

CONTRACT #7
RFS # 317.86-00015
FA # 07-17111-00

Finance & Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of
Tennessee - PPO



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 2600
Nashville, Tennessee 37243

RECEIVED

AUG 11 2009

FISCAL REVIEW

Dave Goetz
COMMISSIONER

Phone: 615.741.4517
Fax: 615.253.8556

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Brian Haile, Deputy Executive Director, Benefits Administration 

Date: August 11, 2009

RE: Amendment Two to the BlueCross BlueShield of Tennessee contract Edison Contract number 2041 (previously FA-07-17111-00)

The enclosed contract amendment between the State, Local Education and Local Government Insurance Committees and BlueCross BlueShield of Tennessee was approved by the Committees on March 31, 2009. The amendment extends the contract with BlueCross and BlueShield of Tennessee (BCBST) to provide administrative services to the state sponsored PPO plan serving the entire Tennessee service area. The contract is extended to January 31, 2012 to provide for one year (1/1/10 through 12/31/10) of administration for the PPO benefits with no increase in administrative fees and, for an additional one year and one month (1/1/11 through 1/31/12) period to provide for payment of run out claims. Contract also allows for the carving out of the pharmacy benefits to a new pharmacy benefit manager during the second or third quarter of 2010.

The option to extend the contract for an additional year was included within the original contract and the Contractor has agreed to maintain the administrative fees at the amount in effect during the calendar year 2009 for calendar year 2010. The amendment continues the provision of the PPO plan option for the State of Tennessee service area. Also, the extension of the contract with BCBST is consistent with the state insurance committees planning effort for the redesign and subsequent implementation of the state sponsored health plan benefits.

The base contract is included, all revisions to the contract summary sheet, amendment #1, the signed non-competitive amendment request and the supplemental documentation required for the Fiscal Review Committee.

Thank you for your consideration of this request.

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Marlene Alvarez	*Contact Phone:	615.253.8358
*Contract Number:	Edison ID# 2041 (was FA-07-17111)	*RFS Number:	31786-00015 (formerly 31786-05007)
*Original Contract Begin Date:	01.01.2007	*Current End Date:	12.31.2009
Current Request Amendment Number: <i>(if applicable)</i>		# 2	
Proposed Amendment Effective Date: <i>(if applicable)</i>		12.01.2009	
*Department Submitting:		Finance & Administration	
*Division:		Benefits Administration	
*Date Submitted:		August 11, 2009	
*Submitted Within Sixty (60) days:		Yes	
<i>If not, explain:</i>			
*Contract Vendor Name:		BlueCross BlueShield of Tennessee – PPO	
*Current Maximum Liability:		\$45,000,000	
*Current Contract Allocation by Fiscal Year: (as Shown on Most Current Contract Summary Sheet)			
FY: 2007	FY: 2008	FY: 2009	FY: 2010
\$11,900,000	\$11,900,000	\$13,450,000	\$7,750,000
*Current Total Expenditures by Fiscal Year of Contract: (attach backup documentation from STARS or FDAS report)			
FY: 2007	FY: 2008	FY: 2009 YTD	FY:
\$5,586,987.00	\$10,780,286.50	\$11,416,454.50	
<p>IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:</p>		<p>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. Monthly funding of contract expenditures is obtained, on an as needed basis, from each separate plan funds (State Fund 55, Local Education Fund 56, and Local Government Fund 58). Plan fund revenues are obtained primarily from employer and employee premiums, which are annually set by the committees, and utilized for paying all health plan fund expenses (claims, and administrative expenses, etc.), and can only be utilized for that purpose.</p>	
<p>IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:</p>		<p>Under TCA –Title 8: Chapter 27-102 (a), 301 (b), and 207 (d) the State, Local Education and Local Government insurance committees have the</p>	

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		<p>authority to enter into contracts with insurance companies, claims administrators, and other organizations for some or all of the insurance benefits or services, including actuarial and consulting advice for the purpose of administering the state sponsored basic health plans. Monthly funding of contract expenditures are obtained, on an as needed basis, from each separate plan fund (State Fund 55, Local Education Fund 56, and Local Government Fund 58). By approving the one year contract extensions, the insurance committees have authorized the payment of expenses from the funds for the additional one year extension. The present estimated maximum liability of the contract is changed based on the estimate of the additional one year expenses due to the contract extension. These contracts are in allotment code 317.86 that is an off-line code and does not submit carry-forward letters. The insurance funds are billed each month and they each carry a fund balance which can be found on the Comprehensive Annual Financial Report (CAFR).</p>	
<p>IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:</p>		<p>Not applicable</p>	
*Contract Funding Source/Amount:	State:	Federal:	
Interdepartmental:	\$45,000,000	Other:	
<p>If "other" please define:</p>			
<p>Dates of All Previous Amendments or Revisions: <i>(if applicable)</i></p>		<p>Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i></p>	
<p>December 2007 - Revision</p>		<p>Re-allocate funds to establish retiree funds codes 51, 52 and 53 as required by Comprehensive Annual Financial Report (CAFR) of the State of Tennessee.</p>	
<p>July 30, 2008 – Revision</p>		<p>Re-allocation of funds</p>	
<p>December 2008 – Amendment # 1</p>		<p>Adds physician pre-certification for high tech imaging diagnostic services and adds Edison responsibilities. Modified reporting requirements.</p>	
<p>Method of Original Award: <i>(if applicable)</i></p>		<p>RFP</p>	
<p>Include a detailed breakdown of the actual expenditures anticipated in each year of the contract. Include specific line items, source of funding, and disposition of any excess fund. <i>(if applicable)</i></p>		<p>See attached – "BCBST Payments Since Inception as of FY 2009"</p>	
<p>Include a detailed breakdown, in dollars, of any savings that the department anticipates will result from this contract. Include, at a minimum, reduction in positions, reduction in</p>		<p>No specific dollar amount of savings is anticipated as a result from this contract amendment.</p>	

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equipment costs, reduction in travel. (if applicable)	
Include a detailed analysis, in dollars, of the cost of obtaining this service through the proposed contract as compared to other options. (if applicable)	This contract is in the third year of the term of the contract. Expenditures for the current year and the extension year of the contract are attached and are based on estimated member enrollment.

BCBST PPO PAYMENTS SINCE INCEPTION

as of FY 2009

STARS Contract Number: FA0717111

Edison Contract Number: 2041

Fiscal Year	Total Payments
2007	5,586,987.00
2008	10,780,286.50
YTD 2009	<u>11,416,454.50</u>
Total	<u><u>27,783,728.00</u></u>

Estimated Expenditures for Administrative Fees for BCBST for Calendar Years 2009 and 2010

	PPO		PPO Limited	
	Estimated	Admin fees	Estimated	Admin fees
	monthly members	(\$12.25 2009) (\$12.25 2010)	monthly members	(\$12.25 2009) (\$12.25 2010)
STATE PLAN:				
Jan-09	45,149	\$ 553,075.25	-	\$ -
Feb-09	45,008	\$ 551,348.00	-	\$ -
Mar-09	44,841	\$ 549,302.25	-	\$ -
Apr-09	44,844	\$ 549,339.00	-	\$ -
May-09	44,534	\$ 545,541.50	-	\$ -
Jun-09	44,356	\$ 543,361.00	-	\$ -
Jul-09	45,000	\$ 551,250.00	-	\$ -
Aug-09	45,000	\$ 551,250.00	-	\$ -
Sep-09	45,000	\$ 551,250.00	-	\$ -
Oct-09	45,000	\$ 551,250.00	-	\$ -
Nov-09	45,000	\$ 551,250.00	-	\$ -
Dec-09	45,000	\$ 551,250.00	-	\$ -
Jan-10	45,000	\$ 551,250.00	-	\$ -
Feb-10	45,000	\$ 551,250.00	-	\$ -
Mar-10	45,000	\$ 551,250.00	-	\$ -
Apr-10	45,000	\$ 551,250.00	-	\$ -
May-10	45,000	\$ 551,250.00	-	\$ -
Jun-10	45,000	\$ 551,250.00	-	\$ -
Jul-10	45,000	\$ 551,250.00	-	\$ -
Aug-10	45,000	\$ 551,250.00	-	\$ -
Sep-10	45,000	\$ 551,250.00	-	\$ -
Oct-10	45,000	\$ 551,250.00	-	\$ -
Nov-10	45,000	\$ 551,250.00	-	\$ -
Dec-10	45,000	\$ 551,250.00	-	\$ -
LOCAL EDUCATION PLAN:				
	Estimated	Admin fees	Estimated	Admin fees
	monthly members	(\$12.25 2009) (\$12.25 2010)	monthly members	(\$12.25 2009) (\$12.25 2010)
Jan-09	34,962	\$ 428,284.50	-	\$ -
Feb-09	34,869	\$ 427,145.25	-	\$ -
Mar-09	34,794	\$ 426,226.50	-	\$ -
Apr-09	34,745	\$ 425,626.25	-	\$ -
May-09	34,674	\$ 424,756.50	-	\$ -
Jun-09	34,800	\$ 426,300.00	-	\$ -
Jul-09	34,800	\$ 426,300.00	-	\$ -
Aug-09	34,800	\$ 426,300.00	-	\$ -
Sep-09	34,800	\$ 426,300.00	-	\$ -
Oct-09	34,800	\$ 426,300.00	-	\$ -
Nov-09	34,800	\$ 426,300.00	-	\$ -
Dec-09	34,800	\$ 426,300.00	-	\$ -
Jan-10	34,800	\$ 426,300.00	-	\$ -
Feb-10	34,800	\$ 426,300.00	-	\$ -
Mar-10	34,800	\$ 426,300.00	-	\$ -
Apr-10	34,800	\$ 426,300.00	-	\$ -
May-10	34,800	\$ 426,300.00	-	\$ -
Jun-10	34,800	\$ 426,300.00	-	\$ -
Jul-10	34,800	\$ 426,300.00	-	\$ -
Aug-10	34,800	\$ 426,300.00	-	\$ -
Sep-10	34,800	\$ 426,300.00	-	\$ -
Oct-10	34,800	\$ 426,300.00	-	\$ -
Nov-10	34,800	\$ 426,300.00	-	\$ -
Dec-10	34,800	\$ 426,300.00	-	\$ -
LOCAL GOVERNMENT PLAN:				
	Estimated	Admin fees	Estimated	Admin fees
	monthly members	(\$12.25 2009) (\$12.25 2010)	monthly members	(\$12.25 2009) (\$12.25 2010)
Jan-09	3,880	\$ 47,530.00	2,129	\$ 26,080.25
Feb-09	3,835	\$ 46,978.75	2,210	\$ 27,072.50
Mar-09	3,815	\$ 46,733.75	2,235	\$ 27,378.75
Apr-09	3,835	\$ 46,978.75	2,283	\$ 27,966.75
May-09	3,819	\$ 46,782.75	2,405	\$ 29,461.25
Jun-09	3,721	\$ 45,582.25	2,397	\$ 29,363.25
Jul-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Aug-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Sep-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Oct-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Nov-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Dec-09	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Jan-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Feb-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Mar-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Apr-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
May-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Jun-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Jul-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Aug-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Sep-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Oct-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Nov-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25
Dec-10	3,800	\$ 46,550.00	2,225	\$ 27,256.25

CONTRACT GRAND TOTALS:

\$ 24,564,692.25

\$ 657,935.25

(These are the estimated admin fee pmts only; does not include the value of any payments under the risk share arrangements)

NON-COMPETITIVE AMENDMENT REQUEST:**RECEIVED**

APPROVED

AUG 11 2009

FISCAL REVIEW

Commissioner of Finance & Administration

1) RFS #	31786 - 00015 (formerly 317.86-050-07)	
2) Procuring Agency :	Finance & Administration, Benefits Administration	
EXISTING CONTRACT INFORMATON		
3) Service Caption :	Self insured Preferred Provider Organization (PPO)	
4) Contractor :	BlueCross BlueShield of Tennessee, Inc.	
5) Contract #	Edison ID # 2041 (formerly FA-07-17111-00)	
6) Contract Start Date :	January 1, 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)	\$45,000,000	
PROPOSED AMENDMENT INFORMATON		
9) Amendment #	# 2	
10) Amendment Effective Date : (attached explanation required if < 60 days after F&A receipt)	December 1, 2009	
11) PROPOSED Contract End Date : (if ALL options to extend the contract are exercised)	January 31, 2012	
12) PROPOSED Maximum Cost : (if ALL options to extend the contract are exercised)	\$54,000,000	
13) Approval Criteria : (select one)	<input checked="" type="checkbox"/> use of Non-Competitive Negotiation is in the best interest of the state <input type="checkbox"/> only one uniquely qualified service provider able to provide the service	
14) Description of the Proposed Amendment Effects & Any Additional Service :		
<p>The amendment extends the contract with BlueCross and BlueShield of Tennessee (BCBST) to provide administrative services to the state sponsored PPO plan serving the entire Tennessee service area. The contract is extended to January 31, 2012 to provide for one year (1/1/10 through 12/31/10) of administration for the PPO benefits with no increase in administrative fees and, for an additional one year and one month (1/1/11 through 1/31/12) period to provide for payment of run out claims. Contract also allows for the carving out of the pharmacy benefits to a new pharmacy benefit manager during the second or third quarter of 2010.</p>		
15) Explanation of Need for the Proposed Amendment :		
<p>The option to extend the contract for an additional year was included within the original contract and the Contractor has agreed to maintain the administrative fees at the amount in effect during the calendar year 2009 for calendar year 2010. The amendment continues the provision of the PPO plan option for the State of Tennessee service area. Also, the extension of the contract with BCBST is consistent with the state insurance committees planning effort for the redesign and subsequent implementation of the state sponsored health plan benefits.</p>		
16) Name & Address of Contractor's Current Principal Owner(s) : (not required for a TN state education institution)		
<p>BlueCross BlueShield of Tennessee, Inc. 801 Pine Street Chattanooga, Tennessee 37402</p>		

17) Office for Information Resources Endorsement : (required for information technology service; n/a to THDA)	
Documentation is ...	<input checked="" type="checkbox"/> Not Applicable to this Request <input type="checkbox"/> Attached to this Request
18) eHealth Initiative Endorsement : (required for health-related professional, pharmaceutical, laboratory, or imaging service)	
Documentation is ...	<input checked="" type="checkbox"/> Not Applicable to this Request <input type="checkbox"/> Attached to this Request
19) Department of Human Resources Endorsement : (required for state employees training service)	
Documentation is ...	<input checked="" type="checkbox"/> Not Applicable to this Request <input type="checkbox"/> Attached to this Request
20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :	
No procurement alternatives were sought. Benefits Administration and the State Insurance Committees are in agreement with the extension of the contract with no increase in administrative fees and favorable risk sharing trend factor of 9.1% negotiated with the Contractor. A contract extension also removes the Contractor's responsibility for administering the pharmacy benefits. The term extension is appropriate and in the best interest of the State and its' employees.	
21) Justification for the Proposed Non-Competitive Amendment :	
The maintenance of the present administrative fees and carve out of the pharmacy benefits in addition to the favorable risk sharing arrangement negotiated with the Contractor are acceptable to the State. The extension of the contract for the additional period is also necessary in order to provide Benefits Administration and the State Insurance Committees the time necessary to implement new plan redesigns for plan year 2011.	
AGENCY HEAD SIGNATURE & DATE : (<u>must</u> be signed & dated by the <u>ACTUAL</u> 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)	
SIGNATURE & DATE	 7/31/09



C O N T R A C T A M E N D M E N T

Agency Tracking # 31786-00015 (formerly 31786-05007)	Edison ID 2041	Contract # FA-07-17111-00	Amendment # 2
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Contractor Blue Cross Blue Shield of Tennessee	Contractor Federal Employer Identification or Social Security # <input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 62-0427913
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Amendment Purpose/ Effects
 Amendment extends term to January 31, 2012; defines the PMPM Administrative Fee for CY 2010; defines the Target Claims/Trend Costs for CY 2010; carves out the pharmacy benefit as of April 2010; and defines the Contractor's responsibilities for claims during the last thirteen months of the contract term ("run-out period").

Contract Begin Date January 1, 2007	Contract End Date December 31, 2012	Subrecipient or Vendor <input type="checkbox"/> Subrecipient <input checked="" type="checkbox"/> Vendor	CFDA #(s)
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FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			\$11,900,000.00		\$11,900,000.00
2008			\$11,900,000.00		\$11,900,000.00
2009			\$13,450,000.00		\$13,450,000.00
2010			\$11,750,000.00		\$11,750,000.00
2011			\$5,000,000.00		\$5,000,000.00
TOTAL:			\$54,000,000.00		\$54,000,000.00

American Recovery and Reinvestment Act (ARRA) Funding – YES NO

— COMPLETE FOR AMENDMENTS —			Agency Contact & Telephone # Marlene Alvarez – Manager of Procurement & Contracting Tennessee Department of Finance & Administration, Benefits Administration 312 Rosa L Parks Avenue, Suite 2600 Nashville, Tennessee 37243 615.253.8358	
END DATE AMENDED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			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)	
FY	Base Contract & Prior Amendments	THIS Amendment ONLY		
2007	\$11,900,000.00			
2008	\$11,900,000.00			
2009	\$13,450,000.00			
2010	\$7,750,000.00	4,000,000.00		
2011		5,000,000.00	Speed Code Multiple funds apply	Account Code 78901000
TOTAL:	\$45,000,000.00	9,000,000.00		

— OCR USE —

Procurement Process Summary (non-competitive, FA- or ED-type only)

The original contract (FA-07-17111) was procured through the RFP process.

**AMENDMENT TWO
TO CONTRACT # FA-07-17111-00 (Edison ID # 2041)**

This Contract Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, 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 text of Contract Section A.3.2. is deleted in its entirety and replaced with the following:
 - A.3.2. Retail and Mail Order Claims Adjudication – the Contractor shall:
 - Adjudicate and process all electronic point of sale and paper retail and mail order pharmacy claims incurred through March 31, 2010 or as otherwise determined by the State in strict accordance with the State Pharmacy Benefits as contained in the State Plan Document (Appendix 7.3 of RFP #317.86-035).
 - 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 subscriptions.
 - Make efforts to recover overpayments and reimburse underpayments to the State in accordance with applicable law and any applicable State polices regarding the collection of overpayment and reimbursement of underpayment.
 - Have the ability to refill mail order prescriptions online through the website, by telephone, or by mail, subject to compliance with all applicable federal and state laws and regulations.

2. The text of Contract Section A.5.13. is deleted in its entirety and replaced with the following:
 - A.5.13. For the time period beginning January 1, 2011, 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 prior term period of this contract with no additional administrative cost to the State. The Contractor shall process incurred claims, at no additional cost to the State, in one of the two following ways: (1) in the event of a premature contract termination, for thirteen (13) months following the termination date of the contract; or (2) in the event of a normal contract termination, for the last thirteen (13) months of the term of the contract. The Contractor shall continue to provide services to any covered participant, should this contract terminate or be canceled, who is hospitalized on the effective date of termination or cancellation. Said coverage shall discontinue when the member is discharged from the hospital.

3. The text of Contract Section A.8.6. is deleted in its entirety and replaced with the following:
 - A.8.6. The Contractor is required to transmit medical and prescription drug claims to the State's current healthcare decision support system (DSS) vendor on a quarterly basis or more frequently as mutually agreed to by both parties during and following the term of this contract, until all claims incurred during the term of this contract have been paid or until time period under A.5.13. is exhausted. Data shall be submitted in the format detailed in Appendix 7.7. of RFP #317.86-035. The Contractor shall ensure that all claims processed for payment have complete ICD-9 and CPT4 codes and valid provider identifications.

For each quarter of the contract term, and any extensions thereof, claims data must meet the quality standards detailed in Contract Attachment A, Performance Guarantee # 9, as determined the by the State's healthcare claims data management vendor.

The Contractor will work with the State's DSS vendor to identify a mutually-agreeable data format similar to the format detailed in Appendix 7.7 of RFP # 317.86-035 for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The State's current DSS vendor currently charges a maximum of \$30,000 per new contractor. Furthermore, the Contractor will 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, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this contract.

Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter. Failure to submit data by the deadline will result in an assessment against the Contractor in the amount of \$100 per day for the first and second working days past the compliance date, and \$500.00 for each working day thereafter, to a maximum of \$10,000 per quarter. Compliance reporting submitted by the State's data management vendor upon receipt of quarterly claims data will be used to measure performance. Performance is measured, reported and reconciled quarterly.

4. The text of Contract Section B. is deleted in its entirety and replaced with the following:
 - B.1. This contract shall be effective for the period commencing on January 1, 2007 and ending on January 31, 2012. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.
5. The text of Contract Section C.1. is deleted in its entirety and replaced with the following:
 - C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Fifty-Four Million Dollars (\$54,000,000.00). 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.

6. The text of Contract Section C.3. is deleted in its entirety and replaced with the following:
 - C.3. Payment Methodology. The Contractor shall be compensated based on the rates herein for services authorized by the State in a Total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones

defined in Section A. The contractor shall be compensated based upon the following PMPM Rates.

PMPM Rates by Plan Type and Calendar	PMPM 2007	PMPM 2008	PMPM 2009	PMPM 2010
State Plan	\$9.50	\$9.50	\$12.25	\$12.25
Local Education Plan	\$9.50	\$9.50	\$12.25	\$12.25
Local Government Plan	\$9.50	\$9.50	\$12.25	\$12.25

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed services for the amount stipulated. The State shall compensate the contractor monthly for all services outlined in this contract, At the PMPM rates indicated, based on the number of members certified by the State to the Contractor. This information is referenced in A.5.13.

- C.3.1. The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim:	State's Cost per Claim:
Professional Claim	\$4.00
Institutional Claim	\$9.75
Claim Based Access Fee Only if Charged by Host Plan	3.70% of the discount received from the Host Plan if required. Maximum of \$2,000 per claim.

All other fees related to the Blue Card Program, as described in Contract Attachment E Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment E. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.

Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter.

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

C.4. **Risk Sharing Agreement:** The Contractor agrees to the process for the calculation of the risk sharing agreement as illustrated in Contract Attachment C, Sample of Claims Trend Adjustment Calculation, and the following provisions of the risk sharing agreement:

C.4.1. **Risk Sharing PMPM Claims Cost Calculation:** The Contractor agrees that for the calculation of the PMPM claims cost for Base Year 2006 and the contract years 2007, 2008, and 2009 for use in determining the Risk Sharing Payment Provisions (Section C.4.3 below), will be as follows:

- The State, Local Education, and Local Government weighted PPO Cost PMPM claims will be totaled, for each year as indicated below.

Year	Claims, by plan	For claims incurred during	And paid during
2006 BASE YEAR	State, Local Education, and Local Government weighted PPO Cost Per Member Per Month (PMPM) claims	January 1, 2006 through December 31, 2006	January 1, 2006 through June 30, 2007
2007		January 1, 2007 through December 31, 2007	January 1, 2007 through June 30, 2008
2008		January 1, 2008 through December 31, 2008	January 1, 2008 through June 30, 2009
2009		January 1, 2009 through December 31, 2009	January 1, 2009 through June 30, 2010
2010		January 1, 2010 through December 31, 2010	January 1, 2010 through June 30, 2011

- Pharmacy claims will be excluded from the calculation for the 2010 Contract year.

C.4.2. Risk Sharing Guaranteed Trend Adjustment Percentages: The Contractor agrees that the following Guaranteed Claims Trend Adjustments percentages will be utilized in determining the Target Incurred PMPM cost during contracts years 2007, 2008 and 2009:

Contract Year	Contractor's Guaranteed Claims Trend Adjustment
2007	8.9%
2008	8.5%
2009	9.2%
2010	9.1%

- The Target Incurred PMPM cost will apply in determining the Risk Sharing Payment Provisions (Section C.4.3 below).

C.4.3. Risk Sharing Payment Provisions: The Contractor agrees to the Risk Sharing Payment Calculation as illustrated in Attachment C of this document, with the understanding that:

- Payments by the State to the Contractor, if any, shall not exceed \$3.00 Per Member Per Month (PMPM) per year during the term of the contract; and
- Payments by the Contractor to the State, if any, shall not exceed \$5.00 Per Member Per Month (PMPM) per year during the term of the contract.

C.4.4. Risk Sharing Settlement Date: The Contractor agrees that the settlement date for the Risk Sharing Payment Provisions (Section C.4.3 above) will be no later than Nine (9) months from the end of EACH contract year. For example, year four (calendar year 2010) will be settled no later than September 30, 2011.

C.4.5. Risk Sharing Adjustment: Should the State elect to modify the benefits as provided in the PPO option, the State and Contractor will work together and shall mutually agree to appropriately modify the risk sharing arrangement based on the impact of these changes on the claims experience for the year the changes are implemented.

8. The following provision is added as Contract Section A.3.9.:

A.3.9. Effective April 1, 2010, or on an alternate date as determined by the State, the State will exercise the option contained in Section A.3.8. of this Contract and carve out the

pharmacy benefit. The Contractor will no longer be responsible for administering the pharmacy benefits, except for pharmacy claims incurred prior to 12:00 A.M. on April 1, 2010, or on an alternate date as determined by the State. The Contractor will be given 60 days notice of any alternate date.

9. The following provision is added as Contract Section A.3.10.:

A.3.10. Effective April 1, 2010, or on an alternate date as determined by the State, the Contractor shall begin to accept weekly pharmacy claims data from the State's pharmacy benefits manager via secure medium. The data shall be in a mutually agreeable format.

10. The following provision is added as Contract Section A.3.11.:

A.3.11. At the State's request, the Contractor shall provide current member pharmacy data, via secure medium, to the State's new pharmacy benefit manager, within thirty (30) days of the request. The data may include, but is not limited to, current prior authorizations, overrides, and open refills (mail and retail). New Pharmacy Benefits Manager (PBM) will execute Contractor's standard Confidentiality Non-Disclosure Agreement (CNDA) before release of information, as required under this section.

The revisions set forth herein shall be effective December 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

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

**STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:**

M.D. GOETZ, JR., CHAIRMAN

DATE



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 Donna Rowland
Curtis Johnson David Shepard
Gerald McCormick Curry Todd
Mary Pruitt Eddie Yokley
Craig Fitzhugh, *ex officio*
Speaker Jimmy Naifeh, *ex officio*

Sen. Douglas Henry, Vice-Chairman
Senators

Bill Ketron Reginald Tate
Doug Jackson Jamie Woodson
Paul Stanley
Randy McNally, *ex officio*
Lt. Governor Ron Ramsey, *ex officio*

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

DATE: November 14, 2008

SUBJECT: **Contract Comments**
(Contract Services Subcommittee Meeting 11/12/08)

CC
BK

RFS# 317.86-050

Department: Finance & Administration/Benefits Administration

Contractor: BlueCross BlueShield of Tennessee (BCBS)

Summary: This vendor is responsible for providing self-insured Preferred Provider Organization (PPO) services for enrollees of the State Employee, Local Education and Local Government Plans. The proposed amendment changes references from TIS to Edison, requires certain non-routine diagnostic services at a cost of \$0.27 per member per month and requires various reports. The term of the contract as well as the maximum liability remain the same.

Maximum liability: \$45,000,000

Maximum liability w/amendment: \$45,000,000

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

cc: Ms. Laurie Lee, Executive Director, Benefits Administration
Mr. Robert Barlow, Director, Office of Contracts Review



RECEIVED

OCT 20 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: John Anderson, Director of Public Sector Plans, Benefits Administration

Date: October 20, 2008

RE: Amendment One to the BlueCross BlueShield of Tennessee contract for the purpose of adding services, effective January 1, 2009, for the review of diagnostic services for medical appropriateness and necessity in addition to Contractor responsibilities for the transmission of enrollment through Edison. Contract number FA-07-17111

The enclosed contract amendment between the State, Local Education and Local Government Insurance Committees and BlueCross BlueShield of Tennessee was approved by the Committees on July 31, 2008. Section A.2.7.3 of the contract allows for the addition of the proposed services. The addition of these services will increase the administrative by \$0.27 Per Member Per Month (PMPM). The Maximum Liability is sufficient to cover the addition of these services. Additional language within the contract amendment addresses the Contractor's responsibilities under the new Edison System.

The base contract is included, all revisions to the contract summary sheet, the signed non-competitive amendment request and the supplemental documentation required for the Fiscal Review Committee.

Thank you for your consideration of this request.

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Marlene Alvarez	*Contact Phone:	615.253.8358
*Contract Number:	FA-07-17111	*RFS Number:	317.86-050-07
*Original Contract Begin Date:	01.01.2007	*Current End Date:	12.31.2009
Current Request Amendment Number: <i>(if applicable)</i>		1	
Proposed Amendment Effective Date: <i>(if applicable)</i>		01.01.2009	
*Department Submitting:		Finance & Administration	
*Division:		Benefits Administration	
*Date Submitted:		October 20, 2008	
*Submitted Within Sixty (60) days:		Yes	
<i>If not, explain:</i>			
*Contract Vendor Name:		BlueCross BlueShield of Tennessee – PPO	
*Current Maximum Liability:		\$45,000,000.	
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Contract Summary Sheet)</i>			
FY: 2007	FY: 2008	FY: 2009	FY: 2010
\$11,900,000	\$11,900,000	\$13,450,000	\$7,750,000
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from STARS or FDAS report)</i>			
FY: 2007	FY: 2008	FY: 2009 YTD	FY:
\$5,586,987.00	\$10,780,286.50	\$3,458,522.00	\$
<p>IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:</p>		<p>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. Monthly funding of contract expenditures is obtained, on an as needed basis, from each separate plan funds (State Fund 55, Local Education Fund 56, and Local Government Fund 58). Plan fund revenues are obtained primarily from employer and employee premiums, which are annually set by the committees, and utilized for paying all health plan fund expenses (claims, and administrative expenses, etc.), and can only be utilized for that purpose.</p>	
<p>IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:</p>		<p>Under TCA –Title 8: Chapter 27-102 (a), 301 (b), and 207 (d) the State, Local Education and Local Government insurance committees have the authority to enter into contracts with insurance</p>	

Supplemental Documentation Required for
Fiscal Review Committee

		<p>companies, claims administrators, and other organizations for some or all of the insurance benefits or services, including actuarial and consulting advice for the purpose of administering the state sponsored basic health plans. Monthly funding of contract expenditures are obtained, on an as needed basis, from each separate plan fund (State Fund 55, Local Education Fund 56, and Local Government Fund 58). By approving the one year contract extensions, the insurance committees have authorized the payment of expenses from the funds for the additional one year extension. The present estimated maximum liability of the contract is changed based on the estimate of the additional one year expenses due to the contract extension. These contracts are in allotment code 317.86 that is an off-line code and does not submit carry-forward letters. The insurance funds are billed each month and they each carry a fund balance which can be found on the Comprehensive Annual Financial Report (CAFR).</p>	
<p>IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:</p>		<p>Not applicable</p>	
<p>*Contract Funding Source/Amount:</p>	<p>State:</p>	<p>Federal:</p>	
<p>Interdepartmental:</p>	<p>\$45,000,000</p>	<p>Other:</p>	
<p>If "other" please define:</p>			
<p>Dates of All Previous Amendments or Revisions: <i>(if applicable)</i></p>		<p>Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i></p>	
<p>November 2007 – Revision</p>		<p>Re-allocate funds to establish retiree funds codes 51, 52 and 53 as required by Comprehensive Annual Financial Report (CAFR) of the State of Tennessee.</p>	
<p>July 30, 2008 – Revision</p>		<p>Re-allocation of funds</p>	
<p>Method of Original Award: <i>(if applicable)</i></p>		<p>RFP</p>	

BLUE CROSS BLUE SHIELD OF TENNESSEE PPO CONTRACT PAYMENTS

FISCAL YEAR 2007

	STATE		LOCAL EDUCATION		LOCAL GOV'T		LOCAL LIMITED		COMBINED TOTAL
	Active	Retired	Active	Retired	Active	Retired	Active	Retired	
Jan-07	423,823.50	74,594.00	333,364.50	48,098.50	46,103.50	1,121.00	11,267.00	28.50	\$ 938,400.50
Feb-07	420,954.50	74,641.50	332,167.50	48,355.00	46,265.00	1,092.50	11,618.50	28.50	\$ 935,123.00
Mar-07	419,482.00	74,071.50	331,322.00	47,804.00	45,752.00	978.50	12,217.00	9.50	\$ 931,636.50
Apr-07	418,855.00	74,052.50	330,951.50	47,965.50	46,436.00	893.00	12,416.50	28.50	\$ 931,598.50
May-07	417,248.50	73,368.50	330,742.50	46,977.50	45,847.00	959.50	12,502.00	19.00	\$ 927,664.50
Jun-07	414,475.50	72,722.50	329,251.00	46,901.50	45,381.50	902.50	12,901.00	28.50	\$ 922,564.00
Total FY 2007	\$ 2,514,839.00	\$ 443,450.50	\$ 1,987,799.00	\$ 286,102.00	\$ 275,785.00	\$ 5,947.00	\$ 72,922.00	\$ 142.50	\$ 5,586,987.00

FISCAL YEAR 2008

	STATE		LOCAL EDUCATION		LOCAL GOV'T		LOCAL LIMITED		COMBINED TOTAL
	Active	Retired	Active	Retired	Active	Retired	Active	Retired	
Jul-07	414,295.00	73,026.50	329,460.00	46,749.50	45,752.00	883.50	13,727.50	28.50	\$ 923,922.50
Aug-07	410,219.50	73,558.50	328,947.00	47,120.00	43,994.50	817.00	14,069.50	28.50	\$ 918,754.50
Sep-07	409,649.50	74,176.00	326,610.00	49,086.50	45,809.00	788.50	14,212.00	28.50	\$ 920,360.00
Oct-07	410,827.50	73,672.50	325,783.50	50,549.50	45,590.50	779.00	14,079.00	28.50	\$ 921,310.00
Nov-07	411,397.50	72,874.50	325,707.50	50,483.00	44,878.00	722.00	14,525.50	28.50	\$ 920,616.50
Dec-07	408,329.00	72,675.00	323,190.00	50,131.50	44,346.00	731.50	14,620.50	28.50	\$ 914,052.00
Jan-08	395,665.50	71,630.00	308,275.00	48,963.00	40,299.00	712.50	15,893.50	47.50	\$ 881,486.00
Feb-08	393,015.00	71,991.00	308,123.00	48,279.00	40,831.00	684.00	16,093.00	66.50	\$ 879,082.50
Mar-08	393,005.50	71,801.00	307,657.50	48,668.50	40,052.00	712.50	15,950.50	57.00	\$ 877,904.50
Apr-08	393,357.00	71,696.50	308,009.00	47,766.00	40,318.00	722.00	16,140.50	57.00	\$ 878,066.00
May-08	391,837.00	71,411.50	307,819.00	47,405.00	39,947.50	741.00	16,131.00	57.00	\$ 875,349.00
Jun-08	390,497.50	71,012.50	305,035.50	46,806.50	38,969.00	760.00	16,273.50	28.50	\$ 869,383.00
Total FY 2008	\$ 4,822,095.50	\$ 869,525.50	\$ 3,804,617.00	\$ 582,008.00	\$ 510,786.50	\$ 9,053.50	\$ 181,716.00	\$ 484.50	\$ 10,780,286.50

FISCAL YEAR 2009

	STATE		LOCAL EDUCATION		LOCAL GOV'T		LOCAL LIMITED		COMBINED TOTAL
	Active	Retired	Active	Retired	Active	Retired	Active	Retired	
Jul-08	388,578.50	70,423.50	305,852.50	46,825.50	38,826.50	817.00	16,273.50	57.00	\$ 867,654.00
Aug-08	388,692.50	71,174.00	305,235.00	46,730.50	39,187.50	760.00	16,245.00	57.00	\$ 868,081.50
Sep-08	384,655.00	71,060.00	302,404.00	49,001.00	38,617.50	760.00	16,425.00	57.00	\$ 862,979.50
Oct-08	379,838.50	73,824.50	298,575.50	51,034.00	39,111.50	788.50	16,577.50	57.00	\$ 859,807.00
FYTD 2009	\$ 1,541,764.50	\$ 286,482.00	\$ 1,212,067.00	\$ 193,591.00	\$ 155,743.00	\$ 3,125.50	\$ 65,521.00	\$ 228.00	\$ 3,458,522.00

GRAND TOTAL \$ 19,825,795.50

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED

Commissioner of Finance & Administration
Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.

1) RFS #	317.86 - 050 - 07	
2) State Agency Name :	Finance & Administration	
EXISTING CONTRACT INFORMATION		
3) Service Caption :	Self insured Preferred Provider Organization (PPO)	
4) Contractor :	BlueCross BlueShield of Tennessee, Inc.	
5) Contract #	FA - 07 - 17111 - 00	
6) Contract Start Date :	January 1, 2007	
7) <u>Current</u> Contract End Date IF <u>all</u> Options to Extend the Contract are Exercised :	December 31, 2009	
8) <u>Current</u> Total Maximum Cost IF <u>all</u> Options to Extend the Contract are Exercised :	\$45,000,000	
PROPOSED AMENDMENT INFORMATION		
9) <u>Proposed</u> Amendment #	#.1	
10) <u>Proposed</u> Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	January 1, 2009	
11) <u>Proposed</u> Contract End Date IF <u>all</u> Options to Extend the Contract are Exercised :	December 31, 2009	
12) <u>Proposed</u> Total Maximum Cost IF <u>all</u> Options to Extend the Contract are Exercised :	\$45,000,000	
13) Approval Criteria : (select one)	<input checked="" type="checkbox"/>	use of Non-Competitive Negotiation is in the best interest of the state
	<input type="checkbox"/>	only one uniquely qualified service provider able to provide the service
14) Description of the Proposed Amendment Effects & Any Additional Service :		

The present contract with BlueCross and BlueShield of Tennessee (BCBST), reserves the right during the term of the Contract, for the State to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs. This contract amendment, effective January 1, 2009, would provide a review program requiring physicians to pre-certify, based on medical necessity criteria, all high-tech, diagnostic, imaging procedures. The provision of this new service would cost the State an additional administrative fee of \$0.27 PMPM. BCBST will guarantee the State an annual return on investment (ROI) equal to the cost of the service. Also, this amendment adds the Contractor's responsibilities for the transfer of plan enrollment information between the

State's Edison system.

15) Explanation of Need for the Proposed Amendment :

The contract with BCBST reserves the right, during the term of the Contract, for the State to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs that have demonstrated the ability to improve the health status of plan members and the effectiveness of the quality of care delivered. This amendment provides services, at an additional \$0.27 PMPM, that requires physicians to obtain pre-certification for out-patient, high-tech, diagnostic, imaging services. Pre-certification will encourage cost-effective imaging tests while maintaining high quality patient care. Also, the amendment is necessary to define the Contractor's responsibilities for the interface with the State's Edison system.

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
Chattanooga, Tennessee 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 :

Benefits Administration is in agreement with the increase in the PMPM administrative fee of \$0.27.PMPM providing for enhancement for the pre-certification review of outpatient, high-tech, diagnostic, imaging services including the guarantee of annual ROI. This amendment is appropriate and in the best interest of the State and its' employees.

21) Justification for the Proposed Non-Competitive Amendment :

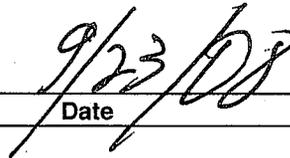
The modest increase of \$0.27 PMPM in the administrative fees providing the pre-certification review program, and the acceptance by the Contractor of the data interface requirements between Edison are acceptable to the State.

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



Date



FAX/EMAIL TRANSMITTAL

to Request OIR Procurement Endorsement

TO : Jane Chittenden, Director
OIR Procurement & Contract Management **FAX #** 741-6164

FROM : Marlene D. Alvarez, Procurement &
Contracting Manager **FAX #** 253-8556

DATE : October 14, 2008

RFS # 317.86 – 050 – 07

RE : Procurement Endorsement — BlueCross BlueShield of TN (PPO),
amendment transfer Contractor responsibilities from Tennessee
Insurance System (TIS) to Edison

INFORMATION SYSTEMS PLAN PROJECT: PROJECT NUMBER or N/A

NUMBER OF FAX PAGES (including cover) : 1

The nature and scope of service detailed in the attached service procurement document(s) appears to require Office for Information Resources (OIR) review and support, because the procurement involves information technology or information systems services.

This communication seeks to ensure that OIR is aware of the procurement and has an opportunity to review the matter. Please determine whether OIR is supportive of the procurement. If you have any questions or concerns about this matter, please call **Marlene D. Alvarez** at **615-253-8358**.

Please indicate below your response to this proposed procurement, and return this communication at your earliest convenience (note the return FAX number above).

Thank you for your help.

Attachment(s)

Must include the entire contract or amendment document and where applicable, the non-competitive contract or amendment request form. The original contract and any prior amendments that were applied to the same section of the contract must be provided with an amendment. Electronic copies of the contract, amendments, and request form without signature are acceptable.

RFP documents must be provided in electronic form.

OIR Endorsement :

Mark Buzgel (gs)

10/17/08

OIR Chief Information Officer

Date

CONTRACT SUMMARY SHEET

021908

RFS # 317 . 86 — 050 — 07	Contract # FA-07-17111-01
State Agency Finance and Administration	State Agency Division Benefits Administration
Contractor Name BlueCross BlueShield of Tennessee	Contractor ID # (FEIN or SSN) <input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 62-0427913

RECEIVED
JAN 13 2009
LOCAL REVIEW
COPY

Service Description
Self Insured Preferred Organization (PPO) administrative services for State, Local Education and Local Government members. Amendment adds physician pre-certification for high tech imaging diagnostic services and adds Edison responsibilities.

Contract Begin Date January 1, 2007	Contract End Date December 31, 2009	SUBRECIPIENT or VENDOR? Vendor	CFDA #
-----------------------------------------------	-----------------------------------------------	------------------------------------------	---------------

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
317.86	See detail	891	See detail		
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			\$11,900,000.00		\$11,900,000.00
2008			\$11,900,000.00		\$11,900,000.00
2009			\$13,450,000.00		\$13,450,000.00
2010			\$7,750,000.00		\$7,750,000.00
TOTAL:			\$45,000,000.00		\$45,000,000.00

COMPLETE FOR AMENDMENTS ONLY —			State Agency Fiscal Contact & Telephone #
FY	Base Contract & Prior Amendments	THIS Amendment ONLY	Maureen Abbey, Director – Office of Business and Finance 312 Rosa L. Parks Avenue, Suite 2000 Nashville, TN 37243-1102 615.741.6070
2007	\$11,900,000.00		State Agency Budget Officer Approval
2008	\$11,900,000.00		
2009	\$13,450,000.00		
2010	\$7,750,000.00		
TOTAL:	\$45,000,000.00		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)
End Date:	Dec. 31, 2009	Dec. 31, 2009	

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)

DIR/PCM
12-1-09

**AMENDMENT ONE
TO FA-07-17111-00**

This Contract Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, 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 text of Contract Section A.2.7. is deleted in its entirety and replaced with the following:
 - A.2.7. The Contractor, in consultation with the State, shall have in place on the contract effective date disease management programs, acceptable to the State, for the following chronic conditions: congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma. In addition to these disease management programs, the Contractor shall provide a program for high-risk pregnancies. The Contractor shall provide these disease management programs for those high cost, high prevalence diseases in the State-sponsored population, designed to optimize the health status of members therefore reducing the need for high cost medical intervention. The State reserves the right to review and comment on these programs. Failure to provide programs that meet the State's minimum standards will result in an assessment against the Contractor for payment to the State in the amount of \$75,000 for each program of each year of the contract term in which the Contractor fails to provide disease management programs meeting the minimum standards. At a minimum, each disease management program shall contain the following program components:
 - A Population identification process;
 - Evidence-based practice guidelines;
 - Collaborative practice models to include physician and support service providers;
 - Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
 - Process and outcomes measurement, evaluation, and management; and
 - Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).
 - A.2.7.1. The Contractor shall provide for each disease management program an evaluation methodology that is statistically valid and designed to measure program impact on health status, utilization of medical and pharmacy services and impact on the cost of care for the PPO plan members identified with the chronic condition. The evaluation methodology must be reviewed and approved by the State and its benefits consultant.
 - A.2.7.2. The Contractor shall provide a written report to the State, no less than semiannually, detailing plan member participation in each disease management program, and in addition, a written report to the State, no less than annually, with the results of the program evaluation referenced in A.2.7.1. An exception will be made for the first year's report, which shall be due by the end of the 15th month following implementation.
 - A.2.7.3. The State reserves the right during the term of the Contract to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs that have demonstrated the ability to improve the health status of plan members and effectiveness and quality of care delivered. Effective January 1, 2009, Contractor shall review certain non-routine diagnostic services and the setting for such services in regards to medical appropriateness and necessity before the services are performed. Services subject to such review include Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Positron Emission Tomography

(PET) scans, and nuclear cardiac imaging studies. Diagnostic and imaging services that are performed in the emergency room or as part of inpatient care will not require prior authorization and are excluded from review under this program. The cost to the State for the review of these high tech imaging procedures will be \$0.27 Per Member Per Month (PMPM) in additional administrative fees as contained in Section C.3.Payment Methodology. Contractor guarantees that the Return on Investment (ROI), measured annually and based on a methodology approved by the State's benefits consultant, for this service will cover the State's annual cost for the service.

A.2.7.4. To assure continuity of care, the Contractor shall, upon cancellation or termination of the contract for any reason, submit to the State a roster of Plan members who are, at the date termination is effective, receiving disease management services, together with all the identifying information and conditions that make the members' enrollment in the specified disease management program appropriate.

2. The text of Contract Section A.5.5. is deleted in its entirety and replaced with the following:

A.5.5. The State shall determine all Plan policies and benefits (see Appendix 7.3 of RFP # 317.86-035). Should the Contractor have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request a determination in writing. The State will then respond in writing making a determination within thirty (30) days. The Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

A.5.5.1. The State shall have the sole responsibility for and authority to clarify and/or revise the PPO benefits available under this program. It is understood between the parties that the program cannot and does not cover all medical situations. In a case where the benefits are not referenced in the PPO Plan Document or are not clear, the Contractor shall utilize their policies in adjudicating claims, and the Contractor shall advise the Division of Benefits Administration in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

3. The text of Contract Section A.5.14. is deleted in its entirety and replaced with the following:

A.5.14. 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 must 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 Benefits 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:

- discontinue further investigation if there is insufficient justification; or
- continue the investigation and report back to the Division of Benefits Administration and the Division of State Audit; or
- continue the investigation with the assistance of the Division of State Audit; or
- discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

4. The text of Contract Section A.7.5. is deleted in its entirety and replaced with the following:

A.7.5. The Contractor shall respond to all inquiries in writing from the Division of Benefits Administration within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

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

A.8. DATA AND SPECIFIC REPORTING REQUIREMENTS

The Contractor shall:

A.8.1. Maintain an electronic data interface with the State of Tennessee’s Edison System, for the purpose of processing State member enrollment information. The Contractor is responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of Protected Health Information (PHI) with the State of Tennessee, the State recommends the use of second level authentication. This is accomplished using the State’s standard software product which supports Public Key Infrastructure (PKI). The Contractor will agree to design a solution, in coordination with the State, to connect to the State’s SFTP server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor is expected, with adequate notice, to cooperate with the State to maintain the security of protected information according to all applicable State and Federal standards. Furthermore, the Contractor must adhere to the privacy and security regulations required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

A.8.1.1. Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State’s approval, as detailed below. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

A.8.2. Maintain, in its computer system, in-force enrollment records of all State plan participants. Specific additional obligations, relative to this requirement, are the following:

A.8.2.1. **Weekly Enrollment Update:** To ensure that State plan participants’ enrollment records remain accurate and complete, the Contractor commits to the following:

- to retrieve, via secure medium (see A.8.1.) weekly enrollment data electronic transfer files from the State, in the State’s Edison 834 file values (See Attachment G), for participants who are maintained in the State’s Edison System [files will include full population records for all participants and will be in the format of ANSI ASC X12.84, Benefit Enrollment and Maintenance (834), version 004010X095A1, with a few fields being customized by the state];
- to complete each of the following tasks by the indicated deadline:

Required Task	Deadline	Penalty for missed deadline
1. systematically process and update, via computer programs, the Contractor’s database, utilizing the State’s weekly enrollment file records	within three (3) <u>working</u> days of receipt of the files from the State	\$100.00 per day for the first (1 st) and second (2 nd) working days out of compliance; \$500.00 per working day thereafter
2. resolve all mismatches identified by the processing of the weekly files; “mismatches” are defined as: Any difference of values between the State’s and the Contractor’s databases.	within six (6) <u>working</u> days of receipt of the files from the State	\$100.00 per day for the first (1 st) and second (2 nd) working days out of compliance; \$500.00 per working day thereafter

- and to complete and submit to the State a *Weekly File Transmission Statistics*

Report (format to be provided by the State), within seven (7) working days of receipt of the weekly files. Submission of this report shall be via email to designated staff in Benefits Administration.

The Contractor shall also require of its subcontractors, as applicable, to maintain Weekly Enrollment Updates on a timely basis.

NOTE: Section A.8.2.1 shall be monitored by the State as Performance Guarantee # 7. (see Contract Attachment A).

- A.8.2.2. **State of Tennessee Enrollment Data Match:** Upon request by the State, not to exceed two (2) times annually, the Contractor shall submit to the State its full file of State enrollees, by which the State will conduct a data match against the State's Edison database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its data base of State members, as required by Sections A.8.2.1.

Failure by the Contractor to submit records, and in an agreed upon format, within fourteen (14) calendar days of the request from the State, shall result in a non-compliant penalty amount of \$10,000 per request.

Results of this match will be communicated to the Contractor, including any requirements – and associated timeframes – for resolving the discrepancies identified by the data match. Failure by the Contractor to resolve the discrepancies, within the specified timeframe(s) will result in a non-compliant penalty amount to the Contractor of \$10,000.

For the purpose of the requirements of this section, "mismatches" are defined as: Any difference of values between the State's and the Contractor's databases.

- A.8.3. Maintain a duplicate set of all records relating to the benefit payments in 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 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.8.4. Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.
- A.8.5. Annually provide the State with a GeoNetworks® report showing service and geographic access (see Contract Attachment A, Performance Guarantee # 8). 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 sixty (60) days from the date the Contractor was first notified of the problem.
- A.8.6. The Contractor is required to transmit medical and prescription drug claims to the State's current healthcare decision support system (DSS) vendor and to the Department of Finance and Administration, Office for Information Resources on a quarterly basis or more frequently as mutually agreed to by both parties during and following the term of this contract, until all claims incurred during the term of this contract have been paid. Data shall be submitted in the format detailed in Appendix 7.7. of RFP #317.86-030. The

#317.86-035.

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Contractor shall ensure that all claims processed for payment have complete ICD-9 and CPT4 codes and valid provider identifications.

For each quarter of the contract term, and any extensions thereof, claims data must meet the quality standards detailed in Contract Attachment A, Performance Guarantee # 9, as determined the by the State's healthcare claims data management vendor.

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The Contractor will work with the State's DSS vendor to identify a mutually-agreeable data format similar to the format detailed in Appendix 7.7 of RFP # ~~017-86-030~~ for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The State's current DSS vendor currently charges a maximum of \$30,000 per new contractor. Furthermore, the Contractor will 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, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this contract.

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Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter. Failure to submit data by the deadline will result in an assessment against the Contractor in the amount of \$100 per day for the first and second working days past the compliance date, and \$500.00 for each working day thereafter, to a maximum of \$10,000 per quarter. Compliance reporting submitted by the State's data management vendor upon receipt of quarterly claims data will be used to measure performance. Performance is measured, reported and reconciled quarterly.

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

A.10. SERVICES PROVIDED BY THE STATE

The State shall provide enrollment records. These records shall include enrollment data for participants and covered dependents. The Contractor's computer system shall be compatible with and/or have the capability to utilize the enrollment information provided by the State, in the State's proprietary transaction formats.

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

C.3. Payment Methodology. The Contractor shall be compensated based on the rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following PMPM Rates:

PMPM Rates by Plan Type and Calendar	PMPM 2007	PMPM 2008	PMPM 2009
State Plan	\$9.50	\$9.50	\$12.25
Local Education Plan	\$9.50	\$9.50	\$12.25
Local Government Plan	\$9.50	\$9.50	\$12.25

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM rates indicated, based upon the number of members certified by the State to the Contractor.

- C.3.1. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the payment rates fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): 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 in December 2008 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %)
- C.3.2. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): 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 in December 2009 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).
- C.3.3. The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim:	State's Cost per Claim:
Professional Claim	\$4.00
Institutional Claim	\$9.75
Claim Based Access Fee Only if Charged by Host Plan	4.36% of the discount received from the Host Plan if required. Maximum of \$2,000 per claim.

All other fees related to the Blue Card Program, as described in Contract Attachment E Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment E. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.

Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter.

8. 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 Alvarez, Manager of Procurement and Contracting
Tennessee Department of Finance & Administration

Benefits Administration Division
 312 Rosa L Parks Avenue, Suite 2600
 Nashville, TN 37243
 Email: Marlene.Alvarez@state.tn.us
 Telephone: 615.253.8358
 FAX: 615.253.8556

The Contractor:

Janet Jorges, Director Client Management
 BlueCross BlueShield of Tennessee, Inc.
 Corporate Accounts
 801 Pine Street
 Chattanooga, Tennessee 37402
 Email janet_jorges@bcbst.com
 Telephone: 423.535.5914
 FAX: 423.752.7733

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

9. The Contract Attachment A is deleted in its entirety and replaced with the new Contract Attachment A attached hereto.
10. 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.
11. Contract Attachment G attached hereto is added as a new Contract Attachment.

The revisions set forth herein shall be effective January 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.:

Linda Andrew 12-9-08
 CONTRACTOR SIGNATURE DATE
Linda Andrew Senior VP / Chief Marketing Officer
 PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

M. D. Goetz, Jr. 12-11-08
 M. D. GOETZ, JR., CHAIRMAN MOA DATE *98*

APPROVED:

M.D. Goetz, Jr. JP 12-19-08
 M. D. GOETZ, JR., COMMISSIONER DATE
 DEPARTMENT OF FINANCE AND ADMINISTRATION

John G. Morgan 12/23/08
 JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

**ATTACHMENT A
PERFORMANCE GUARANTEES**

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

1. 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	\$5,000.00 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.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 95% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of State member claims with no in processing or procedural errors, divided by the total number of State member claims within the audit sample. <u>This excludes financial errors.</u>
Assessment	\$5,000.00 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.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: <ul style="list-style-type: none"> • 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 COB and subrogation will be excluded when calculating compliance with the "non-investigated claims" performance standard.
Assessment	Non-Investigated Claims (clean): \$1,000.00 for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. All Claims: \$1,000.00 for each full percentage point below the required minimum standard of 96% within 30 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.
4. Telephone Response Time	
Guarantee	Ninety-five percent (95%) of incoming member services calls will be answered by either a member services representative or a voice activated response system 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	\$1,000.00 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.
5. Member Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Member Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the contract term.
Definition	Member Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Member Satisfaction Survey question that measures overall satisfaction.
Assessment	\$50,000.00 Annual guarantee.
Compliance	The Compliance Report is the Contractor's results from National Committee Quality

report	Assurance (NCQA) annual Adult Member Satisfaction Survey. Performance will be measured, reported, and reconciled annually.	
6. Member Handbooks and Provider Network Directories Distributed		
Guarantee	Member Handbooks and Provider Network Directories will be distributed prior to Annual Transfer Period which commences on October 15 (adjusted for weekends) of each calendar year.	
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 \$10,000 per year in which the standard is not met.	
Compliance report	The Compliance Report reported by Division of Benefits Administration Plan operations. Annual guarantee is measured, reported, and reconciled annually.	
7. Weekly Enrollment Update (see Contract Section A.8.2.1)		
Guarantee	All Weekly Eligibility file processing and mismatch deadlines will be met as detailed at A.8.2.1.	
Definition	See A.8.2.1	
Assessment	See A.8.2.1	
Compliance report	Measured and reported weekly; reconciled annually.	
8. 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 State, Local Education, and Local Government Plan members will have the Access Standard indicated.	
Definition	Provider Group	
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Acute Care Hospitals	1 facility within 30 miles
Assessment	\$25,000.00 if <u>ANY</u> of the above listed standards is not met, either individually or in combination.	
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.	
9. Claims Data Quality		
Guarantee	As measured by the State's current vendor for Claims Data Management, the Contractor's data submission to said vendor must meet the following Data Quality measures.	
Definition	Measure	
	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
Assessment	\$2,500.00 if <u>ANY</u> of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Measured and reported by the State's Claims Data Management vendor quarterly; reconciled annually.	
10. Member ID Card Distribution		
Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 90% of plan members, by December 20, for those members whose enrollment information is received from the State by December 8, preceding the January 1 start date, for each contract year.	
Definition	The actual distribution of to plan a minimum of 90% of all member Id cards by the specified dates.	
Assessment	Should the above standard not be met, the total amount shall be \$15,000 per year in which the standard is not met.	
Compliance	Compliance Report submitted by Contractor. Performance is measured, reported, and	

report	reconciled annually.
11. Submission of Quarterly Data to Data Management Vendor	
Guarantee	Quarterly claims data will be submitted by the contractor to the state's current data management vendor no later than the last day of the month following the end of each calendar quarter.
Definition	Quarterly claims data are received by the State's current data management vendor no later than the last day of the month following the end of each calendar quarter.
Assessment	Failure to submit quarterly 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 for the first and second working days past the compliance date, and \$500 for each working day thereafter, to a maximum of \$10,000 per quarter.
Compliance report	Compliance reporting submitted by the State's current data management vendor upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.

**ATTACHMENT G
EDISON 834 FILE VALUES**

Special Notes:

Items highlighted in yellow indicate TN specific values. Due to the variety of coverage codes required by the State of TN, it was necessary to add custom values to the 834 mapping document. The coverage code of E1D could include Spouse dependents. The coverage code of IND will be used for Dependent Only coverage. The Relationship of '38' denotes a Child claimed on Income Tax. Any dependent with a Relationship of '38' and a "F" in INS09 is not a Student. All dependents in Edison will have the student flag turned on (INS09 = "F") until age 19. At age 19 and greater, only students (with the exception of the Relationship '38') will have INS09 = "F". The REF03, REF04 and HD11 fields contain TN Specific information that is not defined on the PeopleSoft delivered 834. REF04 is defined as a Group Element field, so the budget code is preceded by "zz:"

FIELD NAME	BN_834_F IELD_ VALUE	EFFDT	BN_834_ FLD_DESCR1	BN_834_ FIELD_ MAPPD	BN_834_ FLD_DESCR2	DATA_T YPE_CD	DEFAULT_ EDI_CD
COBRA_EVE NT_CLASS	RED	1/1/1900 0:00	Reduction in Hours	2	Reduction of work hours	Y	N
COBRA_EVE NT_CLASS	OVG	1/1/1900 0:00	Overage	7	Ineligible Child	Y	N
COBRA_EVE NT_CLASS	MIL	1/1/1900 0:00	Military Leave	1	Termination of Employment	Y	N
COBRA_EVE NT_CLASS	MED	1/1/1900 0:00	Medicare Entitlement	3	Medicare	Y	N
COBRA_EVE NT_CLASS	RET	1/1/1900 0:00	Retired	1	Termination of Employment	Y	N
COBRA_EVE NT_CLASS	DEP	1/1/1900 0:00	Married Dependent	7	Ineligible Child	Y	N
COBRA_EVE NT_CLASS	DEA	1/1/1900 0:00	Death	4	Death	Y	N
COBRA_EVE NT_CLASS	GMC	1/1/1901 0:00	Gross Misconduct -Not Eligible	1	Termination of employment	N	N
COBRA_EVE NT_CLASS	TER	1/1/1900 0:00	Termination	1	Termination of Employment	Y	N
COBRA_EVE NT_CLASS	DIV	1/1/1900 0:00	Divorce	5	Divorce	Y	N
COVRG_CD	©	1/1/1901 0:00	Employee plus 1	E1D	Employee and One Dependent	N	N
COVRG_CD	7	1/1/1900 0:00	Dom Partner Adult+Child (ren)	E6D	Employee and Two or More Dependents	Y	N

COVRG_CD	6	1/1/1900 0:00	Domestic Partner Child (ren)	E5D	Employee and One or More Dependents	Y	N
COVRG_CD	5	1/1/1900 0:00	Domestic Partner Adult	E1D	Employee and One Dependent	Y	N
COVRG_CD	4	1/1/1900 0:00	Family	E6D	Employee and Two or More Dependents	Y	N
COVRG_CD	3	1/1/1900 0:00	Employee + Dependents	E5D	Employee and One or More Dependents	Y	N
COVRG_CD	2	1/1/1900 0:00	Employee + Spouse	ESP	Employee and Spouse	Y	N
COVRG_CD	1	1/1/1900 0:00	Employee Only	EMP	Employee Only	Y	N
COVRG_CD	G	1/1/1901 0:00	Employee plus 2	E2D	Employee plus two dependents	N	N
COVRG_CD	F	1/1/1901 0:00	2 Dependent Coverage	TWO	2 Dependent Coverage	N	N
COVRG_CD	H	1/1/1901 0:00	Generic Coverage Code	EHD	Generic coverage code for all Family Members	N	N
COVRG_CD	I	1/1/1901 0:00	Multiple Dependents Only	DEP	Multiple Dependents Only	N	N
COVRG_CD	D	1/1/1901 0:00	Split	ECH	Split	N	N
COVRG_CD	B	1/1/1901 0:00	Family	FAM	Family	N	N
COVRG_CD	A	1/1/1901 0:00	Single	EMP	Employee Only	N	N
COVRG_CD	E	1/1/1901 0:00	Dependent only	IND	Dependent Only	N	N
EMPL_STAT US	T	1/1/1900 0:00	Terminated	TE	Terminated	Y	N
EMPL_STAT US	A	1/1/1900 0:00	Active	FT	Full time active employee	Y	N
EMPL_STAT US	V	1/1/1900 0:00	Terminated Pension Pay Out	TE	Terminated	Y	N

EMPL_STAT US	W	1/1/1900 0:00	Short Work Break	FT	Full time active employee	Y	N
EMPL_STAT US	X	1/1/1900 0:00	Retired-Pension Administration	RT	Retired	Y	N
EMPL_STAT US	U	1/1/1900 0:00	Terminated With Pay	TE	Terminated	Y	N
EMPL_STAT US	D	1/1/1900 0:00	Deceased	TE	Terminated	Y	N
EMPL_STAT US	L	1/1/1900 0:00	Leave of Absence	L1	Leave of Absence	Y	N
EMPL_STAT US	P	1/1/1900 0:00	Leave With Pay	L1	Leave of Absence	Y	N
EMPL_STAT US	Q	1/1/1900 0:00	Retired With Pay	RT	Retired	Y	N
EMPL_STAT US	R	1/1/1900 0:00	Retired	RT	Retired	Y	N
EMPL_STAT US	S	1/1/1900 0:00	Suspended	FT	Full time active employee	Y	N
MAR_STATU S	W	1/1/1900 0:00	Widowed	W	Widowed	Y	N
MAR_STATU S	U	1/1/1900 0:00	Unknown	R	Unknown	Y	N
MAR_STATU S	S	1/1/1900 0:00	Single	I	Single	Y	N
MAR_STATU S	M	1/1/1900 0:00	Married	M	Married	Y	N
MAR_STATU S	H	1/1/1900 0:00	Head of Household	U	Head Of Household	Y	N
MAR_STATU S	E	1/1/1900 0:00	Separated	S	Separated	Y	N
MAR_STATU S	D	1/1/1900 0:00	Divorced	D	Divorced	Y	N
MAR_STATU S	C	1/1/1900 0:00	Common-Law	U	Common-Law	Y	N
PLAN_TYPE	1X	1/1/1901 0:00	Wellness	WELL	Wellness	N	Y
PLAN_TYPE	1Z	1/1/1901 0:00	Mental Health Substance Abuse	AK	Mental Health Substance Abuse	N	Y
PLAN_TYPE	10	1/1/1900 0:00	Medical	HLT	Health	Y	Y
PLAN_TYPE	11	1/1/1900 0:00	Dental	DEN	Dental	Y	Y

		0:00					
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	HLT	Health	Y	Y
PLAN_TYPE	13	1/1/1900 0:00	Major Medical	MM	Major Medical	Y	Y
PLAN_TYPE	14	1/1/1900 0:00	Vision	VIS	Vision	Y	Y
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	HLT	Health	Y	Y
PLAN_TYPE	16	1/1/1900 0:00	Domestic Partner Dental	DEN	Dental	Y	Y
PLAN_TYPE	17	1/1/1900 0:00	Domestic Partner Vision	VIS	Vision	Y	Y
PLAN_TYPE	10	1/1/1900 0:00	Medical	AG	Preventive Care/Wellness	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	EPO	Exclusive Provider Org (EPO)	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	FAC	Facility	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	HE	Hearing	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	HMO	Health Maintenance Org (HMO)	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	MOD	Mail Order Drug	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	PDG	Prescription Drug	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	POS	Point of Service (POS)	Y	N
PLAN_TYPE	10	1/1/1900 0:00	Medical	PPO	Preferred Provider Org (PPO)	Y	N
PLAN_TYPE	11	1/1/1900 0:00	Dental	DCP	Dental Capitation (DMO)	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	AG	Preventive Care/Wellness	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	DEN	Dental	Y	N

PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	EPO	Exclusive Provider Org (EPO)	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	FAC	Facility	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	HMO	Health Maintenance Org (HMO)	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	MOD	Mail Order Drug	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	PDG	Prescription Drug	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	POS	Point Of Service (POS)	Y	N
PLAN_TYPE	12	1/1/1900 0:00	Medical/Dental	PPO	Preferred Provider Org (PPO)	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	AG	Preventive Care/Wellness	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	EPO	Exclusive Provider Org (EPO)	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	FAC	Facility	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	HE	Hearing	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	HMO	Health Maintenance Org (HMO)	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	MOD	Mail Order Drug	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	PDG	Prescription Drug	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	POS	Point Of Service (POS)	Y	N
PLAN_TYPE	15	1/1/1900 0:00	Domestic Partner Medical	PPO	Preferred Provider Org (PPO)	Y	N
PLAN_TYPE	16	1/1/1900 0:00	Domestic Partner Dental	DCP	Dental Capitation (DMO)	Y	N
PLAN_TYPE	1V	1/1/1901 0:00	Medicare Supplement	SUP	Medicare Supplement	N	Y

PLAN_TYPE	1Y	1/1/1901 0:00	Employee Assistance Program	AG	Employee Assistance Program	N	Y
RELATIONSH IP	CN	1/1/1901 0:00	Natural Child	19	Child	N	N
RELATIONSH IP	CS	1/1/1901 0:00	Step Child	19	Child	N	N
RELATIONSH IP	A	1/1/1900 0:00	Aunt	06	Uncle or Aunt	Y	N
RELATIONSH IP	B	1/1/1900 0:00	Brother	14	Brother or Sister	Y	N
RELATIONSH IP	D	1/1/1900 0:00	Daughter	19	Child	Y	N
RELATIONSH IP	E	1/1/1900 0:00	Employee	38	Collateral Dependent	Y	N
RELATIONSH IP	FA	1/1/1900 0:00	Father	03	Father or Mother	Y	N
RELATIONSH IP	FI	1/1/1900 0:00	Father-in-Law	13	Mother-in-law or Father-in-law	Y	N
RELATIONSH IP	FR	1/1/1900 0:00	Friend	38	Collateral Dependent	Y	N
RELATIONSH IP	GC	1/1/1900 0:00	Grandchild	05	Grandson or Granddaughter	Y	N
RELATIONSH IP	GF	1/1/1900 0:00	Grandfather	04	Grandfather or Grandmother	Y	N
RELATIONSH IP	GM	1/1/1900 0:00	Grandmother	04	Grandfather or Grandmother	Y	N
RELATIONSH IP	M	1/1/1900 0:00	Mother	03	Father or Mother	Y	N
RELATIONSH IP	MI	1/1/1900 0:00	Mother-in-Law	13	Mother-in-law or Father-in-law	Y	N
RELATIONSH IP	N	1/1/1900 0:00	Neighbor	38	Collateral Dependent	Y	N
RELATIONSH IP	NA	1/1/1900 0:00	Domestic Partner Adult	53	Life Partner	Y	N
RELATIONSH IP	ND	1/1/1900 0:00	Domestic Partner Daughter	38	Collateral Dependent	Y	N
RELATIONSH IP	NE	1/1/1900 0:00	Nephew	07	Nephew or Niece	Y	N
RELATIONSH IP	NI	1/1/1900 0:00	Niece	07	Nephew or Niece	Y	N

RELATIONSH IP	NS	1/1/1900 0:00	Domestic Partner Son	38	Collateral Dependent	Y	N
RELATIONSH IP	O	1/1/1900 0:00	Other	38	Collateral Dependent	Y	N
RELATIONSH IP	R	1/1/1900 0:00	Other Relative	38	Collateral Dependent	Y	N
RELATIONSH IP	RO	1/1/1900 0:00	Roommate	38	Collateral Dependent	Y	N
RELATIONSH IP	S	1/1/1900 0:00	Son	19	Child	Y	N
RELATIONSH IP	SI	1/1/1900 0:00	Sister	14	Brother or Sister	Y	N
RELATIONSH IP	SP	1/1/1900 0:00	Spouse	01	Spouse	Y	N
RELATIONSH IP	T	1/1/1900 0:00	Estate	31	Court Appointed Guardian	Y	N
RELATIONSH IP	U	1/1/1900 0:00	Uncle	06	Uncle or Aunt	Y	N
RELATIONSH IP	X	1/1/1900 0:00	ExSpouse	25	Ex-spouse	Y	N
RELATIONSH IP	XC	1/1/1900 0:00	Recognized Child	19	Child	Y	N
RELATIONSH IP	XD	1/1/1900 0:00	Foster Daughter	10	Foster Child	Y	N
RELATIONSH IP	XS	1/1/1900 0:00	Foster Son	10	Foster Child	Y	N
RELATIONSH IP	CT	1/1/1901 0:00	Child claimed on income tax	38	Child	N	N
RELATIONSH IP	CG	1/1/1901 0:00	Grandchild	05	Grandson or Granddaughter	N	N
RELATIONSH IP	CL	1/1/1901 0:00	Legal Guardian	19	Child	N	N
RELATIONSH IP	SD	1/1/1901 0:00	Special Decision	19	Child	N	N
SMOKER	Y	1/1/1900 0:00	Smoker - Yes	T	Tobacco Use	Y	N
SMOKER	N	1/1/1900 0:00	Smoker - No	U	Unknown	Y	N
TIMEZONE	ADT	1/1/1900 0:00	DST Atlantic Time (Canada)	TD	Atlantic Daylight Time	Y	N
TIMEZONE	WEST	1/1/1900 0:00	West Europe Time, Berlin, Rome, Paris	01	Equivalent to ISO P01	Y	N

TIMEZONE	AKDT	1/1/1900 0:00	DST Alaska Time	AD	Alaska Daylight Time	Y	N
TIMEZONE	AKST	1/1/1900 0:00	Alaska Time	AS	Alaska Standard Time	Y	N
TIMEZONE	ARST	1/1/1900 0:00	Arabian Time, Abu Dhabi, Muscat	04	Equivalent to ISO P04	Y	N
TIMEZONE	AST	1/1/1900 0:00	Atlantic Time (Canada)	TS	Atlantic Standard Time	Y	N
TIMEZONE	AZDT	1/1/1900 0:00	DST Azores Time, Cape Verde Is.	UT	Universal Time Coordinate	Y	N
TIMEZONE	AZST	1/1/1900 0:00	Azores Time, Cape Verde Is.	24	Equivalent to ISO M01	Y	N
TIMEZONE	BST	1/1/1900 0:00	Bangkok Time, Hanoi, Jakarta	07	Equivalent to ISO P07	Y	N
TIMEZONE	CASST	1/1/1900 0:00	Central Asia Time, Almaty, Dhaka	06	Equivalent to ISO P06	Y	N
TIMEZONE	CAUDT	1/1/1900 0:00	DST Central Australia, Adelaide	10	Equivalent to ISO P10	Y	N
TIMEZONE	CAUST	1/1/1900 0:00	Central Australia, Adelaide	09	Equivalent to ISO P09	Y	N
TIMEZONE	CDT	1/1/1900 0:00	DST Central Time	CD	Central Daylight Time	Y	N
TIMEZONE	CPST	1/1/1900 0:00	Central Pacific, Magadan, Solomon Is.	11	Equivalent to ISO P11	Y	N
TIMEZONE	CST	1/1/1900 0:00	Central Time	CS	Central Standard Time	Y	N
TIMEZONE	DST	1/1/1900 0:00	Dateline Time, Eniwetok, Kwajalein	13	Equivalent to ISO M12	Y	N
TIMEZONE	EDT	1/1/1900 0:00	DST Eastern Time	ED	Eastern Daylight Time	Y	N
TIMEZONE	EKDT	1/1/1900 0:00	DST Ekaterinburg Time	06	Equivalent to ISO P06	Y	N
TIMEZONE	EKST	1/1/1900 0:00	Ekaterinburg Time	05	Equivalent to ISO P05	Y	N
TIMEZONE	EST	1/1/1900	Eastern Time	ES	Eastern	Y	N

		0:00			Standard Time		
TIMEZONE	GFTDT	1/1/1900 0:00	DST GFT Time, Athens, Istanbul, Minsk	03	Equivalent to ISO P03	Y	N
TIMEZONE	GFTST	1/1/1900 0:00	GFT Time, Athens, Istanbul, Minsk	02	Equivalent to ISO P02	Y	N
TIMEZONE	GMDT	1/1/1900 0:00	DST GMT, London, Dublin, Lisbon, Edinburgh	01	Equivalent to ISO P01	Y	N
TIMEZONE	GMT	1/1/1900 0:00	GMT, London, Dublin, Lisbon, Edinburgh	GM	Greenwich Mean Time	Y	N
TIMEZONE	HST	1/1/1900 0:00	Hawaiian Time	HT	Hawaii-Aleutian Time	Y	N
TIMEZONE	IRDT	1/1/1900 0:00	DST Iran Time, Tehran	04	Equivalent to ISO P04	Y	N
TIMEZONE	IRST	1/1/1900 0:00	Iran Time, Tehran	03	Equivalent to ISO P03	Y	N
TIMEZONE	IST	1/1/1900 0:00	India Time, Bombay, Calcutta, New Delhi	05	Equivalent to ISO P05	Y	N
TIMEZONE	MADT	1/1/1900 0:00	DST Mid- Atlantic Time	24	Equivalent to ISO M01	Y	N
TIMEZONE	MAST	1/1/1900 0:00	Mid-Atlantic Time	23	Equivalent to ISO M02	Y	N
TIMEZONE	MDT	1/1/1900 0:00	DST Mountain Time	MD	Mountain Daylight Time	Y	N
TIMEZONE	MST	1/1/1900 0:00	Mountain Time	MS	Mountain Standard Time	Y	N
TIMEZONE	NDT	1/1/1900 0:00	DST Newfoundland Time	ND	Newfoundland Daylight Time	Y	N
TIMEZONE	NST	1/1/1900 0:00	Newfoundland Time	NS	Newfoundland Standard Time	Y	N
TIMEZONE	NZDT	1/1/1900 0:00	DST New Zealand Time, Auckland, Wellington	13	Equivalent to ISO M12	Y	N

TIMEZONE	NZST	1/1/1900 0:00	New Zealand Time, Auckland, Wellington	12	Equivalent to ISO P12	Y	N		
TIMEZONE	PDT	1/1/1900 0:00	DST Pacific Time, Tijuana	PD	Pacific Daylight Time	Y	N		
TIMEZONE	PST	1/1/1900 0:00	Pacific Time, Tijuana	PS	Pacific Standard Time	Y	N		
TIMEZONE	RDT	1/1/1900 0:00	DST Russian Time, Moscow, St. Petersburg, Volgogra	04	Equivalent to ISO P04	Y	N		
TIMEZONE	RST	1/1/1900 0:00	Russian Time, Moscow, St. Petersburg, Volgograd	03	Equivalent to ISO P03	Y	N		
TIMEZONE	SAEST	1/1/1900 0:00	SA Eastern Time, Buenos Aires, Georgetown	22	Equivalent to ISO M03	Y	N		
TIMEZONE	SDT	1/1/1900 0:00	DST Sydney Time, Canberra, Melbourne	11	Equivalent to ISO P11	Y	N		
TIMEZONE	SMST	1/1/1900 0:00	Samoa Time, Midway Island	14	Equivalent to ISO M11	Y	N		
TIMEZONE	SST	1/1/1900 0:00	Sydney Time, Canberra, Melbourne	10	Equivalent to ISO P10	Y	N		
TIMEZONE	TST	1/1/1900 0:00	Tokyo Time	09	Equivalent to ISO P09	Y	N		
TIMEZONE	WAUST	1/1/1900 0:00	West Australia Time, Perth	08	Equivalent to ISO P08	Y	N		
TIMEZONE	WEDT	1/1/1900 0:00	DST West Europe Time, Berlin, Rome, Paris	02	Equivalent to ISO P02	Y	N		
TIMEZONE	AFST	1/1/1900 0:00	Afghanistan Time, Kabul	04	Equivalent to ISO P04	Y	N		
	CSA	1/1/1901	Central State Active	CSA Central State Active	Edison Benefit Program Code and Description	Y	2000	REF	REF03

	FIR	1/1/1901	Full Time Irregular Officer Cd	FIR Full Time Irregular Officer Cd	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	FML	1/1/1901	FML Benefits Billing	FML FML Benefits Billing	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	GA1	1/1/1901	Local Gov Active Prem Level 1	GA1 Local Gov Active Prem Level 1	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	GA2	1/1/1901	Local Gov Active Prem Level 2	GA2 Local Gov Active Prem Level 2	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	GA3	1/1/1901	Local Gov Active Prem Level 3	GA3 Local Gov Active Prem Level 3	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	HED	1/1/1901	Higher Education	HED Higher Education	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	OLA	1/1/1901	Offline Actives	OLA Offline Actives	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	OLC	1/1/1901	Offline Closed	OLC Offline Closed	Edison Benefit Program Code and Description	Y	2000	REF	REF03

	PAR	1/1/1901	Part Time Non-1450 Hours	PAR Part Time Non-1450 Hours	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	PTN	1/1/1901	Local Education 25 Hours	PTN Local Education 25 Hours	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	PTP	1/1/1901	Part Time 1450 Hours	PTP Part Time 1450 Hours	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RCS	1/1/1901	Retiree Central State	RCS Retiree Central State	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RG1	1/1/1901	Local Gov Retiree Prem Level 1	RG1 Local Gov Retiree Prem Level 1	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RG2	1/1/1901	Local Gov Retiree Prem Level 2	RG2 Local Gov Retiree Prem Level 2	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RG3	1/1/1901	Local Gov Retiree Prem Level 3	RG3 Local Gov Retiree Prem Level 3	Edison Benefit Program Code and Description	Y	2000	REF	REF03

	RGF	1/1/1901	Retiree Grandfathered	RGF Retiree Grandfathered	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RSS	1/1/1901	Loc Ed Retiree Support Staff	RSS Loc Ed Retiree Support Staff	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	RTE	1/1/1901	Loc Ed Retiree Teacher	RTE Loc Ed Retiree Teacher	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	SUR	1/2/1901	Survivor Benefit Program	SUR Survivor Benefit Program	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	TEA	1/1/1901	Local Education	TEA Local Education	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	WCP	1/1/1901	Worker's Compensation	WCP Worker's Compensation	Edison Benefit Program Code and Description	Y	2000	REF	REF03
	Y	1/1/1901	Payment Indicator	Y	Payment Indicator	Y	2300	HD	HD11
	N	1/1/1901	Payment Indicator	N	Payment Indicator	Y	2300	HD	HD11
	Range 01000 thru 99929	1/1/1901	Budget Code	Range 01000 thru 99929	Budget Code	Y	2000	REF	REF04

CONTRACT SUMMARY SHEET

021908

RFS # 317.86 — 050 — 07 Revision 7-30-08		Contract # FA-07-17111-	
State Agency Finance and Administration		State Agency Division Benefits Administration	
Contractor Name BlueCross BlueShield of Tennessee		Contractor ID # (FEIN or SSN) <input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 62-0427913	

Service Description:
Self Insured Preferred Organization (PPO) administrative services for State, Local Education and Local Government members.
(Revision moves funds from fund 58 to fund 53 under cost center 80.)

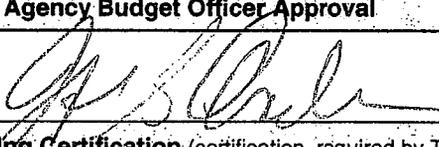
Contract Begin Date January 1, 2007	Contract End Date December 31, 2009	SUBRECIPIENT or VENDOR? Vendor	CFDA #
-----------------------------------------------	-----------------------------------------------	------------------------------------------	---------------

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
317.86	See detail	891	See detail		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			\$11,900,000.00		\$11,900,000.00
2008			\$11,900,000.00		\$11,900,000.00
2009			\$13,450,000.00		\$13,450,000.00
2010			\$7,750,000.00		\$7,750,000.00
TOTAL:			\$45,000,000.00		\$45,000,000.00

— COMPLETE FOR AMENDMENTS ONLY —			State Agency Fiscal Contact & Telephone #
FY	Base Contract & Prior Amendments	THIS Amendment ONLY	John Anderson 26 th Floor, Tennessee Tower 615-741-8642
			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)
TOTAL:			
End Date:			

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)

OIR/EM
8/1/08

C O N T R A C T S U M M A R Y S H E E T

RFS #		Contract #	
317.86-050-07		FA-07-17111-00	
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.		<input type="checkbox"/> C- or <input checked="" type="checkbox"/> V- 62-0427913	
Service Description			
Self-Insured Preferred Provider Organization (PPO) administrative services for State, Local Education, and Local Government members.			
Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
January 1, 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
317.86	21, 80	891	55, 56, 58		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007		OCR RELEASED	\$11,900,000		\$11,900,000
2008			\$11,900,000		\$11,900,000
2009		DEC 04 2006	\$13,450,000		\$13,450,000
2010		TO ACCOUNTS	\$7,750,000		\$7,750,000
TOTAL:			\$45,000,000		\$45,000,000

— COMPLETE FOR AMENDMENTS ONLY —			State Agency Fiscal Contact & Telephone #
FY	Base Contract & Prior Amendments	THIS Amendment ONLY	John Anderson 13 th Floor, Tennessee Tower 615-741-8642 JM
FY: 2007			State Agency Budget Officer Approval
FY: 2008			
FY: 2009			
TOTAL:			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)
End Date:			

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

PROCESSED

SEARCHED INDEXED
SERIALIZED FILED
MAR 20 2009
FBI - MEMPHIS

DIRECTOR OF ACCOUNTS

C O N T R A C T S U M M A R Y S H E E T S U P L E M E N T

Contract Number	FA-07-						
Fiscal Year	2007						
Allotment Code	Cost Center	Object Code	Fund	Grant Code	Subgrant Code	CFDA #	Amount
317.86	21	891	55				\$6,250,000
317.86	21	891	56				4,750,700
317.86	21	891	58				650,000
317.86	80	891	58				249,300
TOTAL							\$11,900,000

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE,
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.

This Contract, by and between the State of Tennessee, State, Local Education, and Local Government Insurance Committees, hereinafter referred to as the "State" and **BlueCross BlueShield of Tennessee, Inc.**, hereinafter referred to as the "Contractor," is for the delivery of Self Insured Preferred Provider Organization (PPO and PPO Limited Plan) services, including customer service, administrative services, claims adjudication, utilization management, case management, care management, disease management services, and development and maintenance of a statewide provider network for the PPO and PPO Limited options in Tennessee; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a not-for-profit corporation The Contractor's address is:

BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga, Tennessee 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 administrative services for the State's self-insured PPO and PPO Limited (sponsored by the Local Government Insurance Committee only) options for employees, retirees and their survivors, as well as eligible dependents, who elect to participate in the PPO options offered by the Contractor, hereinafter referred to as "subscribers", "participants", or "members", in accordance with RFP #317.86-035 and its clarifications; the Contractor's Technical proposal in response to RFP #317.86-035; the Contractor's Cost Proposal in response to RFP #317.86-035; and this agreement (Collectively referred to as the "Contract").

Definitions:

- **"Subscribers"** are defined as eligible employees, retirees, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), who are enrolled in the PPO options sponsored by the State, Local Education, and Local Government Insurance Committees. This definition specifically excludes eligible subscribers who: a) elect not to be covered under the benefit options; or b) are enrolled in either the Point of Service (POS) option, or one of the HMO options, each of which is contracted separately by the State; or c) are dependents of covered employees under (a) or (b) above.
- **"Members"** are defined as eligible employees and their dependents; retirees and their dependents and survivors; and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) and their dependents; who are enrolled in the PPO options sponsored by the State, Local Education, and Local Government Insurance Committees. This definition specifically excludes eligible subscribers who: a) elect not to be covered under the benefit options; or b) are enrolled in a Point of Service (POS) option, or one of the (HMO) options, each of which is contracted separately by the State; or c) are dependents of covered employees under (a) or (b) above.
- **"Participant"** refers to any individual accessing services under the PPO options.

A.1 PREFERRED PLAN ORGANIZATION PROVIDER NETWORK

A.1.1 The Contractor shall maintain and administer a PPO Plan provider network covering the entire State of Tennessee service area, for plan 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, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), Centers of Excellence for high risk cost procedures, nursing homes, laboratories, 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.1.1.1 As required by Contract Attachment A, Performance Guarantee #8 (Provider/Facility Network Accessibility), the State shall monitor network access. When requested by the State, the Contractor shall, within 10 business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by annual network reports.

A.1.2 The Contractor shall maintain a network of specialized providers (Centers of Excellence) for the provision of service of high cost/high risk and specialization. Centers of Excellence criteria for provider inclusion within the network shall be based on price, quantity, quality, and patient outcome, as described in the Contractor's Proposal. The Contractor shall also develop specific criteria for Centers of Excellence referrals and follow-up.

A.1.3 The Contractor shall develop and maintain a network of PPO providers appropriate to the availability and supply of physicians and hospitals in the defined SMSAs of the states contiguous to the State of Tennessee. Contiguous network providers shall be defined as those providers with service locations located within Metropolitan Statistical Areas that are contiguous to the State of Tennessee. Those Metropolitan Statistical Areas shall include the following:

- Alabama – Huntsville/Decatur SMSA
- Georgia – Chattanooga/Cleveland/Athens SMSA
- Mississippi – Memphis SMSA
- North Carolina – Asheville/Brevard SMSA
- Virginia – Johnson City/Kingsport/Bristol SMSA
- Kentucky – Corbin-Loudon SMSA

PPO benefits received through these providers shall be consistent with the State PPO benefits.

A.1.3.1 The Contractor agrees to provide the BlueCard Program of the BlueCross BlueShield Association that governs member benefits provided by network providers located outside the State of Tennessee. This program is described in further detail in Contract Attachment E.

A.1.4 The Contractor shall report to the State within five working 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 thirty (30) calendar days prior to the removal of a hospital, clinic or ambulatory surgery center from the network. See also Section A.9.

A.1.5 The Contractor cannot take action to disenroll network primary care providers or hospital providers for one (1) year beginning each January 1, following the State's Annual Transfer Period, 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.1.6 The Contractor, following review and approval by the State, shall, annually update, print and distribute to subscribers' homes benefits information and provider directories. The booklet must be state-specific and shall describe and outline PPO benefits and exclusions, the Contractor's network of providers, and the Drug Formulary. Distribution shall be made to every subscriber. The number of booklets printed shall be for 125% of the number of subscribers. At the discretion of the

State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties. Said booklets shall be updated and distributed to subscribers' homes at least annually. The costs associated with printing and distribution of said booklets are the sole responsibility of the Contractor. Upon mutual agreement of the State and the Contractor, electronic means may be utilized to inform members of the network of providers.

- A.1.7 The Contractor shall maintain the capability to respond to inquiries from participants 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.
- A.1.8 The Contractor shall ensure that the State and its health benefits participants financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to the State and plan participants.
- A.1.9 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 must be performed at least every three years.
- A.1.10 The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the program requirements. There must be provisions for face-to-face contact in addition to telephone and written contact. Additionally the Contractor must review and assess the practice patterns of network providers, share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.
- A.1.11 The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management, care management, and case management procedures, and other services as required for participation in the PPO provider network.
- A.1.12 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of participants.
- A.1.13 The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.
- A.1.14 The Contractor will quarterly notify the State in writing prior to any global adjustments to provider fee schedules, facility per diems, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for the PPO plans. As part of any changes in future provider reimbursement methods, the State would be willing to explore the use of any Contractor proposed methods of payment that include provider incentives based on valid and reliable performance measures in areas such as clinical performance, patient satisfaction, and use of information technology.

A.2 MEDICAL AND CARE MANAGEMENT SERVICES

- A.2.1 The Contractor shall provide a medical and care management system designed to help individual plan members secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor must provide a system for reviewing the appropriateness of hospital inpatient care, skilled nursing, inpatient rehabilitative care and other levels of care as

necessary. The Contractor must have in place an effective process that identifies and manages those members in need of inpatient care. The following services must be provided:

- 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 the identification of appropriate additional or alternative services as needed. Process must include admission review, or the pre-certification/ authorization of inpatient stay.
- 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.
- 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.
- Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

The Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of services and the demonstrated effectiveness of the programs.

A.2.2 The aforementioned services should be included as required and appropriate for hospital admissions. Pre-admission certification should not be employed for admissions for the normal delivery of children. 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 must 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 must be promptly processed and involve physician-to-physician consultation.

A.2.3 The Contractor shall maintain a case management/care management program for Plan members (see **Contract Section A.2.4**), utilizing procedures and criteria to prospectively and retrospectively identify members that would benefit from case management/care management services. The process of care management shall be capable of identifying the level of a patient's health status through stratification of risk in order for patients to receive the proper level of management appropriate to their condition. Care coordination/care management should consist of a full continuum of services designed to meet the level of need of the plan member (wellness information through catastrophic case management). Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of case management and care management services by the target population. Annually, the Contractor shall provide a written report that demonstrates the effectiveness of these programs as determined through valid and reliable measures of cost, quality and outcomes. The Contractor shall utilize a system of Evidence Based Medicine in the development and use of clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. The Contractor shall also develop specialty care and outpatient case management/care management protocols when appropriate.

A.2.3.1 The Contractor shall, upon cancellation or termination of the contract for any reason, submit to the State a roster of Plan members who are, at the date termination is effective, receiving Care or Case Management services, together with all the identifying information and conditions that make the members' care appropriate for case management.

A.2.4 The Contractor shall submit to the State, at contract implementation, two (2) written copies describing its medical management/case management/care management procedures and evaluation methodology. Additionally, the Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to these programs during the course of the contract.

A.2.5 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.2.6 The Contractor's PPO Plan must be accredited by either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or URAC. If such accreditation is through NCQA, the Contractor shall annually submit to the State its HEDIS report card.

A.2.7 The Contractor, in consultation with the State, shall have in place on the contract effective date disease management programs, acceptable to the State, for the following chronic conditions: congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma. In addition to these disease management programs, the Contractor shall provide a program for high-risk pregnancies. The Contractor shall provide these disease management programs for those high cost, high prevalence diseases in the State-sponsored population, designed to optimize the health status of members therefore reducing the need for high cost medical intervention. The State reserves the right to review and comment on these programs. Failure to provide programs that meet the State's minimum standards will result in an assessment against the Contractor for payment to the State in the amount of \$75,000 for each program of each year of the contract term in which the Contractor fails to provide disease management programs meeting the minimum standards. At a minimum, each disease management program shall contain the following program components:

- A Population identification process;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
- Process and outcomes measurement, evaluation, and management; and
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

A.2.7.1 The Contractor shall provide for each disease management program an evaluation methodology that is statistically valid and designed to measure program impact on health status, utilization of medical and pharmacy services and impact on the cost of care for the PPO plan members identified with the chronic condition. The evaluation methodology must be reviewed and approved by the State and its benefits consultant.

A.2.7.2 The Contractor shall provide a written report to the State, no less than semiannually, detailing plan member participation in each disease management program, and in addition, a written report to the State, no less than annually, with the results of the program evaluation referenced in A.2.7.1. An exception will be made for the first year's report, which shall be due by the end of the 15th month following implementation.

A.2.7.3 The State reserves the right during the term of the Contract to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs that have demonstrated the ability to improve the health status of plan members and effectiveness and quality of care delivered.

A.2.7.4 To assure continuity of care, the Contractor shall, upon cancellation or termination of the contract for any reason, submit to the State a roster of Plan members who are, at the date termination is effective, receiving disease management services, together with all the identifying information and conditions that make the members' enrollment in the specified disease management program appropriate.

A.3 PHARMACY

The Contractor shall provide the following required programs and service components for the retail and mail order pharmacy benefits.

A.3.1 Administrative and Account Management Support – the Contractor shall:

- Provide qualified licensed pharmacy personnel and actuarial input to assist the State in the analysis of the pharmacy program, its benefits, and policy and plan design changes.
- Collaborate with the State in proactively identifying opportunities to improve the quality of service, cost effectiveness and operational efficiency of the pharmacy benefits.
- Provide quarterly reviews of pharmacy network adequacy, Plan performance, service levels and other factors that focus on managing pharmacy benefit cost.

A.3.2 Retail and Mail Order Claims Adjudication – the Contractor shall:

- Adjudicate and process all electronic point of sale and paper retail and mail order pharmacy claims incurred during the term of the contract in strict accordance with the State Pharmacy Benefits as contained in the State Plan Document (**Appendix 7.3 [of RFP #317.86-035]**).
- 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 subscriptions.
- Make efforts to recover overpayments and reimburse underpayments to the State in accordance with applicable law and any applicable State policies regarding the collection of overpayment and reimbursement of underpayment.
- Have the ability to refill mail order prescriptions online through the website, by telephone, or by mail, subject to compliance with all applicable federal and state laws and regulations.

A.3.3 Mail Order Customer Service – the Contractor shall:

- Provide a toll-free telephone number dedicated to the pharmacy mail-order program.
- Provide special telephone services for member consultations with a registered pharmacist.
- Provide a pharmacy claims appeal process consistent with the State appeals process.
- Provide a web site for plan members providing access to pharmacy plan benefits, retail pharmacy network, Preferred Drug List (PDL), drugs requiring Prior Authorization, drugs dispensed with limitations, link to mail-order, and, if available, a secure site for members to access their pharmacy claims.

A.3.4 Retail Network – the Contractor shall:

- 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 or deductibles, and agree to accept the Contractor's reimbursement as payment in full for covered prescription drugs allowing no balance billing.
- Provide participating pharmacies with a toll-free telephone service number.
- Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.
- Require its network retail pharmacies, who have agreed with the Contractor's terms and conditions for mail order pharmacy to provide three month drug supplies via US Postal service, upon request by members, as required by the State's mail order pharmacy policy. The network of pharmacies referenced herein, shall be in place prior to the State's 2006 Annual Transfer Period (currently scheduled for October 16 through November 15, 2006).

A.3.5 Formulary/Preferred Drug List (PDL) and Utilization Review – the Contractor shall:

- Implement and maintain a Formulary/ PDL for the retail and mail order program that is designed to maximize the prescribing and dispensing of safe and clinically and cost effective drugs within each therapeutic class. Changes in the PDL shall be approved and communicated to the State and affected plan members no less than 30 days prior to change implementation date, unless, a shorter notification time is mutually agreed to by the Contractor and State.

- 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:
 - Drug to drug interaction
 - Duplicate therapy
 - Known drug sensitivity
 - Over utilization
 - Maximum daily dosage
 - Early refill indicators
 - Suspected fraud
- Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.
- 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.
- Provide a specialty pharmacy program to address the introduction of new biological drugs and drugs to treat plan members with conditions such as hepatitis C, multiple sclerosis, arthritis and hemophilia. Such a program should provide for significant discounts off the Average Wholesale Price (AWP), delivery to the member, and pharmacist and nursing support.
- Have the ability to lock a member suspected of abusing the system into just one network pharmacy.

A.3.6 Therapeutic Substitution and Generic Dispensing Program – the Contractor shall:

- Provide a Therapeutic Substitution program with provisions for appropriate contact to prescribing physician in order to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. Results of the program should be reported to the State on an annual basis.
- Provide a Generic Dispensing program designed to maximize the acceptance and use of medically appropriate generic drugs under the retail and mail service program. The program shall target physicians, pharmacists and plan members. Results of the program should be reported to the State on annual basis.
- Maintain a communication plan by which notification will be made to affected members when the most frequently utilized brand name medications lose their patent classification and become available as a generic equivalent.

A.3.7 Pharmacy Rebates and Audits – the Contractor shall:

- Remit to the State no less than quarterly a check for all pharmacy rebates obtained on behalf of the State due to the use of pharmaceuticals by members of the State-sponsored Plans for the rebates accrued during the claim period ending 6 months prior to the rebate payment date.
- With provision by the State of 60 days notice, and with execution of any applicable third party confidentiality agreements, submit to examination and audit of applicable pharmacy benefit data by the State, including manufacturer rebate contracts and rebate payments, by the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) during the term of this contract and for three years after final contract payment (longer if required by law). For the purpose of this requirement, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. Such audits shall include third party confidentiality agreements between the auditor and the party being audited.
- With provision by the State of 60 day notice, and with the execution of any applicable third party confidentiality agreements, provide full disclosure of rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State, including line item detail by National Drug Code number and line item detail by pharmaceutical manufacturer showing actual cost remitted and other related claim and financial information as needed to satisfy the scope of the audit. The Contractor will, upon request by the State, disclose to the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) any administrative fees or other reimbursements received in connection with any rebates,

discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments which include volume of pharmaceutical use by or on behalf of the State. In addition, Contractor will, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

- With the execution of any applicable third party confidentiality agreements, provide at any time, upon 60 day notice from the State, access to audit the pharmacy rebate program, including but not limited to rebate contracts, special discounts, fee reductions, incentive programs or the like with pharmacy manufacturers and program financial records as necessary to perform accurate and complete audit of rebates received by the State. At the State's discretion, the State's authorized independent auditor (experienced in conducting rebate audits) may perform such audit. The State is responsible for the cost of it's authorized third party representative for such audits. If the outcome of the audit results in an amount due to the State, payment of such settlement will be made within 60 days of the Contractor's receipt of the final audit report.

A.3.8 Pharmacy Benefit Carve Out: The State reserves the authority to "carve out" the pharmacy benefit during the term of the contract upon a 120-day notice to the Contractor. If the State notifies the Contractor of its intention to exercise this option, the Contractor shall remain responsible for the payment of incurred pharmacy claims up to the effective date of the carve out of the pharmacy benefit.

A.4 BEHAVIORAL HEALTH

A.4.1 The Contractor is responsible for working directly with the State's "carve-out" Employee Assistance Program (EAP)/Mental Health and Substance Abuse (MHSA) program contractor. The Contractor **is not** responsible for providing benefits or paying claims for mental health and substance abuse services. Coordination by the Contractor shall include the following:

- Assistance in the co-management of medical/psychiatric disorders to include co-funding arrangements and consultations when necessary between medical staff.
- Assistance in the identification of claims appropriate for medical and MHSA.
- Payment of claims for all prescriptions for psychotropic medications written by EAP/MHSA contractor network physicians.
- Inclusion of EAP/MHSA benefit information in its PPO Member handbook, including toll free telephone number for the State's EAP/MHSA Contractor.
- Other activities necessary for the appropriate coordination of benefits and claims payment of medical and MHSA benefits.

A.5 CLAIMS PROCESSING

A.5.1 The Contractor shall process all medical claims in strict accordance with the State of Tennessee, Standard PPO Benefits, as detailed in the State, Local Education, and Local Government Plan Documents (**Appendix 7.3 of RFP #317.86-035**), and its clarifications and revisions. The Contractor may not modify these benefits during the term of this contract without the approval of the State.

A.5.1.1 Upon request by the State, the Contractor shall modify its benefits administration system to reflect approved Plan benefit amendments (new, changed, or cancelled) within 30 days of notification by the State. Should said benefit amendment(s) not be effective within 30 days, the Contractor shall have until the effective date of the amendment to modify its benefits administration system.

A.5.2 The Contractor shall ensure that the majority of all claims will be paperless for the members. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.

A.5.3 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

The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of RFP #317.86-035 and meets the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996. The Contractor must 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.5.3.1 To maintain the privacy of personal health information, the Contractor shall provide to the State a method of securing email for daily communications between the State and the Contractor.

A.5.4 The Contractor shall confirm eligibility of each participant as claims are submitted, on the basis of the enrollment information provided by the State, which applies to the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, either filed directly by Participants and/or the provider(s), in accordance with the Performance Guarantees contained in Contract Attachment A. The Contractor shall provide services to participants who elect PPO coverage.

A.5.5 The State shall determine all Plan policies and benefits (see **Appendix 7.3 [of RFP #317.86-035]**). Should the Contractor have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request a determination in writing. The State will then respond in writing making a determination within thirty (30) days. The Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

A.5.5.1 The State shall have the sole responsibility for and authority to clarify and/or revise the PPO benefits available under this program. It is understood between the parties that the program cannot and does not cover all medical situations. In a case where the benefits are not referenced in the PPO Plan Document or are not clear, the Contractor shall utilize their policies in adjudicating claims, and the Contractor shall advise the Division of Insurance Administration in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

A.5.6 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide participants 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. Contractor shall update enrollment and shall mail participant I.D. cards no later than 14 days from receipt of the new enrollment or change in enrollment.

A.5.7 The Contractor shall produce coordination of benefits (COB) savings (excluding Medicare COB) within a reasonable amount (defined as between 1.5 and 2%) of incurred claims per calendar year.

A.5.8 The Contractor shall institute subrogation based on a mutually agreeable process between the Contractor and the State. Such process shall include:

- A defined process for the recovery of monies received through subrogation;
- Notification, upon request by the State, of the status of cases under review for subrogation; and
- Identification to the State of all subrogation subcontractors and, upon request by the State, copies of said subcontracts.

The State authorizes the Contractor to retain administrative fees, on a per patient basis, of no more than 5% of the gross recoveries received. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). 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.5.9 To ensure coordination between the State and Contractor regarding Medicare Secondary Payer (MSP) claims issues, the Contractor shall resolve within 31 days issues communicated by the State to the Contractor.

A.5.10 The Contractor shall determine eligible expenses that are medically necessary. The Contractor must 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.5.11 The Contractor shall have a process in place based on the most appropriate up to date clinical and pharmacological information for determining those procedures and services that are considered experimental/investigative. The Contractor shall provide to the State within 15 days of contract implementation detailed information on the Contractor's process for determining experimental/investigational procedures and services.

A.5.12 Within 30 days of a notification by the State of a retroactive cancellation of a member's coverage, the Contractor shall notify the State of any claims paid, on behalf of the member, which were incurred during the indicated retroactive period. The State will notify the Contractor whether to initiate a recovery of the claims paid.

A.5.13 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 thirteenth (13th) month following contract termination.

A.5.14 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 must 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 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:

- discontinue further investigation if there is insufficient justification; or
- continue the investigation and report back to the Division of Insurance Administration and the Division of State Audit; or
- continue the investigation with the assistance of the Division of State Audit; or

- discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

A.5.15 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, 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 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 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.5.15.1 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 PPO plan participants and that all costs incurred are in accordance with the contract terms and PPO 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.5.15.2 Audits may commence at any time within the three (3) year period following the period being audited. However, the State will not request an audit for the same purpose more than two (2) times in any one (1) contract year.
- A.5.15.3 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.5.15.4 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 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.5.15.5 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.5.15.6 If requested, the Contractor agrees to provide all of the following in anticipation of any audit:
 - a. Requested claim and/or eligibility data must be provided in Microsoft Access format and include a complete data dictionary/manual defining the codes or other nomenclature used therein. Prescription drug claims data must be provided in NCPDP format version 2.0 or higher.

- b. An Operations Questionnaire completed and returned at least two weeks before commencement of any on-site audit. The Contractor shall not unduly restrict the size or scope of such questionnaire. A current SAS-70 report may be provided to supplement the questionnaire.
- c. Provide complete on-line computer system access to eligibility information which will allow the auditors to verify eligibility, cost center and claim allocation division codes, employee and dependent effective and termination dates, the status of the employee, and Medicare/Coordination of Benefits status.
- d. Complete on-line computer access to auditing/inquiry mode of the automated system and full-time use of a computer terminal for each auditor that will allow for complete re-adjudication of any claim.
- e. Access to network provider fee schedules, pricing modules, rebundling software, reasonable and customary schedules, case management, utilization review notes, contracts and any internal policies or procedures as they relate to the payment structure and managed care administration provisions of the State's benefit plans.
- f. Assistance/instruction in utilizing the on-line computer system and with questions regarding system coding/functions, and claim handling procedures. This includes at least one claims administrator representative to remain with the Auditors for the first full day of the on-site audit. This individual should be knowledgeable regarding system use and the audited benefit plan, and responsible for providing written responses to claims questions/potential errors. Thereafter, a representative of the claim administration staff must provide accurate and complete written responses to questions and/or potential errors identified for the audited claims within one working day.
- g. Access to detailed plan descriptions and internal administrative guidelines, manuals, etc., relating to both State and general administrative claim procedures. If applicable, for Prescription Drugs / Rebates: Access to a minimum of five manufacturer contracts designated by the State. These will be based on cost and utilization.

A.6 CLAIMS PAYMENT AND RECONCILIATION PROCESS

- A.6.1 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.6.2 The State shall fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, daily or at the time of each issuance of checks or ACH, provided the Contractor's payment process includes timely delivery of checks and settlement of ACH transactions. Unless otherwise mutually agreed to in writing by the parties, the Contractor shall notify the State of the day's funding requirement amount in the manner described in the Contractor's Proposal. The funding option for the State shall include either receiving an ACH debit from the Contractor to a designated State bank account, or wire transfer of funds to the Contractor's designated bank account. The parties shall mutually agree upon the funding option. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State shall not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.~~
- A.6.3 The Contractor further acknowledges the State will monitor and age the outstanding check balance and the Contractor agrees, upon request of the State, to conduct a review and/or cancel-
reissue of stale dated outstanding items. In a format mutually agreed to, the Contractor on a daily basis, shall provide a detailed listing of the payment activity, including check serial numbers and ACH payment identifiers, payee names, payment amounts, plan group (State, Local Education

and Local Government) and associated claim numbers, balancing to the required funding amount for that day. Said listing shall enable the State to reconcile the payment detail to the required funding amount, while providing related payment information needed to record the necessary accounting entries by expense classifications. The Contractor shall further provide monthly check Reconciliation Reports that provide detail (check number, issue date, payee name, claim numbers, check amount, paid or cancel date) of all checks issued or cancelled during the month, and detailed listing of outstanding checks at each month-end.

- A.6.4 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.6.5 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. The Contractor shall repay the State the amount of any such overpayment within thirty (30) calendar days of discovery of the overpayment. Overpayments due to provider fraud or fraud of any other type, other than fraud by employees or agents of the Contractor, will not be considered overpayments for purposes of this Section. The Contractor agrees to assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud. The State will not hold the Contractor responsible for overpayments caused by the State's errors or errors caused by any other agency or department of the State of Tennessee; however, the Contractor shall assist the State in recovery of such overpayments. The requirement that the Contractor assist the State in identifying or recovering overpayments as provided in this Section does not require the Contractor to become a party to any legal proceeding as a result thereof.
- A.6.6 New York Surcharge. If a Member receives services from a New York state hospital, the New York Surcharge will be built into the claim submitted by the Host Plan, which will submit payment of the New York Surcharge as if it had been incurred by the Host Plan directly. The New York Surcharge will be handled this way regardless of whether or not the Member received services through the BlueCard PPO Program. The State has the duty of completing any reports that may be due, in addition to funding any surcharges applied and Contractor will assist in gathering the material and information necessary to complete any report.

A.7 CUSTOMER AND ADMINISTRATIVE SERVICES

- A.7.1 The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems, and to assist with State employee meetings. The Contractor shall answer, in writing, within ten (10) business days of receipt ninety percent (90%) of all written inquiries from participants concerning requested information, including the status of claims submitted and benefits available through the PPO options, its clarifications and revisions.
- A.7.2 The Contractor, upon request by the State, shall review and comment on proposed revisions to the PPO option benefits. When so requested, the Contractor shall comment in regard to:
- Industry practices; and
 - The overall cost impact to the program; and
 - Any cost impact to the Contractor's fee; and
 - Impact upon utilization management performance standards; and
 - Necessary changes in the Contractor's reporting requirements; and
 - System changes.
- A.7.3 The Contractor shall maintain a formal grievance procedure, by which participants and providers may appeal decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. At contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's

grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate. The State sponsors an appeal process available to member participants of self-insured plan options.

A.7.4 The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The State appeals process is available to plan members after the Contractor's appeal process has been exhausted. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals.

A.7.5 The Contractor shall respond to all inquiries in writing from the Division of Insurance Administration within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.7.6 The Contractor shall maintain statewide, toll-free phone lines manned by qualified benefit specialists and for the exclusive purpose of participant inquiries. These phone lines shall be operated in accordance with details provided in the Contractor's proposal, and perform consistent with the Performance Guarantees in Contract Attachment A.

A.7.7 The Contractor shall designate an individual with overall responsibility for administration of this contract. This person shall be at the Contractor's executive level and shall designate the following positions to interface directly with the State: (1) Program Director (external and marketing operations); and (2) Program Director (internal and administrative functions). Said designees shall be responsible for the coordination and operation for all aspects of the contract.

A.7.8 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, as well as trends in the provision of group health care benefits. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities. The Contractor shall also provide information to the State administrative personnel 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.7.9 The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the PPO Plan options. This assistance may include but not be limited to:

- written information;
- audio/video presentations;
- attendance at meetings, workshops, and conferences; and
- training of State Insurance Benefit Analysts and Insurance Preparers on Contractor's administrative and benefits procedures.

Any on-site visits shall require the prior approval of the State.

A.7.10 The Contractor shall, in consultation with and following approval by the State, print and distribute all plan descriptive booklets, identification cards, primary care physician selection cards, letters, administrative forms and manuals pertaining to or sent to the State's members. Additionally, the Contractor must develop and print annual employee benefit booklets detailing the benefits, procedures for accessing services, and other information helpful to the State's members. The

number to be printed shall be in sufficient quantities for the State's members and shall be mailed to members' homes with the provider directory.

Failure to have any of the above communications materials approved by the State before release shall result in an assessment of \$1000 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. The cost of printing and distributing descriptive booklets, identification cards, and administrative forms and manuals shall be the responsibility of the Contractor. This provision excludes enrollment forms, which are the State's responsibility.

- A.7.11 If the Contractor maintains State-dedicated internet pages, it shall provide up to date information. In association with the State's Annual Enrollment and Transfer Period (AETP), the Contractor shall also provide by the first day of the period (generally October 15) all information pertinent to each new plan year.
- A.7.12 With regard to the above, exemption of incidental pieces such as newsletters, and health promotional pieces will be considered by the State if the Contractor guarantees that pieces will be generic in nature and do not address State Plan eligibility issues or specific coverage issues.
- A.7.13 The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefit levels, premiums and cessation of coverage as requested by the State, individual participants, and providers.
- A.7.14 The Contractor shall perform, following review and approval by the State, customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor and shall involve a statistically valid random sample of participants. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.
- A.7.15 The Contractor shall not modify the PPO services or benefits provided to members during the term of this contract without the consent of the State.
- A.7.16 The Contractor shall annually verify eligibility of dependents 19 to 24 years of age according to State eligibility guidelines, and report the results to the State. The Contractor is responsible for sending a follow-up letter if no response is received from the initial verification letter.
- A.7.17 The Contractor shall determine medical eligibility of incapacitated dependents according to State eligibility guidelines, and report the results to the State.

A.8 **DATA AND SPECIFIC REPORTING REQUIREMENTS**

The Contractor shall:

- A.8.1 Maintain an electronic data interface with the State's Tennessee Insurance System (TIS), for the purpose of accessing State member enrollment information. The Contractor is responsible for equipping itself with the hardware and software necessary for achieving and maintaining access via the Internet, using IBM's Host on Demand software, provided by the State.
 - A.8.1.1 Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State's approval, as detailed below. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

A.8.2 Maintain, in its computer system, in-force enrollment records of all State plan participants. Specific additional obligations, relative to this requirement, are the following:

A.8.2.1 **Weekly Enrollment Update:** To ensure that State plan participants' enrollment records remain accurate and complete, the Contractor commits to the following:

- to accept, via secure medium [FTP-to-FTP Server Connections via a site to site Virtual Private Network (VPN) tunnel, or other secured means approved by the State] weekly enrollment data electronic transfer files from the State, in the State's proprietary transaction formats, for participants who are maintained in the State's TIS system (files will include recent adds, changes, and terminations; see **Appendix 7.6 [of RFP #317.86-035]**);
- to complete each of the following tasks by the indicated deadline:
 1. Systematically process and update, via computer programs, the Contractor's database, utilizing the State's weekly enrollment file records within three (3) working days of receipt of the files from the State; and
 2. Resolve all mismatches identified by the processing of the weekly files; "mismatches" are defined as: Any difference of values between the State's and the Contractor's databases within six (6) working days of receipt of the files from the State.
- to complete and submit to the State, the *Weekly Enrollment Update Report* (sample provided in **Appendix 7.6 [of RFP #317.86-035]**), within seven (7) working days of receipt of the weekly files; and
- to continue accepting and processing weekly enrollment electronic updates until the end of the third month following termination of the contract.

The Contractor shall also transmit weekly enrollment updates to any subcontractors within four working days of receipt of the files from the State and require of its subcontractors, as applicable, to maintain weekly enrollment updates within two working days of receiving the files from the Contractor.

NOTE: Section A.8.2.1 shall be monitored by the State as Performance Guarantee #7.a (see Contract Attachment A).

A.8.2.2 **Quarterly Enrollment Data Reconciliation:** To ensure that State plan participants' enrollment records remain accurate and complete, the Contractor commits to the following:

- to accept, via secure medium [FTP-to-FTP Server Connections via a site to site Virtual Private Network (VPN) tunnel, or other secured means approved by the State] quarterly enrollment data electronic transfer files from the State, in the State's proprietary transaction formats, for participants maintained in the State's TIS system (see **Appendix 7.6 [of RFP #317.86-035]**);
- to complete each of the following tasks by the indicated deadline:
 1. Systematically compare, via computer programs, the State's full file of State enrollees quarterly to the Contractor's database of State members within five (5) working days of receipt of the file from the State, and
 2. Resolve all mismatches identified by the reconciliation processing of the quarterly files; "mismatches" are defined as: Any difference of values between the State's and the Contractor's databases within ten (10) working days of receipt of the files from the State
- to complete and submit to the State the *Quarterly Enrollment Data Reconciliation Report* (sample provided in **Appendix 7.6 [of RFP #317.86-035]**), within eleven (11) working days of receipt of the quarterly files; and
- to continue accepting and processing quarterly electronic data reconciliation files until the end of the third month following termination of the contract.

The Contractor shall also transmit quarterly enrollment updates to any subcontractors within six working days of receipt of the files from the State and require of its subcontractors, as applicable, to maintain quarterly enrollment updates within two working days of receiving the files from the Contractor.

NOTE: Section A.8.2.2 shall be monitored by the State as Performance Guarantee #7.b (see Contract Attachment A).

A.8.2.3 State of Tennessee Enrollment Data Match: Upon request by the State, not to exceed two (2) times annually, the Contractor shall submit to the State its full file of State enrollees, by which the State will conduct a data match against the State's TIS database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its data base of State members, as required by **Sections A.8.2.1 and A.8.2.2.**

Data will be sent by the Contractor to the State with a FTP-to-FTP Server Connection via a site-to-site Virtual Private Network (VPN) tunnel or other secure means approved by the State. Failure by the Contractor to submit records, and in the proper format, within fourteen (14) calendar days of the request from the State, shall result in a penalty of \$10,000 per request.

Results of this match will be communicated to the Contractor, including any requirements – and associated timeframes – for resolving the discrepancies identified by the data match. Failure by the Contractor to resolve the discrepancies, within the specified timeframe(s) will result in a penalty to the Contractor of \$10,000.

For the purpose of the requirements of this section, "mismatches" are defined as: Any difference of values between the State's and the Contractor's databases.

A.8.2.4 CMS Quarterly Data Match: The Contractor shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) providing for a quarterly data match of Contractor's full file of State enrollees against CMS Medicare files for purpose of determining primary payers. The Contractor shall also incorporate all regulatory requirements. Furthermore, the data match shall generate a report of all Medicare enrollees identified. Such report shall be submitted to the State within two weeks of the end of each contract quarter. Report format shall be mutually agreed at contract implementation, and will include: name of the head of contract and SSN (or if a dependent, the dependent name and SSN), and the effective dates of Medicare Part A & B.

A.8.3 Maintain a duplicate set of all records relating to the benefit payments in 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 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.8.4 Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.8.5 Annually provide the State with a GeoNetworks® report showing service and geographic access (see **Contract Attachment A: Performance Guarantee #8**). 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 sixty (60) days.

- A.8.6 The Contractor is required to transmit medical and prescription drug claims to the State's healthcare decision support system (DSS) vendor (currently Medstat) until all claims incurred during the term of this contract have been paid. Data shall be submitted in the format detailed in Appendix 7.7 [of RFP #317.86-035]. 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).

For each quarter of the contract term, and any extensions thereof, claims data must meet the quality standards detailed in **Contract Attachment A, Performance Guarantee #9**, as determined by the State's healthcare claims data management vendor (currently Medstat).

The Contractor will work with the State's DSS vendor to identify a mutually-agreeable data format similar to the format detailed in Appendix 7.7 [of RFP #317.86-035] for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The State's DSS vendor currently charges a maximum of \$30,000 per new contractor. Furthermore, the Contractor will 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, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this contract.

Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter (**see Contract Attachment A, Performance Guarantee #12**).

- A.8.7 The Tennessee Insurance System (TIS) is targeted for replacement by the State's Enterprise Resource Planning (ERP) system (operating under the name Edison) on December 31, 2007. (Note: This date is subject to change at the State's discretion.) The Contractor, in support of this transition, will be required, at its own expense, to:

- participate in meetings, if any, intended for the purpose of planning for the transition;
- convert its electronic data interface with TIS, the Weekly Enrollment updates (Section A.8.2.1), the Quarterly Enrollment Data Reconciliation (Section A.8.2.2), and the Enrollment Data Match (Section A.8.2.3), to the new Edison formats and procedures prior to the Edison "go-live" date.

A.9 **SUBMIT MANAGEMENT REPORTS**

The Contractor shall submit Management Reports in a mutually agreeable electronic format (MSWord, MSEXcel, 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 days after the end of each reporting period. Reporting shall continue for the thirteen (13) month period following termination of the contract. Where available, the Contractor shall provide identical reports in the aggregate for comparable employer groups to enable the State's comparison of its program utilization and claim costs with other employer groups.

The Contractor shall also generate and submit to the State, within five working days of the end of each contract quarter, a Quarterly Network Changes Report (see Section A.1.4), also in electronic format.

A.10 **SERVICES PROVIDED BY THE STATE**

- A.10.1 The State shall provide enrollment records. These records shall include changes in participants' status and information concerning covered dependents. The Contractor's computer system shall be compatible or have the capability to utilize the enrollment information provided by the State, in the State's proprietary transaction formats.

- A.10.2 The State shall provide on-line access, or other access deemed mutually acceptable, to all enrollment information maintained by the State and instructions required to interpret such information. The Contractor, at its expense, will provide and maintain the necessary software, phone lines, modems, CRTs and other equipment required for this purpose.
- A.10.3 The State shall fund applicable accounts from which the Contractor will make claims payments during the term of the contract, and for the thirteen (months) following its termination, for care and treatment services delivered within the term of the contract (reference Contract Section A.5.13).

B CONTRACT TERM

- B.1 This Contract shall be in effect commencing on January 1, 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 term.
- B.2 Term Extension. The State reserves the right to extend this 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 the State notifies the Contractor in writing of its intention to do so at least Two Hundred Seventy (270) days prior to the Contract expiration date. An extension of the term of this Contract will be effected through an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract, and shall be based upon rates provided for in the original contract.

C PAYMENT TERMS AND CONDITIONS

- C.1 Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Forty-Five Million Dollars (\$45,000,000.00). 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 Per Member Per Month (PMPM) 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 Payment Methodology. The Contractor shall be compensated based on the rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following PMPM Rates:

PMPM Rates by Plan Type and Calendar	PMPM 2007	PMPM 2008	PMPM 2009
State Plan	\$9.50	\$9.50	\$11.98

Local Education Plan	\$9.50	\$9.50	\$11.98
Local Government Plan	\$9.50	\$9.50	\$11.98

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM rates indicated, based upon the number of members certified by the State to the Contractor.

- C.3.1 If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): 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 December 2008 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %)
- C.3.2 If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): 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 December 2009 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).
- C.3.3 The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim	State's cost per Claim
Professional Claim	\$4.00
Institutional Claim	\$9.75
Claim Based Access Fee Only if Charged by Host Plan	4.3% of the discount received from the Host Plan if required. Maximum of \$2,000 per claim.

All other fees related to the Blue Card Program, as described in Contract Attachment E Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment E. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.

Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter.

- C.4 Risk Sharing Agreement: The Contractor agrees to the process for the calculation of the risk sharing agreement as illustrated in **Contract Attachment C, Sample of Claims Trend Adjustment Calculation**, and the following provisions of the risk sharing agreement:

C.4.1 Risk Sharing PMPM Claims Cost Calculation: The Contractor agrees that for the calculation of the PMPM claims cost for Base Year 2006 and the contract years 2007, 2008, and 2009 for use in determining the Risk Sharing Payment Provisions (Section C.4.3 below), will be as follows:

- The State, Local Education, and Local Government weighted PPO Cost PMPM claims will be totaled, for each year as indicated below.

Year	Claims, by plan	For claims incurred during	And paid during
2006 BASE YEAR	State, Local Education, and Local Government weighted PPO Cost Per Member Per Month (PMPM) claims	January 1, 2006 through December 31, 2006	January 1, 2006 through June 30, 2007
2007		January 1, 2007 through December 31, 2007	January 1, 2007 through June 30, 2008
2008		January 1, 2008 through December 31, 2008	January 1, 2008 through June 30, 2009
2009		January 1, 2009 through December 31, 2009	January 1, 2009 through June 30, 2010

C.4.2 Risk Sharing Guaranteed Trend Adjustment Percentages: The Contractor agrees that the following Guaranteed Claims Trend Adjustments percentages will be utilized in determining the Target Incurred PMPM cost during contracts years 2007, 2008 and 2009:

Contract Year	Contractor's Guaranteed Claims Trend Adjustment
2007	8.9%
2008	8.5%
2009	9.2%

The Target Incurred PMPM cost will apply in determining the Risk Sharing Payment Provisions (Section C.4.3 below).

C.4.3 Risk Sharing Payment Provisions: The Contractor agrees to the Risk Sharing Payment Calculation as illustrated in Attachment C of this document, with the understanding that:

- **Payments by the State to the Contractor, if any, shall not exceed \$3.00 Per Member Per Month (PMPM) per year during the term of the contract; and**
- **Payments by the Contractor to the State, if any, shall not exceed \$5.00 Per Member Per Month (PMPM) per year during the term of the contract.**

C.4.4 Risk Sharing Settlement Date. The Contractor agrees that the settlement date for the Risk Sharing Payment Provisions (Section C.4.3 above) will be no later than Nine (9) months from the end of EACH contract year. For example, year one (calendar year 2006) will be settled no later than September 30, 2007.

C.4.5 Risk Sharing Guaranteed Claims Trend under Contract Extension. If this Contract is extended, per Section B.2, the Guaranteed Claims Trend Percentage Adjustment (reference Section C.4.1) shall be no greater than three percentage points above the Guaranteed Claims Trend Percentage Adjustment for the calendar year prior to the termination year.

C.5 Performance Guarantees. The Contractor agrees to be bound by the provisions contained in Contract Attachment A, 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) days before the effective date of termination, and the Contractor shall give said notice to the State at least Two Hundred and Seventy (270) 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" and "Nondiscrimination" (sections D.6. and D.7.). 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 as 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.

On behalf of itself and its participants, the State hereby acknowledges its understanding that this Agreement 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.

- 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:

Marlene D. Alvarez, RFP Coordinator
Tennessee Department of Finance & Administration
Division of Insurance Administration
312 Eighth Ave. No., 26th Floor WRS Tennessee Tower
Nashville, TN 37243-0295

Phone: 615-253-8358
Fax: 615-253-8556
Email: marlene.alvarez@state.tn.us

The Contractor:

Leasa McKay, Business Segment Director
BlueCross BlueShield of Tennessee, Inc.
Corporate Accounts
801 Pine Street
Chattanooga, Tennessee 37402

Phone: 423-535-3530
Fax: 423-752-7733
Email: Leasa.McKay@bcbst.com

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 (hereafter referenced as "Assessments", as contained in Contract Attachment A, 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. 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 Assessments contained in above referenced, Attachment A, and agree 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 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 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. All Clarifications and addenda made to the Contractor's Proposal
- c. The Request for Proposal and its associated amendments
- d. Technical Specifications provided to the Contractor
- e. 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 Date/Time Hold Harmless. As required by *Tennessee Code Annotated*, Section 12-4-118, the contractor shall hold harmless and indemnify the State of Tennessee; its officers and employees;

and any agency or political subdivision of the State for any breach of contract caused directly or indirectly by the failure of computer software or any device containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

E.10 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.11 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 offense 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.12 Use of Names and Service Marks. The State agrees to allow Contractor to use the State's name and service mark on I.D. cards and other forms necessary to implement this Agreement, and to promote the State's relationship with Contractor to potential or existing providers. Such promotional use may consist of accurate factual statements relating to the contract but may not include a statement of the State's endorsement or satisfaction of Contractor's services without the prior written consent of the State. Contractor shall not use The State's name or service mark for any other purpose without the prior written consent of the State.

The State agrees that the names, logos, symbols, trademarks, trade names, and service marks of Contractor, whether presently existing or hereafter established, are the sole property of Contractor and Contractor retains the right to the use and control thereof. The State shall not use Contractor's name, logos, symbols, trademarks or service marks in advertising or promotional materials without the prior written consent of Contractor and shall cease any such usage immediately upon written notice by Contractor or upon termination of this Agreement, whichever is sooner.

The State agrees that the names, logos, symbols, trademarks, trade names, and service marks of BlueCross BlueShield Association, whether presently existing or hereafter established, are the sole property of BlueCross BlueShield Association and BlueCross BlueShield Association retains the right to the use and control thereof. The State shall not use BlueCross BlueShield Association's name, logos, symbols, trademarks or service marks in advertising or promotional

materials without the prior written consent of BlueCross BlueShield Association and shall cease any such usage immediately upon written notice by BlueCross BlueShield Association or upon termination of this Agreement, whichever is sooner.

This provision does not restrict the State's use of any names, logos, symbols, trademarks, trade names, and service marks of BlueCross Blue Shield Association, or any other contractor, as required for the operation of the insurance plans. This provision does not apply to the State's use of any public documents or public records that may contain or relate to such names, logos, symbols, trademarks, trade names, and service marks.

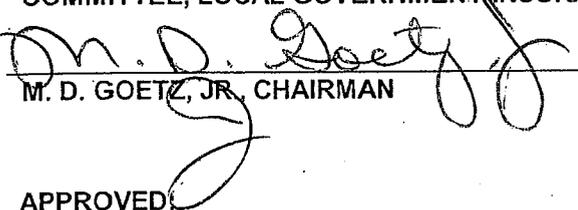
IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Joan Harp 10-17-06
JOAN HARP, PRESIDENT COMMERCIAL BUSINESS AND DATE
ESTABLISHED MARKETS

JOAN HARP PRESIDENT/CREM
PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

STATE OF TENNESSEE, STATE INSURANCE COMMITTEE, LOCAL EDUCATION INSURANCE COMMITTEE, LOCAL GOVERNMENT INSURANCE COMMITTEE:

M. D. Goetz, Jr. 11-6-06
M. D. GOETZ, JR, CHAIRMAN DATE
APPROVED 

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. NOV 28 2006
M. D. GOETZ, JR., COMMISSIONER DATE

COMPTROLLER OF THE TREASURY:

John G. Morgan 11-30-06
JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

Contract Attachment A 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. 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	\$5000 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.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 95% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of State member claims with no in processing or procedural errors, divided by the total number of State member claims within the audit sample. This excludes financial errors.
Assessment	\$5000 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.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: <ul style="list-style-type: none"> • 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 COB and subrogation will be excluded when calculating compliance with the "non-investigated claims" performance standard.
Assessment	Non-Investigated Claims (clean): \$1000 for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. All Claims: \$1000 for each full percentage point below the required minimum standard of 96% within 30 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.
4. Telephone Response Time	
Guarantee	Ninety-five percent (95%) of incoming member services calls will be answered by either a member services representative or a voice activated response system 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	\$1000 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.
5. Member Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Member Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the contract term.
Definition	Member Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Member Satisfaction Survey question that measures overall satisfaction.
Assessment	\$50,000 . Annual guarantee.
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Member Satisfaction Survey. Performance will be measured, reported, and reconciled annually.

6. Member Handbooks and Provider Network Directories Distributed		
Guarantee	Member Handbooks and Provider Network Directories will be distributed prior to Annual Transfer Period which commences on October 15 (adjusted for weekends) of each calendar year.	
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 \$10,000 per year in which the standard is not met.	
Compliance report	The Compliance Report reported by Division of Insurance Administration Plan operations. Annual guarantee is measured, reported, and reconciled annually.	
7.a. Weekly Enrollment Update (see Contract Section A.8.2.1)		
Guarantee	1. The Contractor will systematically process and update, via computer programs, the Contractor's database, utilizing the State's weekly enrollment file records, within three (3) working days of receipt of the files from the State. 2. Contractor will resolve all mismatches identified by the processing of the weekly files, within six (6) working days of receipt of the files from the State. "Mismatches" are defined as: any difference of values between the State's and the Contractor's databases.	
Definition	Guarantee #1 is defined as the demonstrated actual processing and updating of the Contractor's data based on the State's weekly enrollment file records. Guarantee #2 is defined as the demonstrated correction of "mismatches" identified in the State's weekly enrollment file records.	
Assessment	For Guarantee 1 and 2, both separately and individually, the Contractor will be assessed \$100.00 per day for the first (1 st) and second (2 nd) working days out of compliance; \$500.00 per working day thereafter.	
Compliance report	Compliance reported by Contractor's submission of the <i>Weekly Enrollment Update Report</i> within seven (7) working days of the receipt of the weekly files. Weekly Update is measured and reported weekly; and reconciled annually.	
7.b. Quarterly Enrollment Data Reconciliation (see Contract Section A.8.2.2)		
Guarantee	1. The Contractor will systematically compare, via computer programs, the State's full file of State enrollees quarterly to the Contractor's database of State members within five (5) working days of receipt of the file from the State. 2. Contractor will resolve all mismatches identified by the reconciliation processing of the quarterly files; "mismatches" are defined as: any difference of values between the State's and the Contractor's databases within ten (10) working days of the receipt of the files from the State.	
Definition	Guarantee #1 is defined as the demonstrated actual comparison and updating of the Contractor's data base based on the on the State's quarterly full file of State enrollees.. Guarantee #2 is defined as the demonstrated correction of "mismatches" identified in the State's quarterly full file records.	
Assessment	For Guarantee 1 and 2, both separately and individually, the Contractor will be assessed \$100.00 per day for the first (1 st) and second (2 nd) working days out of compliance; \$500.00 per working day thereafter.	
Compliance report	Compliance reported by Contractor's submission of the <i>Quarterly Enrollment Data Reconciliation Report</i> within eleven (11) working days of the receipt of the quarterly files. Enrollment Reconciliation is measured and reported quarterly, and reconciled annually.	
8. 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 State, Local Education, and Local Government Plan members will have the Access Standard indicated.	
Definition	Provider Group	Access Standard
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Acute Care Hospitals	1 facility within 30 miles
Assessment	\$25,000 if ANY of the above listed standards is not met, either individually or in combination.	
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.	

9. Claims Data Quality		
Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor (Medstat). The Contractor's quarterly data submission to Medstat must meet the following Data Quality measures.	
Definition	<i>Measure</i>	<i>Benchmark</i>
	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
Assessment	\$2500 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.)	
10. Tennessee Insurance System Interface		
Guarantee	Contractor's interface with the Tennessee Insurance System (TIS) will be fully operational by December 1, 2006.	
Definition	Fully operational with the TIS interface shall mean that electronic files received by the Contractor from the State of Tennessee via VPN, 3490 cartridge tape, email, Internet web posting, compact disc, or any other acceptable electronic medium will be processed and the data loaded directly into the Contractor's production database. The production database will be the source of reference for the Contractor's business processes, including but not limited to claims processing and customer service.	
Assessment	Should the TIS interface not be fully operational – as defined above – within the allotted time, the Contractor shall pay to the State of Tennessee a assessment of \$500 per day, for every day out of compliance, until the interface is fully operational.	
Compliance report	Compliance as reported by Plan operations. Measured and reported beginning December 2, 2006 and continuing – as necessary – until the interface is fully operational. (Reconciled upon final recognition of operational status.)	
11. Member ID Card Distribution		
Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 90% of plan members, by December 20, for those members whose enrollment information is received from the State by December 8, preceding the January 1 start date, for each contract year.	
Definition	The actual distribution of to plan a minimum of 90% of all member Id cards by the specified dates.	
Assessment	Should the above standard not be met, the total amount shall be \$15,000 per year in which the standard is not met.	
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.	
12. Submission of Quarterly Data to Data Management Vendor		
Guarantee	Quarterly claims data will be submitted by the contractor to the state's data management vendor (MedStat) no later than the last day of the month following the end of each calendar quarter.	
Definition	Quarterly claims data are received by MedStat no later than the last day of the month following the end of each calendar quarter.	
Assessment	Failure to submit quarterly 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 for the first and second working days past the compliance date, and \$500 for each working day thereafter, to a maximum of \$10,000 per quarter.	
Compliance report	Compliance reporting submitted by MedStat upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.	

Contract Attachment B Management Reporting Requirements

As required by Contract Section A.9, the Contractor shall submit Management Reports by which the State can assess the PPO program's general activity and usage, as well as treatment and success tendencies. 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 A (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) **Paid Claims Data by Quarter**, including 30 day run-out, and demonstrating Year-to-Date totals. All data should be broken out by Plan (State, Local Education, and Local Government).

- Number of Employee Months
- Number of Member Months
- Total Paid Medical Expenses
- Inpatient data:

<ul style="list-style-type: none"> ○ Admissions per 1,000 members, for: 	<ul style="list-style-type: none"> ▪ Medical/Surgical ▪ Maternity ▪ Other ▪ Total
<ul style="list-style-type: none"> ○ Days per 1,000 Members, for: 	<ul style="list-style-type: none"> ▪ Medical/Surgical ▪ Maternity ▪ Other ▪ Total
<ul style="list-style-type: none"> ○ Average Length of Stay 	

- Outpatient data:

<ul style="list-style-type: none"> ○ Distribution of Dollars paid for Outpatient Services (expressed as percentages), for: 	<ul style="list-style-type: none"> ▪ Medical ▪ Surgery/ Diagnostic/Therapeutic ▪ Anesthesia ▪ Other ▪ Total
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- Enrollment analysis, indicating:

<ul style="list-style-type: none"> ○ Month 1, Month 2, Month 3 of the current quarter, and YTD, for: 	<ul style="list-style-type: none"> ▪ Number of Employees ▪ Number of Members ▪ Members per Employee ▪ Number of Patients ▪ Average Age of Employee ▪ Average Age of Member
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- Prescription drug utilization- Retail and Mail Order:

<ul style="list-style-type: none"> ○ Number of Prescriptions ○ Total Cost ○ Average Cost per Prescription ○ Average Cost per member per month 	
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- Top 10 Drugs by Number of Claims, demonstrating:

<ul style="list-style-type: none"> ○ Drug Name ○ Number of Prescriptions ○ Brand Name or Generic ○ Allowed Ingredient Change ○ Allowed Quantity ○ Cost per Unit 	
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- Top 10 Drugs by Cost, demonstrating:

<ul style="list-style-type: none"> ○ Drug Name ○ Number of Prescriptions ○ Brand Name or Generic ○ Allowed Ingredient Change ○ Allowed Quantity 	
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o Cost per Unit	
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3) **Quarterly Network Changes Update Report**, submitted electronically.

Contract Attachment C
Example of Claims Trend Adjustment Calculation

FOR ILLUSTRATIVE PURPOSES ONLY

Calculation of Target Claims Level For 2007

Following is a Claims Trend Adjustment Calculation, which illustrates: 1) how the claims trend factor and Risk Free Corridor are calculated; 2) whether the State or the Contractor bears the Risk Sharing responsibility for contract year 2007; and 3) the dollar value of the Risk Sharing responsibility.

- For all three PPO plans (State, Local Education, and Local Government), the Average Cost Per Member Per Month (PMPM) claims, incurred will be calculated by the State as follows:
 1. Actual Claims incurred January 1, 2006 through December 31, 2006, and paid January 1, 2006 through June 30, 2007 (PMPM);
 2. Plus (+) Actual provider capitation payments for January 1, 2006 through December 31, 2006 (PMPM);
 3. Less (-) Claims amounts in excess of \$150,000, for each individual plan member for the given contract year;
 4. Less (-) With proper documentation, claims incurred during the contract year that were the result of an overturned appeal by the State.
 5. Equals (=) Total Actual Incurred per member per month Claims Cost for 2006.
- The resultant 2006 PMPM claims cost will be adjusted by applying the Contractor's total **Guaranteed Trend Adjustment Percentage** below (Guaranteed Trend) to arrive at the 2007 PPO Claims Target.

PPO Feature	Proposed percent Trend Adjustment to 2006 PPO PMPM Cost
PPO Plan Design	0.0 %
Provider Pricing Arrangements	2.0 %
Medical Management	(1.0)%
Utilization	1.0 %
Pharmacy	5.5%
Other	0.0%
Guaranteed Proposed Total Adjustment for 2007 Target	7.5%

Step	Description	Illustration
1	Calculate 2006 PPO PMPM Claims Cost: Through the State's claims data management vendor, the State will calculate the 2006 average PMPM incurred claims cost (excluding MSHA claims), for PPO members of all Plans (State, Local Education, and Local Government).	Assume: 2006 PPO Claims Cost = \$275.00 PMPM
2	Calculate 2007 PMPM Claims Target, by applying Proposer's Guaranteed Trend Factor: The 2006 PMPM claims cost is adjusted by applying the Contractor's total Guaranteed Trend Factor (sum of the figures in the table above: 7.5%) to arrive at the PMPM 2007 Claims Target.	$\$275.00 + (7.5\% \times \$275.00) = \$295.62$ (2007 PMPM Claims Target)
3	Determine actual 2007 PPO PMPM incurred claims cost (using actual claims data).	Assume: 2007 PPO Claims Cost = \$295.50 PMPM
4	Calculate Risk Free Corridor. The corridor is from 5% below to 5% above the 2007 Claims Target (Step 2).	Calculate: $95\% \times \$295.62 = \280.84 (Lower Limit) $105\% \times \$295.62 = \310.40 (Upper Limit) Risk-free corridor = \$280.84 – \$310.40
5	Determine risk sharing obligation, if any. The settlement date for the risk sharing agreement will be no later than 9 months from the end of the effective period. For example, year 1 (calendar year 2007) will be settled by September 30, 2008.	Example: Actual PMPM Claims experience of \$295.50 is within the corridor; therefore, no payments would be made under the Risk Sharing arrangement.

Contract Attachment D
HIPAA BUSINESS ASSOCIATE AGREEMENT TO
COMPLY WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, State Insurance Committee, Local Government Insurance Committee and Local Government Insurance Committee** (hereinafter "Covered Entity") and **BlueCross BlueShield of Tennessee, Inc.** (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

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 (7 days) seven 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 (30 days) thirty 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 in 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 an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least seven (7) 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 in 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 in 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., Chairman
Title: State of Tennessee (Division of Insurance Administration), State, Local Education and Local Government Insurance Committee
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 Linda Andreae
Title V.P. Product Performance
Address 801 Pine Street
Phone (423) 535-7924
Fax:
Email Linda_Andreae@bcbst.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.:



Linda Andreae, V.P. Product Performance

11-1-06

Date:

STATE OF TENNESSEE, STATE INSURANCE COMMITTEE, LOCAL EDUCATION INSURANCE
COMMITTEE AND LOCAL GOVERNMENT INSURANCE COMMITTEE



M.D. GOETZ, JR, CHAIRPERSON

11-6-06

Date:

Contract Attachment E
BLUECARD PPO PROGRAM

- E.1 This Attachment describes the general operation of the BlueCard/BlueCard PPO Program and describes the responsibilities of Contractor and State in relation to methods of paying claims and the fees and allowances resulting from administration of the BlueCard/BlueCard PPO Program. Contractor is referred further in this Attachment as a "Home Plan."
- E.1.1 Like all BlueCross and BlueShield Licensees, Contractor participates in a program called "BlueCard." Whenever Members access health care services outside the geographic area Contractor serves ("Service Area,") 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 ("Policies.")
- E.1.2 Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site BlueCross and/or BlueShield Licensee ("Host Plan,") Contractor remains responsible to State for fulfilling Contractor's contract obligations. However, the Host Plan will be responsible, in accordance with applicable BlueCard Policies, if any, only for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.
- E.2 Liability Calculation Method Per Claim. The calculation of Members' liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price Contractor pays the Host Plan.
- E.2.1 The calculation of State's liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the negotiated price Contractor pays the Host Plan.
- E.2.2 Methods used to determine a negotiated price will vary among Host Plans, depending on the terms of each Host Plan's provider contracts. The negotiated price that Contractor pays a Host Plan on a health care claim processed through BlueCard may represent:
- E.2.2.1 the actual price the Host Plan paid to the health care provider ("Actual Price"); or
- E.2.2.2 an estimated price, determined by the Host Plan in accordance with BlueCard Policies, based on the Actual Price adjusted 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 ("Estimated Price"); or
- E.2.2.3 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 the Host Plan's health care providers, or for a specified group of providers ("Average Price.") An Average Price may result in greater variation to the Member and Employer from the Actual Price than would an Estimated Price.
- E.2.3 Host Plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively adjust the Estimated Price or Average Price to correct for overestimation or underestimation of past prices. However, this prospective adjustment will not affect the amount the Member and State pay, which BlueCard defines as a final price.
- E.2.4 Use of the Estimated Price or Average Price calculation method may result in the Host Plan's holding some portion of the amount the Employer pays in a variance account, pending settlement

with the Host Plan's participating providers. Since all amounts paid are final, the funds held in a variance account (if any) do not belong to State. These funds are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

E.2.5 Statutes in a few states may require a Host Plan either to:

E.2.5.1 use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or

E.2.5.2 add a surcharge.

E.2.6 If any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Contractor would then calculate Member liability and Employer's liability for any covered health care services consistent with the applicable state statute in effect at the time the Member received those services.

E.3 Return of Overpayments. Under BlueCard, recoveries from a Host Plan or its participating providers can come from anti-fraud and abuse audits, provider audits, credit balance audits, utilization review refunds, and unsolicited refunds, among other sources. Host Plans may use third parties to assist in discovering or collecting recovery amounts. The third party's fees 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.

E.4 BlueCard Fees and Compensation. State understands and agrees:

E.4.1 to pay certain fees and compensation to Contractor, as contained in Section A.1.3.1 of the contract, which Contractor is obligated under BlueCard to pay to the Host Plan, to the BlueCross BlueShield Association ("BCBSA,") or to BlueCard vendors, unless our contract obligations to the State require those fees and compensation to be paid only by Contractor; and

E.4.2 that BCBSA may revise fees and compensation under the BlueCard program from time to time without Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Contractor will notify the State as soon as practicable if these fees and compensation arrangements are modified.

E.4.3 Some of these fees and compensation arrangements are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to Employer as an additional claim liability.

E.4.4 Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO provider directories. If you do not have a complete listing, or want an updated listing of these types of fees or the amount of these fees paid directly by the State, you should contact Contractor. All such applicable fees are listed in section A of this Contract.

E.4.5 The claim-based access fee, if one is charged, will not exceed 4.36% of the discount received from the Host Plan on such claim, or no more than \$2,000 per claim.

E.5 The BlueCard/BlueCard PPO Program provides that Contractor or other Home Plan must pay the Host Plan an Administrative Expense allowance for each Original Claim that the Host Plan processes. The amount of the Administrative Expense Allowance is determined according to the terms of the BlueCard/BlueCard PPO Policies and Procedures and varies according to the type of claim processed. Current Administrative Expense Allowance charges are as follows:

Standard

Large Group Locations*

- | | | |
|-----------------------|---------|---------|
| • Professional Claim | \$ 5.00 | \$ 4.00 |
| • Institutional Claim | \$11.00 | \$ 9.75 |

*Large Group Locations are defined as: (1) Accounts having 1,000 or more, up to 9,999, Subscribers in a PPO product with 20 or more Subscribers residing in a single Host Plan Service Area; or (2) Accounts having 10,000 or more Subscribers in a PPO product. The State is considered a large group.

- E.6 A Host Plan can charge an Access Fee only if the Host Plan's contract with the provider requires that the provider accept the payment rate negotiated by the Host Plan as payment in full for the services provided. The provider cannot seek to recover from the Member any amount above the Host Plan's payment rate except for applicable deductibles and copayments. When a Host Plan charges an Access Fee, the Host Plan certifies that it has an enforceable agreement with the provider that holds the Member harmless from balance billing and that the Host Plan will enforce such agreement.
- E.7 Through the BlueCard Worldwide Program, Members also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When Members need to locate a hospital or doctor, they can call 1.800.810.BLUE, or call collect at 1.804.673.1177; they can also visit the web site <https://international.worldaccess.com/bcbsa/index.asp?page=login>, or they can call Contractor. When Members need inpatient medical care, they should call the BlueCard Worldwide Service Center, who will refer them to a participating hospital. Members will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, copayment and/or coinsurance). In an emergency, Members should go to the nearest hospital. The BlueCard Worldwide Service Center will also provide referrals to doctors, but Members will have to pay the provider and then file the claim for reimbursement. The administrative costs charged by the BlueCard Worldwide Program will be passed on to the State when they are received by Contractor.

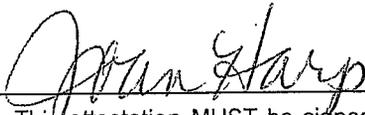
ATTACHMENT F

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	BLUE CROSS BLUE SHIELD OF TENNESSEE, INC.
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:



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.

ATTACHMENT F

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	317.86-035
CONTRACTOR LEGAL ENTITY NAME:	LifeMasters Self-Supported, Inc.
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	94-3206428

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: *John Ego*, VP Client Relations 2/16/07

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.

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	317-86-035
CONTRACTOR LEGAL ENTITY NAME:	SHPS Health Management Solutions, Inc.
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	95-3899237

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:



2/13/07

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.

Matria - Puro Cargo

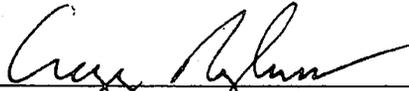
ATTACHMENT F

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	317.86-035
CONTRACTOR LEGAL ENTITY NAME:	Matria Women's and Children's Health, LLC
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	58-2205984

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:



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.

ATTACHMENT F

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	n/a
CONTRACTOR LEGAL ENTITY NAME:	CaremarkPCS Health, L.P. by CaremarkPCS Health Systems, LLC its general partner
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	75-2882129

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:



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.