YES**	**YES**	Maximum $10 copay per test (in addition to any physician fee, etc.); plans may instead have all-inclusive per visit copay.	Included with one well woman visit per calendar year Mammograms performed in an outpatient setting will be subject to the outpatient visit limit of 2 non-surgical visits per calendar year	No copayment
		Immunizations/Vaccinations	**YES**	**YES**	No copay.	Included with one adult physical exam per calendar year	No copayment
		Other (specify)	No	No			$
	Services related to ER visit		**YES**	**YES**	Maximum $25 copay per encounter.	Limited to 2 ER visits per calendar year	$25 copayment per encounter for both emergent and non-emergent services
	Diagnostic and Therapeutic Services						
		PCP visits	**YES**	**YES**	Maximum $25 copay per visit; also, one visit without charge for health assessment every three years.	Subject to office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting	$15 copayment per visit
		Specialist visits	**YES**	**YES**	Maximum $25 copay per visit.	Subject to office visit limit of 5 visits per calendar year for medical, surgical or preventive services performed in an office setting	$15 copayment per visit
		Lab	**YES**	**YES**	Maximum $10 copay per test.	Office visit must be covered for related lab work to be covered Does not count toward visit limit when performed separately from an office visit Office lab services are not covered after the office visit limit is met	No copayment

		Chemotherapy	No	**YES**		Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting, regardless of whether an office visit is filed with the services	No copayment
		Radiation	No	**YES**		Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting, regardless of whether an office visit is filed with the services	No copayment
		Allergy tests, injections, and sera	No	No			$
		Other (specify)	No	No			$
Other Provider Services							
	PT, OT, and speech therapists		No	No			$
	Audiology		No	No			$
	Vision		No	**YES**		Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting Note 1 - Medical benefit only Glasses or contacts following cataract surgery limited to $200 per year	$15 copayment per visit
	Chiropractic		No	No			$
	Podiatry		No	No			$
	Dental Services		No	No			$

	Urgent Care	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services performed in an office setting Subject to outpatient visit limit of 2 non-surgical visits and 1 surgical visit per calendar year	Office Visit - $15 copayment per visit Outpatient - $25 copayment per visit
	Other (specify)	No	No			$
Radiology						
	IP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	Included in $100 copayment per admission No additional copayment per encounter
	OP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year and 1 surgical visit per calendar year Note 1	Included in $25 copayment per visit No additional copayment per encounter

	Office (Combined)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services when performed in conjunction with an office visit Does not count toward visit limit when performed separately from an office visit Office x-ray services are not covered after the office visit limit is met	Included in $15 copayment per visit No additional copayment per encounter
	Other (specify)	No	No			$
Pathology						
	IP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to $10,000 annual payment limit for medical and behavioral health services Note 1	Included in $100 copayment per admission No additional copayment per encounter
	OP (Professional)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to outpatient visit limit of 2 non-surgical visits per calendar year and 1 surgical visit per calendar year Note 1	Included in $25 copayment per visit No additional copayment per encounter

	Office (Combined)	**YES**	**YES**	Maximum $25 copay per encounter.	Subject to office visit limit of 5 visits per calendar year for medical, surgical, diagnostic, preventive or other services when performed in conjunction with an office visit Does not count toward visit limit when performed separately from an office visit Office x-ray services are not covered after the office visit limit is met	Included in $15 copayment per visit No additional copayment per encounter
	Other (specify)	No	No			$
Miscellaneous Services						
	PDN/Home Health Care	No	**YES**		Subject to annual payment limit of $500	No copayment
	Hospice Care	No	**YES**		Subject to annual payment limit of $5,000 for inpatient and/or outpatient services	No copayment
	Air Ambulance	No	No			
	Ground and other ambulance	**YES**	**YES**	Maximum $25 copay per emergent encounter; maximum $50 copay for non-emergency.	Limited to 2 trips per calendar year	No copayment
	Non-Emergency Transportation	No	No			
	Durable Medical Equipment	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Prosthetics	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Corrective Appliance	No	No			

	Medical Supplies	No	**YES**		Subject to combined annual payment limit of $500 for DME, prosthetics and medical supplies	No copayment
	Diabetic supplies and injectibles	No	**YES**		Blood glucose monitors and test strips subject to $250 per quarter payment maximum for pharmacy Diabetic supplies subject to monthly payment maximum of $50 Diabetic supplies must be purchased through the pharmacy benefit to be covered	No copayment for meters Strips subject to $25 copayment Supplies subject to $5 copayment
	Organ/Tissue Transplants and Donor Services	No	No			
	Reconstructive Breast Surgery	No	**YES**		Inpatient - Subject to $10,000 annual payment limit for inpatient medical and behavioral health services Outpatient - Subject to outpatient visit limit of 1 surgical visit per calendar year Note 1	Included in $100 copayment per admission Included in $25 copayment per outpatient visit
	Other (specify)	No	No			$
Pharmacy						
	Generic	**YES**	**YES**	Maximum $10 copay per prescription.	Subject to quarterly payment limit of $250 (includes insulin, blood glucose monitors, blood glucose test strips, and generic drugs)	$10 copayment per 30 day supply

	Name-Brand	No	**YES**	Please see Attachment 6.3, Section A, item A.12 for limitations; maximum $25 copay per prescription.	Subject to quarterly payment limit of $250 (includes insulin, blood glucose monitors, blood glucose test strips, and generic drugs)	$25 copayment per 30 day supply
Other (specify)		No	**YES**		**All services subject to a payment maximum of $25,000 per calendar year**	varies

Part C: Proposer's Discounts by Procedure Code		
CPT4 Code	**Procedure**	**Discount as a % of Billed Charges**
11100	Biopsy of Skin	46.8%
15756	Free Muscle flap w/microvascular anastomosis	72.6%
17000	Destruction, all benign or premalignant lesions	53.7%
19364	Breast Reconstruction w/free flap [1]	62.0%
29881	Arthroscope Knee with Partial	80.1%
30520	Septoplasty or Submucous	79.8%
36415	Venipuncture for specimen	72.5%
43239	Endoscopy upper GI with biopsy	68.0%
45378	Colonoscopy Flex; Diagnosis	61.3%
45385	Colonoscopy Flex; w/removal	62.6%
50541	Laparoscopy - Surgical	70.7%
58150	Total Hysterectomy	73.5%
63030	Exc IV Disk Lumbar	77.7%
70553	MRI Brain; with and without contrast	66.7%
72148	Magnetic image - lumbar spine	71.3%
73721	MRI Lower Extremity	72.7%
76856	Ultrasound, Pelvic - Complete	74.1%
77431	Weekly Radiation Therapy	71.1%
78465	Myocardial Perfusion Imaging	65.8%
80053	Comprehensive Metabolic Panel	60.2%
80061	Lipid Profile	41.9%
88305	Surgical Pathology - Level IV	67.4%
90782	Injection of Medication	82.6%
93015	CV Stress Test	67.9%
93307	Echocardiography, Real Time	64.3%
97010	Hot or Cold Packs Therapy	0.0%
97014	Phys Med - Electrical Stimulation	60.7%
97035	Ultrasound	62.1%
97110	Therapeutic Procedures - Exercises	56.8%
97530	Kinetic Therapy	57.3%
97802	Medical Nutritional Therapy	54.6%
99024	Postoperative Followup Visit [1]	62.0%
99070	Special Supplies [1]	62.0%
99204	Office Visit New Patient - Moderate	42.7%
99205	Office Visit New Patient - Complex	42.5%
99212	Office Visit Established Patient - Minor	48.9%
99213	Office Visit Established Patient - Expanded	47.6%
99214	Office Visit Established Patient - Moderate	45.8%
99232	Hospital Visit - Moderate	54.5%
99233	Hospital Visit - Complex	56.1%
99243	Outpatient Consultation - Minor	50.2%
99244	Outpatient Consultation - Moderate	48.2%
99283	Emergency Department Visit - Moderate	77.0%
99284	Emergency Department Visit - Complex	76.2%

99285	Emergency Department Visit - Severe Urgency	76.9%
99291	Critical Care, First Hour	62.4%

[1] Represents default percentage. Default represents the aggregate discount of billed charges for all selected procedures in the time period.

Part D: Proposer's Discounts by Ancillary Provider						
Provider Type		**Contracted Providers**		**Reimbursement Methodology**		**Discount as a % of Billed Charges**
Durable Medical Equipment		Y		FFS		37.3%
Hospice Facilities		Y		Per Diem		8.6%
Home Health Care Agencies		Y		Per Visit/Per Hour		28.1%
Home IV Therapy Agencies[1]		Y		Per Diem + Drugs		44.1%
X-Ray Facilities[2]		Y		FFS		87.0%
Infusion Therapy Agencies		Y		Per Diem + Drugs		44.1%
Outpatient Surgery Facilities		Y		ASC Grouper		69.1%
Pathology Laboratories		Y		FFS		55.6%
Ambulance Services		Y		FFS		41.7%
MRI Facilities[2]		Y		FFS		87.0%
Lithotripsy[3]		Y		Case Rates		69.1%
Dialysis Centers		Y		Composite + FFS		76.4%
Cardiac Diagnostic Centers[2]		Y		Case Rates		87.0%
Physical Disability Rehabilitation Centers		Y		Inpt - Per Diem Outpatient - FFS		61.3%
Radiation Therapy[2]		Y		FFS		87.0%
Other - Please List						
Extended Care Unit Facility		Y		Per Diem		7.2%
Outpatient Medical Diagnostic Center Total		Y		FFS		87.0%
Public Health Department Total		Y		FFS		24.4%

[1] Utilization may be represented in "Infusion Therapy Agencies" provider type. Discount % based on "Infusion Therapy Agencies" provider type.

[2] Utilization may be represented in "Outpatient Medical Diagnostic Center" provider type. Discount % based on "Outpatient Medical Diagnostic Center" provider type.

[3] Utilization may be represented in "Outpatient Surgical Facilities" provider type. Discount % based on "Outpatient Surgical Facilities" provider type.

Part E: Proposer's Discounts by Region, City

	Hospitals			
	Acute Care	Physical Rehab	Mental Health	Other
East Tennessee	58.3%	55.6%	71.4%	42.3%
Middle Tennessee	42.7%	50.3%	63.1%	44.0%
West Tennessee	45.8%	57.0%	76.2%	30.5%
Rural Blend	58.4%	42.0%	69.6%	19.4%
Tri-Cities	61.1%	46.0%	77.2%	51.2%
Chattanooga	47.1%	51.7%	70.1%	44.1%
Knoxville	49.0%	63.6%	85.8%	46.9%
Nashville	29.6%	34.1%	63.4%	41.3%
Clarksville	37.3%	60.0%	69.9%	52.6%
Memphis	38.7%	55.8%	76.4%	44.1%

	Physicians			
	Primary Care	OBGYN	Specialists	Ancillary
East Tennessee	48.7%	57.9%	65.4%	48.2%
Middle Tennessee	52.4%	60.0%	65.3%	47.1%
West Tennessee	54.3%	61.5%	65.3%	42.8%
Rural Blend	47.0%	69.6%	42.6%	42.0%
Tri-Cities	50.5%	57.8%	65.5%	53.9%
Chattanooga	48.9%	58.4%	66.8%	36.0%
Knoxville	47.6%	59.0%	65.1%	49.3%
Nashville	50.6%	59.9%	67.7%	57.4%
Clarksville	46.7%	64.9%	67.2%	10.8%
Memphis	55.8%	61.1%	66.1%	41.8%

Contract Attachment B
Performance Guarantees

The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the life of the contract.

1. Eligibility Determination	
Guarantee	The Contractor shall determine eligibility of potential members within an average of five business days from (a) receipt of a completed and signed application and authorization for premium payment to (b) mailing of eligibility notice. In addition, for 99% of cases, the Contractor shall determine eligibility and send written notice within 20 business days from receipt of a completed and signed application and authorization for premium payment.
Definition	Eligibility determination will be measured from (a) date of receipt of a completed and signed application and authorization of premium payment to (b) mailing of eligibility notice (see Section A.4.15).
Assessment	Should the above standard not be met, the total amount shall be **$1,000** per quarter in which the standard is not met.
Compliance Report	The Compliance Report is the quarterly internal audit performed by the Contractor. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
2. Member ID Card Distribution	
Guarantee	Member ID cards shall be distributed (defined as "mailed") to a minimum of 95% of members within ten calendar days after the date of eligibility determination.
Definition	The actual distribution of a minimum of 95% of all member ID cards by the specified dates.
Assessment	Should the above standard not be met, the total amount shall be **$5,000** per year in which the standard is not met.
Compliance Report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.
3. Member Handbooks and Provider Network Directories Distributed	
Guarantee	Member Handbooks and Provider Directories shall be distributed to new members no later than 20 calendar days after the date of eligibility determination. Member Handbooks and Provider Network Directories shall also be distributed no later than 20 calendar days after the annual enrollment period.
Definition	Member Handbook and Provider Network Directories will be measured based on date of distribution.
Assessment	Should either of the above listed documents not be distributed as required, the total assessment shall be **$5,000** per year in which the standard is not met.
Compliance Report	The Compliance Report reported by the Contractor to the Division of Insurance Administration Plan operations. Annual guarantee is measured, reported, and reconciled annually.

4. Provider/Facility Network Accessibility		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network will assure that 95% of all members will have the Access Standard indicated.	
Definition	**Provider Group**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Acute Care Hospitals	1 facility within 30 miles
	Pharmacies	1 pharmacy within 30 miles
Assessment	**$10,000** if ANY of the above listed standards is not met, either individually or in combination, starting in CY 2008.	
Compliance Report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The guarantee is measured, reported and reconciled annually starting in the second year.	
5. Claims Payment Dollar Accuracy		
Guarantee	The average quarterly financial accuracy for claims payments will be 95% or higher.	
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors divided by the total paid value of Contractor audited dollars paid.	
Assessment	**$500** for each full percentage point below 95% for each contracted quarter.	
Compliance Report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.	
6. Claims Turnaround Time		
Guarantee	The average quarterly claims payment turnaround time will not be greater than: • 14 calendar days for 90% of **non-investigated (clean)** claims; and • 30 calendar days for 96% of **all** claims	
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays. Any claims that include subrogation will be excluded when calculating compliance with the "non-investigated claims" performance standard.	
Assessment	**Non-Investigated Claims (clean)**: **$200** for each full percentage point below the required minimum standard of 90% within 14 calendar days. Quarterly Guarantee. **All Claims**: **$200** for each full percentage point below the required minimum standard of 96% within 30 calendar days. Quarterly Guarantee.	
Compliance Report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.	

7. Telephone Response Time		
Guarantee	Ninety-five percent (95%) of incoming member services calls will be answered by a member services representative in 30 seconds or less.	
Definition	Telephone Response Time is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.	
Assessment	**$100** for each full second over the 30 second benchmark. Quarterly guarantee.	
Compliance Report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.	
8. Data Quality		
Guarantee	Data Quality is measured by the State's DSS vendor (Medstat). The Contractor's quarterly data submission to Medstat shall meet the following Data Quality measures.	
Definition	*Measure*	*Benchmark*
	Gender	Data missing for ≤ (less than or equal to) 3% of claims
	Date of birth	Data missing for ≤ 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for ≤ 5% of outpatient claims
	Outpatient provider type missing	Data missing for ≤ 1.5% of outpatient claims
	Date of birth	Data missing for ≤ 3% of members
	SSN	Data missing for ≤ 3% of members
	Total Premium	Data missing for ≤ 1.5% of members
Assessment	**$1,000** if ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance Report	Compliance Report consists of the MedStat Quarterly Data Quality report provided by MedStat. Performance measured and reported (by MedStat) quarterly; reconciled annually.	
9. Submission of Quarterly Data to DSS Vendor		
Guarantee	Quarterly claims data shall be submitted by the Contractor to the State's DSS vendor (MedStat) no later than the last day of the month following the end of each calendar quarter.	
Definition	Quarterly claims data is received by MedStat no later than the last day of the month following the end of each calendar quarter.	
Assessment	Failure to submit claims data no later than the last day of the month following the end of each quarter will result in an assessment of **$100** per day to a maximum of **$5,000** per quarter.	
Compliance Report	Compliance reporting submitted by MedStat upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.	

Contract Attachment C
Management Reporting Requirements

As required by Contract Section A.13, the Contractor shall submit Management Reports by which the State can assess the CoverTN program's general activity and usage. Reports shall be submitted electronically, and shall be of the type and at the frequency indicated below. Management Reports shall include:

1) **Performance Guarantee Tracking**, as detailed at Contract Attachment B (each component to be submitted at the frequency indicated), shall include:
   - Status report narrative
   - Detail report on each performance measure by appropriate time period

2) **Quarterly Network Changes Update Report**, submitted electronically.

Contract Attachment D
Premium Amounts for CY 2007

Total Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 103.00	$ 113.00	$ 123.00	$ 133.00
30-39	$ 126.00	$ 139.00	$ 146.00	$ 159.00
40-49	$ 155.00	$ 170.00	$ 175.00	$ 190.00
50-59	$ 189.00	$ 208.00	$ 209.00	$ 228.00
60-64	$ 216.00	$ 238.00	$ 236.00	$ 258.00
65+	$ 253.00	$ 278.00	$ 273.00	$ 298.00

State Share of Premium Amounts by Premium Group

Age	Does not use Tobacco		Uses Tobacco	
	Normal Weight	*Obese*	*Normal Weight*	*Obese*
Under 30	$ 34.33	$ 37.67	$ 41.00	$ 44.33
30-39	$ 42.00	$ 46.33	$ 48.67	$ 53.00
40-49	$ 51.67	$ 56.67	$ 58.33	$ 63.33
50-59	$ 63.00	$ 69.33	$ 69.67	$ 76.00
60-64	$ 72.00	$ 79.33	$ 78.67	$ 86.00
65+	$ 84.33	$ 92.67	$ 91.00	$ 99.33

Contractor's administrative component of the premium amounts: $9.50 per member per month

Contract Attachment E
Attestation Re Personnel Used in Contract Performance

SUBJECT CONTRACT NUMBER:	#317.30-041
CONTRACTOR LEGAL ENTITY NAME:	BlueCross Blue Shield of TN
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	62-0427913

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this contract.

SIGNATURE & DATE: Ronald E. Hall Jan 10, 2007

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

Contract Attachment F

HIPAA BUSINESS ASSOCIATE AGREEMENT TO COMPLY WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Department of Finance and Administration** (hereinafter "Covered Entity") and **BlueCross BlueShield of Tennessee** (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts"

- [contract number(s)] to be determined

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information (defined in Section 1.8 below). Said Service Contracts are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard "Protected Health Information" and, therefore, make this Agreement.

DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.501 and 164.504.

1.2 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.3 "Electronic Protected Health Care Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.6 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.7 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.8 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.9 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.10 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose Protected Health Information other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 Business Associate agrees to use appropriate procedural, physical, and electronic safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement. Said safeguards shall include, but are not limited to, requiring employees to agree to use or disclose Protected Health Information only as permitted or required by this Agreement and taking related disciplinary actions for inappropriate use or disclosure as necessary.

2.3 Business Associate shall require any agent, including a subcontractor, to whom it provides Protected Health Information received from, created or received by, Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5 Business Associate agrees to require its employees, agents, and subcontractors to promptly report, to Business Associate, any use or disclosure of Protected Health Information in violation of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement

2.6 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to provide access, at the request of Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 15 business days from Covered Entity notice to provide access to, or deliver such information.

2.7 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least 15 business days from Covered Entity notice to make an amendment.

2.8 Business Associate agrees to make its internal practices, books, and records including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health and Human Services or the Secretary's designee, in a time and manner designated by the

Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.9 Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of Protected Health Information in accordance with 45 CFR § 164.528.

2.10 Business Associate agrees to provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 15 business days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the Protected Health Information was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure.

2.11 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of Protected Health Information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, Protected Health Information shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for Protected Health Information from Covered Entity.

2.12 Business Associate agrees to adequately and properly maintain all Protected Health Information received from, or created or received on behalf of, Covered Entity

2.13 If Business Associate receives a request from an Individual for a copy of the individual's Protected Health Information, and the Protected Health Information is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for Protected Health Information in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.14 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

3.4 Business Associate agrees to require its employees, agents, and subcontractors to report to Business Associate within five (5) business days, any Security Incident (as that term is defined in 45 CFR Section 164.304) of which it becomes aware. Business Associate agrees to promptly report any Security Incident of which it becomes aware to Covered Entity.

3.5 Business Associate agrees to make its internal practices, books, and records including policies and procedures relating to the security of electronic protected health information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health and Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

4 PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contracts, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any Protected Health Information to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of Protected Health Information and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the Protected Health Information is breached.

4.4 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1)

5 OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of Protected Health Information.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of Protected Health Information.

6 PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7 TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1 This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1 provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2 if Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3 If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health and Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1 Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

7.3.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is unfeasible, Business Associate shall extend the protections of this Memorandum to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such Protected Health Information.

8 MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and /or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Memorandum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
Name: M.D. Goetz, Jr.
Title: Commissioner of the Department of Finance and Administration, State of Tennessee
Address: 312 8th Avenue, North
Nashville, Tennessee 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email: dave.goetz@state.tn.us

BUSINESS ASSOCIATE:
Name: Tena Roberson
Title: Director, Legal Services & Assoc. General Counsel
Address: BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
Phone: (423) 535-5158
Fax: 423-535-4576
Email: tena_roberson@bsbst.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom

or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

IN WITNESS WHEREOF,

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Tena Roberson 1/11/07

TENA ROBERSON, DIRECTOR LEGAL SERVICES **DATE:**

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M.D. Goetz Jr. 1-12-07

M.D. GOETZ, JR., COMMISSIONER **DATE:**