CONTRACT #10
RFS # 317.86-4001
FA # 07-20304

Finance and Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of Tennessee, Inc.

RECEIVED
APR 30 2009
FISCAL REVIEW

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

Dave Goetz
COMMISSIONER

Phone: 615.741.4517
Fax: 615.253.8556

Laurie Lee
EXEXUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director – Fiscal Review Committee

From: Laurie Lee, Executive Director – Benefits Administration

Date: April 29, 2009

RE: **Amendment # 4 to the BlueCross BlueShield Contract for AccessTN**

Please find attached a Non-Competitive Amendment request for Amendment number Four (4) to the existing contract with BlueCross BlueShield of Tennessee, Inc. for the AccessTN Program which has been signed by Commissioner Goetz.

The modification to the contract through this amendment adds language to the original contract for the development, implementation, and provision of a monthly reporting package, application tracking, and reporting services. The amendment provides an increase of $30,000 for programming over an amount established under a prior amendment. Additionally, it adds the required voluntary buyout language and revises definitions contained in the document. Furthermore, the amendment enables the State to perform services that are program integrity related which will increase the State's ability to maximize the efficiency of the use of State funds. The base contract, as well as the prior amendments to the BlueCross BlueShield of Tennessee contract for AccessTN, is included for review.

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

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	**Marlene Alvarez**	*Contact Phone:	**615.253.8358**
***Edison Contract ID #:** *Contract Number:	**2044** **FA – 07 – 20304 – 00**	*RFS Number:	**31786 – 40001** **(formerly 350.40-044)**
*Original Contract Begin Date:	**February 13, 2007**	*Current End Date:	**December 31, 2009**
Current Request Amendment Number: (*if applicable*)	**# 4**		
Proposed Amendment Effective Date: (*if applicable*)	**July 1, 2009**		
*Department Submitting:	**Finance and Administration**		
*Division:	**Benefits Administration**		
*Date Submitted:	**April 30, 2009**		
*Submitted Within Sixty (60) days:	**Yes**		
If not, explain:	**N/A**		
*Contract Vendor Name:	**BlueCross BlueShield of Tennessee, Inc.**		
*Current Maximum Liability:	**$5,750,000.00**		

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

FY: **2007**	FY: **2008**	FY: **2009**	FY: **2010**	FY	FY
$829,000.00	**$1,835,000.00**	**$1,835,000.00**	**$1,251,000.00**	$	$

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

FY: **2007**	FY: **2008**	FY: **2009 YTD**	FY:	FY	FY
$61,775.01	**$643,273.64**	**$590,825.71**	$	$	$

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

*Contract Funding Source/Amount:	State:	**N/A**	Federal:	**N/A**
Interdepartmental:	**$5,750,000.00**		*Other*:	**N/A**
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
Amendment # 3 – August 2008	**Adds programming & invoicing**
Amendment # 2 – June 2007	**Expands scope to include application assistance services**
Amendment # 1 – May 2007	**Adds a high deductible health plan option**

Supplemental Documentation Required for Fiscal Review Committee

Method of Original Award: *(if applicable)*	**RFP**
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. *(if applicable)*	**See attachment labeled *BCBST Payments Since Inception***
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 equipment costs, reduction in travel. *(if applicable)*	**There are no anticipated savings as a result of this amendment. However, the amendment enables the State to perform services that program integrity related which will increase the State's ability to maximize the efficiency of the use of State funds.**
Include a detailed analysis, in dollars, of the cost of obtaining this service through the proposed contract as compared to other options. *(if applicable)*	**See attachment labeled *AccessTN BCBST Projections***

BCBST payments since inception
STARS contract number FA0720304
Edison contract number 2044
as of April 27, 2009

FY	Payments
2007	$114,582.79
2008	$676,223.17
2009	$581,311.84
Total as of 4/27/09	$1,372,117.80

AccessTN BCBST Projections
Contract number 2044

Month	Amount
May-09	$82,000
Jun-09	$82,000
Jul-09	$82,000
Aug-09	$82,000
Sep-09	$82,000
Oct-09	$82,000
Nov-09	$82,000
Dec-09	$82,000
Total	$656,000

NON-COMPETITIVE AMENDMENT REQUEST:

RECEIVED

APPROVED

APR 30 2009

FISCAL REVIEW

Commissioner of Finance & Administration

1) RFS #	31786 – 40001 (formerly 350.40 – 044 – 07)
2) Procuring Agency :	Finance and Administration, Benefits Administration Division
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Provides statewide administrative services for the AccessTN program.
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA–07–20304–00 (Edison Contract ID# 2044)
6) Contract Start Date :	February 13, 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)	$5,750,000.00
PROPOSED AMENDMENT INFORMATON	
9) Amendment #	# 4
10) Amendment Effective Date : (attached explanation required if < 60 days after F&A receipt)	July 1, 2009
11) PROPOSED Contract End Date : (if ALL options to extend the contract are exercised)	December 31, 2009
12) PROPOSED Maximum Cost : (if ALL options to extend the contract are exercised)	$5,750,000.00
13) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service

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

This amendment adds language to the original contract for the development, implementation and provision of a monthly reporting package, application tracking and reporting services and provides an increase of $30,000 for programming over an amount established under a prior amendment to this contract. The amendment also adds the voluntary buyout language requirement to this contract and revises definitions contained in the document.

15) Explanation of Need for the Proposed Amendment :

The programming changes enable the State to perform the above mentioned services that are program integrity functions, and it is in the best interest of the State to continue this business commitment.

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

BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, Tennessee 37402

17) **Office for Information Resources Endorsement :** (required for information technology service; n/a to THDA)
Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**
18) **eHealth Initiative Endorsement :** (required for health-related professional, pharmaceutical, laboratory, or imaging service)
Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**
19) **Department of Human Resources Endorsement :** (required for state employees training service)
Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**
20) **Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :**
This contract is in the third year of the term and the State is satisfied with the performance of the Contractor. The programming changes enable the State to monitor this program and perform critical program integrity function. The agency did not attempt to identify competitive procurement alternatives.
21) **Justification for the Proposed Non-Competitive Amendment :**
The reporting services are run against the data owned by the vendor and could not be performed by the State. The additional requirements added under this amendment will increase the State's ability to ensure the integrity of this program and to maximize the efficiency of the use of State funds.
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)
SIGNATURE & DATE 4/28/09

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CONTRACT AMENDMENT

Agency Tracking #	Edison ID	Amendment #
31786-40001 (formerly 350.40-044)	2044	4

Contractor	Contractor Federal Employer Identification or Social Security #
BlueCross BlueShield of Tennessee, Inc.	☐ C- or ☒ V- 62 – 0427913

Amendment Purpose/ Effects

The AccessTN program amendment updates the Contractor's address & corporation status; adds/clarifies language for retro-active terminations, monthly reporting, application tracking & reporting, and electronic bill programming for the Premium Assistance vendor.

Contract Begin Date	Contract End Date	Subrecipient or Vendor	CFDA #(s)
February 13, 2007	December 31, 2009	☐ Subrecipient ☒ Vendor	

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$829,000.00				$829,000.00
2008	$1,835,000.00				$1,835,000.00
2009	$1,835,000.00				$1,835,000.00
2010	$1,251,000.00				$1,251,000.00
TOTAL:	**$5,750,000.00**				**$5,750,000.00**

— COMPLETE FOR AMENDMENTS —

END DATE AMENDED? ☐ YES ☒ NO

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$829,000.00	$0.00
2008	$1,835,000.00	$0.00
2009	$1,835,000.00	$0.00
2010	$1,251,000.00	$0.00
TOTAL:	**$5,750,000.00**	**$0.00**

Agency Contact & Telephone #

Marlene Alvarez – Procurement & Contracting Manager
312 Rosa L. Parks Avenue, Suite 2600
Nashville, Tennessee 37243

615.253.8358

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

Speed Code	Account Code
Multiple Funds	78901000

— OCR USE —

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

The original contract (FA-07-20304-00) was procured through the RFP process.

AMENDMENT FOUR
TO CONTRACT ID # 2044

This Contract Amendment is made and entered by and between the Access Tennessee Board of Directors, 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 the Contract Preamble Section is deleted in its entirety and replaced with the following:

This Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of AccessTN Self Insured Health Plan Services, including: provider network development and maintenance, eligibility and enrollment, premium billing and collection, medical and care management, disease management, pharmacy benefits, customer service, claims adjudication, maintain an appeals process, financial and program reporting for the AccessTN (PPO) plan option 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.
One Cameron Hill Circle
Chattanooga, TN 37402

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

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

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

Definitions:

- **"Eligible Individuals"** are defined as individuals who meet two sets of eligibility criteria. The individual must be "uninsurable", which can be established by any one of four methods:

  1. Declination letters from two unaffiliated carriers offering individual health insurance in Tennessee (note: this must be from the company and not from a broker or agent);
  2. A doctor's statement, with specific CPT code or ICD-9 information, that the applicant has one of the presumptive medical conditions approved by the Board, and which are subject to change by the Board;
  3. Qualification through underwriting by an AccessTN vendor, using the health history of the applicant and supplemental medical records as necessary; and
  4. As determined by the AccessTN Board of Directors.

  And the individual must meet the following conditions:

  - Be a United States citizen
  - Be a resident of Tennessee for at least the last six months
  - Have used up any continuation of coverage, including COBRA, available when group health insurance terminated
  - Not have access to other health insurance at the time application is submitted
  - Not have had health insurance within the last three months.

- **"Members"** are defined as AccessTN eligible individuals who are enrolled in the PPO option offered by the Contractor.

- **"Plan document"** or **"plan documents"**, regardless of whether or not capitalized, shall mean the Member Handbook that is approved by the State for members of the AccessTN program.

3. The text of Contract Section A.3.4 is deleted in its entirety and replaced with the following:

A.3.4. The Contractor shall maintain the ability to receive information and funds from a premium assistance program for AccessTN members. The premium assistance program may be administered by a separate contractor and the transmittal of information concerning the recipients of the assistance will take place on a monthly basis and shall accommodate the AccessTN billing cycle.

4. The text of Contract Section A.4.14. is deleted in its entirety and replaced with the following:

A.4.14. If the Contractor terminates a plan member retroactively, the Contractor shall initiate the recovery of any claims paid on behalf of such affected plan member during the period covering the retroactivity. Annually, the Contractor shall provide the State with a report of all overpayment recoveries initiated during the previous calendar year, including dollar amounts initiated, recovered, and not recovered, and whether such amounts are for medical or pharmacy claims.

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

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

The State:

Marlene D. Alvarez, Manager of Procurements and Contracting
Tennessee Department of Finance and Administration,
Benefits Administration Division
312 Rosa L Parks Avenue, Suite 2600
Nashville, TN 37243

marlene.alvarez@tn.gov
Telephone: 615.253.8358
Fax: 615.253.8556

The Contractor:

Scott Williams, Product Manager
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402

Scott_Williams@vshptn.com
Telephone: 423.535.6730
Fax: 423.591.9111

with a copy to:

BlueCross BlueShield of Tennessee, Inc.
Attention: Deputy General Counsel
One Cameron Hill Circle
Chattanooga, TN 37402

Tena_Roberson@bcbst.com
Fax: 423.535.1984

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

6. The following provision is added as Contract Section A.2.6.:

A.2.6. The Contractor shall develop and implement a package of reports based on a format agreed upon by the State. The package includes the following reports: Retained Enrollment Report, AccessTN Terminations Report, AccessTN Termination and Voids Member Listing, Data Match Report, Enrollment Report, AccessTN Earned Premium Report, Enrollment by County and Region and Benefits Administration Enrollment Report. The Contractor shall submit these reports to the State monthly.

7. The following provision is added as Contract Section A.2.7.:

A.2.7. Upon request of the State and mutually agreed to by Contractor, applications shall be tracked by the Contractor, and Contractor shall provide to the State a report of the status of applications periodically.

8. 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 payment rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones or increments of service defined in Section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

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 and other service based rates indicated, based upon the number of members certified by the Contractor to the State.

The Contractor shall be compensated for the application assistance service provided at a monthly rate of $4,687.50 per staff member and includes all costs associated in the provision of the service per staff member. The Contractor may be required by the State to provide up to four (4) individual staff assigned to this function on a monthly basis for the term of the Contract, but the number of staff required may be reduced by the State following discussion with the Contractor at any time should the need for the service no longer exist. The State will make a one-time payment of Five Thousand Dollars ($5,000.00) for the Contractor's expense to identify applications that had previously not qualified under the presumptive eligibility category and sending these applications for underwriting services.

The Contractor shall be compensated for the development and associated programming necessary to report premium assistance liability directly to the State (as detailed in A.3.7) and other related programming changes and expenses incurred in implementing, producing and maintaining these reports and billing invoices. The parties agree and acknowledge that the one-time cost associated with the initial development and programming of the premium assistance report shall be twelve thousand two hundred fifty dollars ($12,250.00). Any mutually agreed upon, additional programming costs incurred by the Contractor related to premium assistance reporting or billing shall be compensated at an hourly rate of seventy dollars ($70.00), and the total cost for all work related to premium assistance reporting (including the one-time initial cost) and billing shall not exceed sixty thousand dollars ($60,000.00). The State shall approve estimates for such work in writing in advance of any work performed.

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 the rates shall be 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.3.2 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 the rates shall be 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 2010 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 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.

C.3.4 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 G. 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 G. 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.

9. The following provision is added as Contract Section C.10.:

C.10. Reporting Package Reimbursement. The State shall reimburse Contractor the one-time sum of $10,000 for a portion of the development, implementation and provision of a monthly reporting package provided by the Contractor pursuant to Section A.2.6. The Contractor shall develop the format for the monthly reporting package and submit said format to the State for approval. Upon approval of said format by the State, the Contractor shall include this one-time amount in the next invoice to the State following the execution date of this Amendment.

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

C.11. Application Tracking and Reporting Services Reimbursement. The State shall reimburse Contractor the one-time sum of $7,150 for services provided by Contractor in connection with application tracking and reporting as further set forth in Section A.2.7. The Contractor shall develop the format for the report for application tracking and reporting. The Contractor shall submit said format to the State for approval. Upon approval of said format by the State, the Contractor shall include this one-time amount in the next invoice to the State following the execution date of this Amendment.

11. 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.

The revisions set forth herein shall be effective July 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)

ACCESS TENNESSEE BOARD OF DIRECTORS:

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

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

MEMORANDUM

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

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

cc
BK

DATE: June 25, 2008

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

RFS# 350.40-044
Department: Finance & Administration/Benefits Administration
Contractor: BlueCross BlueShield of Tennessee (BCBST)
Summary: The vendor currently provides statewide administrative services for the AccessTN program. The proposed amendment will allow BCBST to invoice the State directly for services rather than contracting through a third party. The term of the contract remains the same, effective through December 31, 2009, with the option to extend in one-year increments for a total of five years.
Maximum liability: $5,750,000
Maximum liability w/amendment: $5,750,000

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

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

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MAY 29 2008
FISCAL REVIEW

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

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Brian Haile, Deputy Director, Benefits Administration BH

Date: May 29, 2008

RE: Amendment for AccessTN contract adds invoicing responsibilities

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee (BCBST) signed by Commissioner Goetz. The modification to the AccessTN contract through this amendment provides for the addition of responsibilities to develop, implement and maintain the systems and reports necessary to invoice the State directly for a portion of the premium payment. The amendment transfers this responsibility from a third party to BCBST with both parties favoring this approach. The amendment is slated to take effect August 1, 2008.

The base contract and all prior amendments are included for review as is a draft of the amendment to address the inclusion of responsibilities associated with programming fees and invoicing for premium payments for individuals eligible for the AccessTN program.

Thank you for your consideration of this request.

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	#350.40-044-07
2) State Agency Name :	Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	To provide statewide administrative services for the AccessTN program.
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA-07-20304-00
6) Contract Start Date :	February 13, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,750,000.00
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	# 3
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	August 1, 2008
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,750,000.00
13) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state ☐ only one uniquely qualified service provider able to provide the service

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

The amendment expands the Contractor's scope of services to include the development and associated programming necessary to invoice the State directly for the AccessTN premiums and other related program changes. The State shall approve estimates for such work in writing in advance.

15) Explanation of Need for the Proposed Amendment :

Currently another entity determines the eligibility of an individual for premium assistance and the level of the assistance. This

amendment would allow the Contractor to invoice the State directly, streamline the process, minimize the potential for errors and result in a more efficient work process.

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 St - 4G, Chattanooga, TN 37402

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

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

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

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

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

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

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

BlueCross BlueShield of Tennessee is in an excellent position to deal with the proposed requirement and is willing to take on the additional responsibility. The agency did not attempt to identify competitive procurement alternatives.

21) Justification for the Proposed Non-Competitive Amendment :

Under the current arrangement, a third party, Patient Services Incorporated (PSI), determines eligibility of applicants for premium assistance subsidies from the State. Presuming that the applicant will enroll and remit the remainder amount of his or her first month premium, PSI pays the carrier, BCBST, the portion of the State's share (i.e., the premium subsidy amount). If the applicant decides not to enroll, then BCBST must return the state subsidy amount to PSI. The reconciliation process therefore requires a substantial amount of effort and increases the risk of error. Yet, the existing arrangement, while imperfect, allowed the State to implement the program much more quickly and served the State reasonably well during the first phase of the program (while enrollment was relatively smaller).

The State is now in a position to move to a more streamlined process, which will reduce the administrative burden and the risk of mistakes. Under the new system, PSI will determine eligibility of applicants for premium assistance subsidies from the State. BCBST will then invoice the member for his or her remainder amount of the premium. At the time that the member remits payment, BCBST will draft the State's account for the premium subsidy and immediately enroll the person into the program. Both PSI and BCBST favor this new approach.

This new system offers several advantages to the State. First, the new process will eliminate the need to advance a third vendor the funds for premium assistance subsidies. Second, it will substantially reduce the burden of reconciling payments – which is particularly important now that enrollment in the program is accelerating. In terms of cost, BCBST has agreed to assume the new reporting function associated with the new approach for a nominal fee. For these reasons, we believe that this amendment is in the best interests of 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)

M Goetz Jr	5/29/08
Agency Head Signature	**Date**

NEW RFS#
31786-40001

ED:
Kid# 2044

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
350.40-044-07	FA-07-20304-03
State Agency	**State Agency Division**
Dept. of Finance and Administration	Benefits Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program. **Amendment adds programming & invoicing.**

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	

Mark Each TRUE Statement

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.86	21	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$829,000		$829,000
2008			$1,835,000		$1,835,000
2009			$1,835,000		$1,835,000
2010			$1,251,000		~~$1,026,000~~ $1,251,000
TOTAL:			$5,750,000		$5,750,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$829,000	
FY: 2008	$1,835,000	
FY: 2009	$1,835,000	
FY: 2010	$1,251,000	
TOTAL:	$5,750,000	
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th Floor, Tennessee Tower
615-741-8642

State Agency Budget Officer Approval

Brian Haile for John Anderson

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

RECEIVED 08 AUG -6 OHP TRUST REC OFFICE MANAGEMENT SERVICES

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

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

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

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

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

COD

AMENDMENT THREE
TO FA-07-20304-00

This Contract Amendment is made and entered by and between the Access Tennessee Board of Directors, 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 C.3. is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones or increments of service defined in Section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

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 and other service based rates indicated, based upon the number of members certified by the Contractor to the State.

The Contractor shall be compensated for the application assistance service provided at a monthly rate of $4,687.50 per staff member and includes all costs associated in the provision of the service per staff member. The Contractor may be required by the State to provide up to four (4) individual staff assigned to this function on a monthly basis for the term of the Contract, but the number of staff required may be reduced by the State following discussion with the Contractor at any time should the need for the service no longer exist. The State will make a one-time payment of Five Thousand Dollars ($5,000.00) for the Contractor's expense to identify applications that had previously not qualified under the presumptive eligibility category and sending these applications for underwriting services.

The Contractor shall be compensated for the development and associated programming necessary to report premium assistance liability directly to the State (as detailed in A.3.7) and other related programming changes and expenses incurred in implementing, producing and maintaining this report. The parties agree and acknowledge that the one-time cost associated with the initial development and programming of the premium assistance report shall be twelve thousand two hundred fifty dollars ($12,250.00). Any mutually agreed upon, additional programming costs incurred by the Contractor and related to the premium assistance report shall be compensated at an hourly rate of seventy dollars ($70.00), and the total cost for all work related to the premium assistance report (including the one-time initial cost) shall not exceed thirty thousand dollars ($30,000.00). The State shall approve estimates for such work in writing in advance of any work performed.

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 the rates shall be 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.3.2 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 the rates shall be 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 2010 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 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.

C.3.4 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 G 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 G. 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.

2. The following provision is added as Contract Section A.3.7.:

A.3.7. Beginning August 1, 2008 and continuing for the duration of the contract or as otherwise specified by the State, the Contractor shall report directly to the State the amount of the State's premium liability in accordance with the premium assistance percentage reported to Contractor by the Premium Assistance vendor. Contractor's premium assistance report to the State shall occur on a monthly basis and shall accommodate the AccessTN billing cycle. The parties agree and acknowledge that the Contractor shall not be responsible for the determination of the availability of premium assistance or any funds related to such premium assistance. All premium assistance funding shall be paid and accounted for by the State without further action by the Contractor.

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

7/29/08

CONTRACTOR SIGNATURE **DATE**

Steven Coulter, President, Government Business + Emerging Mkts

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

ACCESS TENNESSEE BOARD OF DIRECTORS:

8-6-08

M. D. GOETZ, JR., CHAIRMAN **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M.D. Goetz, Jr. /KW AUG 0 6 2008

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

John G. Morgan 8/7/08

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY **DATE**

GENERAL ASSEMBLY OF THE STATE OF TENNESSEE
FISCAL REVIEW COMMITTEE

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

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

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

MEMORANDUM

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

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

cc
BK

DATE: May 22, 2007

SUBJECT: **Contract Comments**
(Contract Services Subcommittee Meeting 5/21/07)

RFS# 350-40-044
Department: Finance & Administration/ Insurance Administration
Contractor: BlueCross BlueShield of Tennessee
Summary: This vendor is currently responsible for the delivery of AccessTN Self Insured Health Plan Services which includes provider network maintenance, eligibility and enrollment, premium billing and collection, pharmacy benefits, and other customer services. This amendment is for the provision of application assistance. The term of the contract remains the same, effective through December 31, 2009.
Maximum liability: $4,625,000
Maximum liability w/amendment: $5,750,000

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

cc: Mr. Richard Chapman, Director, Insurance Administration
Mr. Robert Barlow, Director, Office of Contracts Review

11

RECEIVED
MAY 15 2007
FISCAL REVIEW

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Richard Chapman

Date: May 9, 2007

RE: Late Request for an Amendment to Include Application Assistance for AccessTN

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee signed by Commissioner Goetz. The modification to the Access Contract through this amendment provides for the application assistance that was proposed to and approved by the Access Tennessee Board on April 19, 2007.

The plan administrator would pend and follow-up on incomplete or incorrectly submitted applications, rather than return or indicate to the applicant that they do not qualify, and would re-route the application for additional consideration if appropriate. During the year, the number of personnel and the cost would be varied between the Plan and Blue Cross as application volume required. The complexity and magnitude of the application for AccessTN has resulted in a rate of incomplete applications which indicates this change in process is warranted. The Plan Administrator is in the ideal position to assist in application assistance and will maintain in HIPAA compliance concerning sharing of health information. The process to develop an amendment, determine the appropriate pricing for the required staffing and prepare the amendment documents was occurring simultaneously. Finalizing the terms of the amendment was not reached until this week. The prior amendment number one to the contract for AccessTN needed to be fully processed prior to discussion of the terms of this amendment.

The base contract and amendment number one is included as is a draft of the amendment created to address the application assistance to be provided by the plan administrator. The addition to the scope of services and the rate of compensation for this service has been approved by the Access Tennessee Board of Directors.

Thank you for your consideration of this request.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

MEMORANDUM

TO: Commissioner M. D. Goetz, Jr.

FROM : Richard Chapman

DATE: May 9, 2007

RE: **Amendment for Application Assistance for AccessTN applicants**

This is to request a start date for the amendment to the BlueCross BlueShield of Tennessee contract with a scope of services to provide application assistance to individuals preparing and/or submitting applications for AccessTN. The plan administrator, at the request of the Access Tennessee Board, is expanding its capability to assist uninsured Tennesseans in the efforts to qualify as uninsurable for the State's new high risk pool. This request is in advance of 60 days after the receipt of the non-competitive contract amendment request provided to you for your approval.

This contract will allow BlueCross BlueShield of Tennessee to provide application assistance services for individuals submitting an application for AccessTN. The plan administrator would pend and follow-up on incomplete or incorrectly submitted applications, rather than return or indicate that the applicant does not qualify, and would re-route the application for additional consideration if appropriate. During the year, the number of personnel and the cost would be varied between the Plan and Blue Cross as application volume required. With the pending May 15, 2007 start date, speed of implementation is in the best interest of the State and reflects the startup nature of this component of Cover Tennessee.

Thank you for your consideration of this request.

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	#350-40-044-07
2) State Agency Name :	Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	To provide statewide administrative services for the AccessTN program.
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA-07-20304-00
6) Contract Start Date :	February 13, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$4,625,000
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	# 2
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	May 1, 2007
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,750,000
13) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service

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

The amendment expands the Contractor's scope of services to include the provision of application assistance services by BlueCross BlueShield of Tennessee to assist individuals applying for AccessTN whose application is incomplete in order to expedite the application process and ensure the timely enrollment of qualified individuals.

15) Explanation of Need for the Proposed Amendment :

Application assistance would assist in streamlining the application process and reduce the number of applications returned for

additional information.

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 St - 4G, Chattanooga, TN 37402

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

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

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

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

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

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

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

BlueCross BlueShield of Tennessee is in an excellent position to deal with the pending applications and will ensure HIPAA compliance in the performance of the application assistance.

21) Justification for the Proposed Non-Competitive Amendment :

It does not seem prudent to seek an additional third party to provide application assistance that adds an additional layer of administration and source of contact for the applicants. BlueCross BlueShield of Tennessee will ensure HIPAA and AccessTN program compliance and be able to facilitate the application process immediately.

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)

M Joe Jr	5/11/07
Agency Head Signature	**Date**

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07-20304-02
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 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	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$829,000		$829,000
2008			$1,835,000		$1,835,000
2009			$1,835,000		$1,835,000
2010			$1,251,000		$1,026,000
TOTAL:			$5,750,000		$5,750,000

OCR RELEASED JUN 25 2007 TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$604,000	$225,000
FY: 2008	$1,610,000	$225,000
FY: 2009	$1,610,000	$225,000
FY: 2010	$801,000	$450,000
TOTAL:	$4,625,000.00	$1,125,000.00
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th Floor, Tennessee Tower
615-741-8642

JM

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)

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

MANAGEMENT SERVICES

AMENDMENT TWO
TO CONTRACT NUMBER FA-07-20304-00

The Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the State and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section A.2.4. in its entirety and insert the following in its place:

A.2.4 The Contractor shall assess whether all potential applicants meet the requirements for enrollment in the Plan according to the eligibility and enrollment requirements. The State reserves the authority to revise the eligibility requirements during the term of this contract. The Contractor shall utilize the following process for enrollment. The Contractor shall review each application for the requirements specified in the plan regulations or as instructed by the State and shall determine if the applicant is eligible to be a member in the plan.

- Beginning on the date the Contractor receives an application, the Contractor shall have fourteen (14) calendar days in which to make a disposition on the application. Disposition shall mean determination that the applicant does not qualify, approve the application, return the application for additional information, or refer the application to State-approved vendors for additional processing.

- If the application is determined to be incomplete, the Contractor will attempt to make the application complete by making phone calls to the applicant or physician if related to medical information. If the Contractor is unable to make contact with the applicant by phone, the Contractor will mail the applicant a postcard requesting the applicant contact the Contractor. The Contractor will return the application if there is no response from the applicant to the postcard within ten (10) business days. In such instances, the applicant may subsequently reapply for coverage.

- The days spent following up on an incomplete application will be excluded from the fourteen (14) calendar days during which the Contractor is required to make a disposition on the application.

- The Contractor shall send a letter to the applicant including an appropriate explanation of the eligibility determination and information about the appeal procedures if the applicant is found to be ineligible for the Plan. The Contractor shall issue a refund check of the initial subscriber contribution based on State established refund guidelines.

- The Contractor shall determine which provision or provisions of the Plan regulations apply to the applicant if the applicant is found to be eligible for the Plan.

- Coverage for eligible members, whose complete applications are approved on or before the 15th of the month, shall begin on the first day of the next month. Coverage for members whose complete applications are approved after the 15th of the month will begin on the first day of the second month.

2. Delete Section C.1. in its entirety and insert the following in its place:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Five Million Seven Hundred Fifty Thousand Dollars ($5,750,000.00). 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.

3. Delete Section C.3. in its entirety and insert the following in its place:

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 Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

The Contractor shall be compensated for the application assistance service provided at a monthly rate of $4,687.50 per staff member and includes all costs associated in the provision of the service per staff member. The Contractor may be required by the State to provide up to four (4) individual staff assigned to this function on a monthly basis for the term of the Contract, but the number of staff required may be reduced by the State following discussion with the Contractor at any time should the need for the service no longer exist. The State will make a one-time payment of Five Thousand Dollars ($5,000.00) for the Contractor's expense to identify applications that had previously not qualified under the presumptive eligibility category and sending these applications for underwriting services.

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 and other service based rates indicated, based upon the number of members certified by the Contractor to the State.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr May 31, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT DATE

Ronald E. Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz, Jr. 6-4-07

M. D. GOETZ, JR., CHAIRMAN DATE

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

per F&A Commissioner Signature stamp

M. D. GOETZ, JR., COMMISSIONER DATE

COMPTROLLER OF THE TREASURY:

John G. Morgan 6-22-07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY 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
Curtiss Johnson
Gerald McCormick
Mary Pruitt
Craig Fitzhugh, *ex officio*
Speaker Jimmy Naifeh, *ex officio*
Donna Rowland
David Shepard
Curry Todd
Eddie Yokley

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

MEMORANDUM

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

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

CC
BK

DATE: April 24, 2007

SUBJECT: **Contract Comments**
(Contract Services Subcommittee Meeting 4/23/07)

RFS# 350.40-044
Department: Finance & Administration
Division: Insurance Administration
Contractor: BlueCross BlueShield of Tennessee
Summary: Vendor is currently responsible for the delivery of AccessTN Self Insured Health Plan Services, including, but not limited to, provider network development and maintenance, eligibility and enrollment, premium billing and collection, pharmacy benefits, customer service and claims adjudication. This amendment is add a third high-deductible health plan option to the existing two health plans.
Maximum liability: $4,600,000
Maximum liability with amendment: $4,625,000

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

cc: Mr. Richard Chapman, Executive Director
Mr. Robert Barlow, Director, Office of Contracts Review

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FISCAL REVIEW

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Richard Chapman, Executive Director

Date: April 18, 2007

RE: Late Request for an Amendment to Establish a High Deductible Health Plan for AccessTN

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee signed by Commissioner Goetz. The modification to the Access Contract amendment is to provide for the administration of the legislatively mandated qualified high deductible plan that was approved by the AccessTN Board in mid February. The Division staff was also finalizing a contract with Blue Cross to administer CoverKids, a grant contract with the entity administering the premium assistance program for AccessTN and finalize the procurement of the enrollment administrator for CoverKids. The process to develop an amendment, determine the appropriate pricing and provide the results to the Board was occurring simultaneously. Finalizing the terms of the amendment was placed behind other activities so that each contract would be in place at the contract start date. The initial contract for AccessTN needed to be fully processed and operational to coincide with other contract implementation dates.

The base contract is included as is a draft of the amendment created to address the addition of a high deductible health plan that meets the requirements of the authorizing legislation for AccessTN and to be in combination with a health savings account (HSA). The addition to the scope of services and the rate of compensation for this service has been approved by the Access Tennessee Board of Directors.

The two plans currently offered are both Preferred Provider Organization (PPO) plans with a $1,000 or $5,000 deductible but are not HSA eligible. Enrollment in this anticipated third option is expected to be minimal as the enrollment in high deductible plans remains fairly small on a national level.

Thank you for your consideration of this request.

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APR 17 2007
FISCAL REVIEW

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Richard Chapman, Executive Director

Date: April 17, 2007

RE: Amendment to Establish a High Deductible Health Plan for AccessTN

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee signed by Commissioner Goetz. The base contract is included as is a draft of the amendment created to address the addition of a high deductible health plan that meets the requirements of the authorizing legislation for AccessTN and to be in combination with a health savings account (HSA). The addition to the scope of services and the rate of compensation for this service has been approved by the Access Tennessee Board of Directors.

The two plans currently offered are both Preferred Provider Organization (PPO) plans with a $1,000 or $5,000 deductible but are not HSA eligible. Enrollment in this anticipated third option is expected to be minimal as the enrollment in high deductible plans remains fairly small on a national level.

Thank you for your consideration of this request.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

MEMORANDUM

To: Commissioner M. D. Goetz, Jr.

From: Laurie Lee

Date: April 16, 2007

Re: Contract Start Date

This is to request a start date for the amendment to the contract with BlueCross BlueShield of Tennessee for administrative services in advance of 60 days after receipt of the non-competitive amendment to this contract.

This contract amendment extends the services of BlueCross BlueShield of Tennessee for the AccessTN product by offering a third option of a high deductible health plan that meets the requirements of the authorizing legislation for AccessTN and to be in combination with a health savings account (HSA).

Given the recent awards for the implementation of these programs, dealing efficiently and effectively with all facets of implementation of the program is in the best interest of the State.

CY07 #362

8-25-05

REQUEST: NON-COMPETITIVE AMENDMENT

OK

APPROVED

per affixed certified/authorized F&A Commissioner signature

Commissioner of Finance & Administration

Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED	
1) RFS #	#350-40-044-07
2) State Agency Name :	Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	To provide statewide administrative services for the AccessTN program.
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA-07-20304-00
6) Contract Start Date :	February 13, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$4,600,000
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	# 1
10) Proposed Amendment Effective Date (attached explanation required if date is < 60 days after F&A receipt)	April 1, 2007
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$4,625,000

13) Approval Criteria : (select one)

- [x] use of Non-Competitive Negotiation is in the best interest of the state
- [ ] only one uniquely qualified service provider able to provide the service

OCR

APR 24 2007

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

This amendment would establish the capability of the State to offer a high deductible health plan that meets the requirements of the authorizing legislation for AccessTN and to be in combination with a health savings account (HSA).

15) Explanation of Need for the Proposed Amendment :

The enabling legislation for AccessTN requires the Board to establish at least two benefit plans and contemplates that one of those plans be a high deductible health plan that meets the legislative requirement and could be combined with a HSA. The HAS-eligible high

deductible health plan would fulfill this legislative requirement. The two plans currently offered are both Preferred Provider Organization (PPO) plans with a $1,000 or $5,000 deductible but are not HAS-eligible. Enrollment in this anticipated third option is expected to be minimal as the enrollment in high deductible plans remains fairly small on a national level.

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 St - 4G, Chattanooga, TN 37402

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

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

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

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

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

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

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

BlueCross BlueShield of Tennessee, Inc. has been approached as to their ability to add this third option to the existing contractual agreement for administration of AccessTN. The Contractor seems confident that they can add this third option economically from an administrative fee standpoint for individuals interested in this option.

21) Justification for the Proposed Non-Competitive Amendment :

As the enrollment is not expected to be high in the High Deductible Option, it seems most cost efficient to use the current Contractor rather than seek an additional, separate contractor to administer this benefit option with a potential limited enrollment.

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
M Goetz II	4/16/02

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Richard Chapman
EXECUTIVE DIRECTOR

February 15, 2007

MEMORANDUM

TO: Members of the Board of Directors - AccessTN

FROM: David Hilley, Director – AccessTN
Richard Chapman, Executive Director

SUBJECT: High Deductible Health Plan Administration

The purpose of this correspondence is to review with you the status of AccessTN's efforts to develop and offer a High Deductible Health Plan that can be combined with a Health Savings Account. The enabling legislation (see Section 56-7-2910, Tennessee Code Annotated) requires that the Board offer at least two health care options to each eligible person. Additionally, the legislation requires that one of the options be modeled after one of the healthcare options offered to state employees under the State Plan and one shall combine a health savings account with a high deductible health plan.

Health savings accounts can be established by financial institutions and other entities and are generally available in the marketplace for both firms and individuals.

The Board, in establishing the plan benefits, adopted a structure that included Plan 2500 which meets the standard for a qualified high deductible plan necessary to qualify through the IRS test for a health savings account and having contributions to the health savings account qualify on a pre-tax basis and for accumulation on a multi-year basis.

When the Division prepared the Request For Proposals for plan administrators, we did not include the administration of a high deductible plan in that procurement. We did include the requirements for Plan 1000 (the medium plan) and Plan 5000 that provides catastrophic coverage after a significant deductible.

Following the award of the contract for plan administration to BlueCross, the Division of Insurance Administration conducted discussions with BlueCross relative to their ability and willingness to administer a high deductible health plan. We believe that this would be appropriate action for the Board to take to meet the legislative requirements and to provide for consolidated administration of AccessTN. Combining administration of these activities would simplify interaction with applicants and plan members, as well as providers; would consolidate administrative activity and would, in our minds, minimize administrative expense by combining all of the administrative activity associated with plan administration with a single contractor.

BlueCross has provided to us an estimate of the monthly fee for the high deductible health plan; $26.00 per member per month. For your reference, the per member per month fee for administration of either of the other plans is $18.57 per member per month. We asked BlueCross for the factors that impacted the higher fee and they indicated to us that, based on their experience with high deductible health plans, there was additional customer service required to deal with the additional inquiries from plan members over and above the normal health plan interaction with plan members. They asserted to us that they believed that an additional staff person would have to be assigned to the customer service unit to deal with the additional inquiries from an estimated 10 percent of the plan members (600) that would enroll in the high deductible option. They estimated the additional salary benefits costs of that individual as approximately $45,000 per year and, predicated upon the enrollment estimates, would result in an increase in the per member per month fee of $8.60.

The Division of Insurance Administration believes that expanding the application of the contract for administration of the high deductible health plan option represents an efficient way to secure these services and we believe that BlueCross' higher fee for that service is justified.

Expansion of the contract to include administration of the high deductible healthcare plan will require the approval of the Commissioner of Finance and Administration for a non-competitive procurement and a review and comment by the State Fiscal Review Committee.

Should you have any questions concerning this matter, staff is prepared to discuss those concerns at your convenience.

RLC

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07-20304- 01
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 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	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$604,000		$604,000
2008			$1,610,000		$1,610,000
2009			$1,610,000		$1,610,000
2010			$801,000		$801,000
TOTAL:			$4,625,000		$4,625,000

OCR RELEASED
JUN 25 2007
TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$600,000	$4,000
FY: 2008	$1,600,000	$10,000
FY: 2009	$1,600,000	$10,000
FY: 2010	$800,000	$1,000
TOTAL:	$4,600,000.00	$25,000.00
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th 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)

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

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2007 JUN 25 AM 8:11
SUPPLIER OFFICE
MANAGEMENT SERVICES

JUN 26

AMENDMENT ONE
TO CONTRACT NUMBER FA-07-20304-00

The Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the State and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section C.1. in its entirety and insert the following in its place:

   C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Four Million Six Hundred Twenty-five Thousand Dollars ($4,625,000.00). 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.

2. Delete Section C.3. in its entirety and insert the following in its place:

   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 Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

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 Contractor to the State.

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 the rates shall be 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.3.2 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 the rates shall be 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 2010 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 authorizes the Contractor to retain administrative fees, on a per patient basis, of no more than 5% of the gross recoveries received due to the subrogation activities required in A.4.11. 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.

C.3.4 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 G 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 G. 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.

3. Delete Section E.2. in its entirety and insert the following in its place:

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:
Ms. Marlene D. Alvarez, Manager of Procurements and Contracting
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 Address: marlene.alvarez@state.tn.us

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

with a copy to:
Associate General Counsel
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga, TN 37402
Attention: Associate General Counsel
Fax: 423-535-1984

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.

4. Delete Attachment D, AccessTN Benefit Summary, in its entirety and insert the following in its place:

Attachment D
AccessTN Benefit Summary

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	**Plan 1000 "premium-assistance eligible"**	**Plan 2500 "HSA-eligible" HDHP**	**Plan 5000 "Catastrophic"**
This listing is for illustration only; plan documents shall control.	**Note: Benefits are subject to change by the AccessTN Board of Directors.**		
PREVENTIVE CARE (annual well-woman exam & / or health assessment exam with specified lab and diagnostic services)	100% in-network	100% in-network	100% in-network
The above is first dollar in-network coverage for wellness care such as an annual physical, not subject to deductible or co-insurance.			
DEDUCTIBLES Individual Maximum Deductible per Plan Year In network Out-of-network	$1,000 $2,000	$2,500 $2,500	$5,000 $10,000
Covered Expenses, as specified plan document, subject to maximum allowable charge	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Pre-Existing Conditions Period- except as stated for specific benefits, to be determined by Board of Directors	6 months	6 months	6 months
Prescription Drugs - Pharmacy does not apply to out of pocket maximum except for Plan 2500 – HSA	No deductible for outpatient drugs	Deductible applies to drugs	No deductible for outpatient drugs

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "premium-assistance eligible"	Plan 2500 "HSA-eligible" HDHP	Plan 5000 "Catastrophic"
Retail up to 34 day supply. Up to 102 day supply through home delivery, including retail pharmacies that agree to the same terms and conditions as a home delivery pharmacy. Self-administered Specialty Pharmacy products limited to a 30 day supply.			
Generic	$10 copayment (or cost if less)	Covered under deductible, coinsurance and out-of-pocket limit to meet federal guidelines for an HSA eligible plan.	$15 copayment (or cost if less)
Preferred Brand Drugs	25% coinsurance subject to a min. of $25, max. of $50		30% coinsurance subject to a min. of $30, max. of $75
Non-Preferred Brand	50% coinsurance subject to a min. of $50, max. of $100	Non-preferred brands are not covered.	60% copayment subject to a min. of $60, max. of $150
Non-Covered Drugs	as identified by formulary	Any drugs not identified by formulary as covered	as identified by formulary
Maximum Out-of-Pocket Expense (does not apply to pharmacy – except for Plan 2500, to out-of-network services, or to co-pays for emergency room)	$5,000	$5,000	$10,000
Maximum Annual Benefits, except for supplemental Organ Transplants as below	$120,000	N/A	$100,000
Supplemental Maximum Benefit for Transplants	$100,000	$100,000	$100,000
Maximum Lifetime Benefits Subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000	$1,000,000
Covered Services include			
Inpatient services - non-emergent service must be preauthorized	80% in-network 60% out-of-network	80% in-network 60% out-of-network Limited to 45 days per year	80% in-network 60% out-of-network
Surgical Procedures Diagnostic Lab and Imaging Services Physician office visits Preventive care other than those services specified above in Preventive Care allowance Chemotherapy and Radiation Therapy Organ Transplant (designated procedures) Provider Administered Specialty Pharmacy	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "premium-assistance eligible"	Plan 2500 "HSA-eligible" HDHP	Plan 5000 "Catastrophic"
Maternity benefits	Subject to 12 month waiting period	Subject to 12 month waiting period	Subject to 12 month waiting period
Approved/Accredited Rehabilitation Facility			
Covered services listed below	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Inpatient Rehabilitation Facility		Limited to 45 days per year	
Outpatient Rehabilitation Facility	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Home Health Care	30 visits per year	30 visits per year	30 visits per year
Non-Hospital & Non-Physician Services			
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Non-Contracted Providers (Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)
Emergency Services (in-state or out-of-state)			
Emergency services (in -network or out-of-network) Note: Out-of-network benefits will be reduced to non-PPO levels if the claims administrator determines the situation was not an emergency.	80% of reasonable charges	80% of reasonable charges	80% of reasonable charges
Emergency Room Visit Copayment waived if admitted; Note: copayment required even if out-of-pocket expenses have been met	$50 copayment per use	Not applicable	$75 copayment per visit
Non-Emergent/Urgent Care			
Urgent Care Situations Urgent Care received at a walk-in clinic	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Urgent Care received through hospital emergency room (in addition to ER copay)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "premium-assistance eligible"	Plan 2500 "HSA-eligible" HDHP	Plan 5000 "Catastrophic"
Appliances & Equipment Durable Medical Equipment	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max
EXCLUSIONS (This is a partial list- includes any services not medically necessary, etc.; see plan document for complete listing of exclusions.)	Cosmetic procedure Human Growth Hormone Hearing aids Eyeglasses, contacts, etc. Dental services Routine foot care Assisted reproductive technology, including fertility drugs Services or supplies related to obesity, including surgical or other treatment for morbid obesity		
SCHEDULE OF PPO MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS			
DEDUCTIBLES- No separate Mental Health deductible	Outpatient services not subject to plan deductible	All services subject to health plan deductible	Outpatient services not subject to plan deductible
COINSURANCE for Mental Health/ Substance Abuse	See below	After $2500 plan deductible met	See below
Inpatient – Including Intermediate Care Services (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 80/60% levels)	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days
Outpatient- In- Network Out-of-Network, subject to MAC [Note- Outpatient therapy sessions are NOT subject to plan deductible; Inpatient above and intermediate levels below are subject to deductible.]	80% in-network 60% out-of-network 45 sessions	80% in-network 60% out-of-network 45 sessions	80% in-network 60% out-of-network 45 sessions
Expenses determined not to be medically necessary by the utilization review organization	$0	$0	$0

Intermediate Care

All intermediate levels of care will be counted as inpatient for purposes of plan limitations.

- Residential Treatment: defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. 1.5 residential treatment days = 1 inpatient day
- Partial Hospitalization: defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often. 2 partial hospitalization days = 1 inpatient day.

- Intensive Outpatient: defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often.
- 5 structured outpatient days = 1 inpatient day

Substance Abuse Limitations

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay. A stay is any substance treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 28 inpatient days.
- Lifetime maximum: Two inpatient stays for detoxification – maximum of 5 days per stay. A stay is any detox treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 5 inpatient days.

Additional Mental Health Limitations

- Inpatient care limit of 30 days per plan year (intermediate levels of care will be considered inpatient treatment for purposes of this limitation).
- Outpatient care limit of 30 visits per plan year is for mental health/substance abuse combined.

Payment is based on the MAC. Covered persons will be responsible for the deductible and any applicable copayment or coinsurance amounts. If non-network providers are used, covered persons will also be responsible for payment of charges above the Mac.

4. Add the following as Section E.12 and renumber any subsequent sections as necessary:

E.12 High Deductible Health Plan Option. One of the AccessTN PPO Plans offered by the State is a High Deductible Health Plan (HDHP), a type of plan that has a higher calendar year deductible than a typical health plan and intended to be eligible for use with a Health Savings Account (HSA). If choosing the HDHP option, a Member may qualify for tax savings by contributing to a HSA. An HSA is a personal tax-exempt trust or custodial account used to pay for qualified medical expenses, which is regulated by the Internal Revenue Service. The parties expressly acknowledge and agree that (i) neither party will provide an HSA as part of the AccessTN PPO HDHP option; (ii) neither party will provide a Member with tax advice; and (iii) Contractor does not make (and the State has not relied upon) any representation, warranty or statement regarding a Member's qualification for an HSA in conjunction with choosing the HDHP option.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — May 4, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT — **DATE**

Ronald E. Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz, Jr. — 5-8-07

M. D. GOETZ, JR., CHAIRMAN — **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

per authorized signature above

M. D. GOETZ, JR., COMMISSIONER DATE

COMPTROLLER OF THE TREASURY:

John G. Morgan 6-22-07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07- 20304-00
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 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	021	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$600,000		$600,000
2008			$1,600,000		$1,600,000
2009			$1,600,000		$1,600,000
2010			$800,000		$800,000
TOTAL:			$4,600,000		$4,600,000

OGR RELEASED
MAR 01 2007
TO ACCOUNTS

—COMPLETE FOR AMENDMENTS ONLY—

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

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th 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)

Contractor Ownership

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

Contractor Selection Method

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

Procurement Process Summary

RECEIVED
2007 FEB 27 AM 10 06
COMPTROLLER'S OFFICE
OFFICE OF
MANAGEMENT SERVICES

08 30 AM

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
ACCESS TENNESSEE BOARD OF DIRECTORS
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.

This Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of AccessTN Self Insured Health Plan Services, including: provider network development and maintenance, eligibility and enrollment, premium billing and collection, medical and care management, disease management, pharmacy benefits, customer service, claims adjudication, maintain an appeals process, financial and program reporting for the AccessTN (PPO) plan option in Tennessee; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a for profit corporation.

The Contractor's address is:

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

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

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

A SCOPE OF SERVICES

The Contractor agrees to provide administrative services for the AccessTN self-insured PPO option for eligible AccessTN members who elect to participate in the AccessTN option offered by the Contractor, hereinafter referred to as "eligible AccessTN members", in accordance with the terms of this agreement.

The Contractor is responsible for providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in Attachment D, AccessTN Benefit Summary, and other duties specifically assumed by it pursuant to this Contract. Contractor does not assume any financial risk or obligation with respect to Plan claims.

Definitions:

- **"Eligible Individuals"** are defined as individuals who meet two sets of eligibility criteria. The individual must be "uninsurable", which can be established by any one of three methods:
  1. Declination letters from two unaffiliated carriers offering individual health insurance in Tennessee (note: this must be from the company and not from a broker or agent);
  2. A doctor's statement, with specific CPT code or ICD-9 information, that the applicant has one of the presumptive medical conditions approved by the Board, and which are subject to change by the Board; and,
  3. Qualification through underwriting by an AccessTN vendor, using the health history of the applicant and supplemental medical records as necessary.

  And the individual must meet the following conditions:
  - Be a United States citizen
  - Be a resident of Tennessee for at least the last six months
  - Have used up any continuation of coverage, including COBRA, available when group health insurance terminated
  - Not have access to other health insurance at the time application is submitted
  - Not have had health insurance within the last six months.

- **"Members"** are defined as AccessTN eligible individuals who are enrolled in the PPO option offered by the Contractor.

A.1 PREFERRED PLAN ORGANIZATION PROVIDER NETWORK

A.1.1 The Contractor shall maintain and administer an AccessTN Plan provider network covering the entire State of Tennessee service area, for plan subscribers, 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/high 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 State of Tennessee.

A.1.1.1 As required by Contract Attachment A, Performance Guarantees # 6 (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 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.

A.1.4 The Contractor cannot take action to disenroll network primary care providers or hospital providers for one (1) year beginning each January 1, 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.1.5 The Contractor, following review and approval by the State, shall, update, print and distribute to subscribers' homes benefits information and provider directories as required by the State. The benefits information and provider directories may be printed as separate documents. The booklet must be AccessTN-specific and shall include a Summary Plan Description describing PPO premiums, benefits and exclusions, the Contractor's network of providers, and the Drug Formulary. Distribution shall be made to every subscriber upon Enrollment. "Enrollment: shall be defined as the date Contractor determines that an applicant is eligible and enters the applicant's data into Contractor's core processing system. 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 is 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.1.6 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 capability shall be by toll-free telephone and an up-to-date internet based directory of providers that includes provider search capability.

A.1.7 The Contractor shall ensure that the AccessTN Plan and its members financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to the AccessTN PPO and its plan participants

through the provision of plan benefits or upon the use of the network in the event that the member exceeds the annual benefit limit.

A.1.8 The Contractor shall ensure that network health care providers only bill members for applicable PPO plan benefit co-payments and coinsurance amounts.

A.1.9 The Contractor shall contract only with health care 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 PPO plan benefit requirements. There must be provisions for face-to-face contact in addition to telephone and written contact between Contractor and network health providers. Additionally, the Contractor must review and assess the practice patterns of network providers consistent with evidence based medicine, 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 plan members.

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 adjustments to provider fee schedules, facility per diems, DRG payments, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for the PPO plan. 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 ELIGIBILITY AND ENROLLMENT SERVICES

A.2.1 The Contractor shall be responsible for administering the AccessTN plan benefits and exclusions as developed and approved by the State on the plan effective date. Within six (6) months of the contract effective date, the Contractor shall develop and maintain the capability to electronically scan applications and accompanying documents and securely transfer them to the Health Underwriting vendor and the Premium Assistance vendor. The transfer may take place by access to a secure internet connection, secure email or other HIPAA compliant means.

A.2.2 The Contractor shall develop an application and information brochure detailing coverage options for the AccessTN Plan. The information brochure developed by the Contractor shall be subject to the State's approval. The application should request all information necessary for determination of eligibility so that no additional information will be required of applicants. Once approved by the State, the Contractor shall produce sufficient copies of the Application form and brochure to meet information requests and inquiries by the public.

A.2.3 The Contractor shall develop an AccessTN PPO subscriber identification card to be distributed to Plan members upon Enrollment.

A.2.4 The Contractor must assess whether all potential applicants meet the requirements for enrollment in the Plan according to the eligibility and enrollment requirements. The State reserves the authority to revise the eligibility requirements during the term of this contract. The Contractor shall utilize the following process for enrollment:

- The Contractor shall review each application for the requirements specified in the plan regulations or as instructed by the State and shall determine if the applicant is eligible to be a member in the plan.

- Beginning on the date the Contractor receives an application, the Contractor shall have fourteen (14) calendar days in which to make a disposition on the application. Disposition shall mean either decline the application, approve the application, return the application for additional information, or refer the application to State-approved vendors for additional processing. If the application is determined to be incomplete, the Contractor will attempt to make the application complete by sending written notification to the applicant detailing what is needed to complete the application, however,. the application shall be considered withdrawn. In such instances, individuals may subsequently reapply for coverage.

- The Contractor shall send a letter to the applicant including an appropriate explanation of the eligibility determination and information about the appeal procedures if the applicant is found to be ineligible for the Plan. The Contractor shall issue a refund check of the initial subscriber contribution based on State established refund guidelines.

- The Contractor shall determine which provision or provisions of the Plan regulations apply to the applicant if the applicant is found to be eligible for the Plan.

- Coverage for eligible members, whose complete applications are approved on or before the 15th of the month, shall begin on the first day of the next month. Coverage for members whose complete applications are approved after the 15th of the month will begin on the first day of the second month.

A.2.5 The Parties understand that there may on occasion be more applicants than available program openings, or "slots". The State, or an entity acting on the State's behalf, shall develop, maintain and implement an intake and enrollment processing procedure, which will utilize random selection processing, when there are more applications than available program slots. Contractor agrees to provide to the State, or the entity acting on behalf of the State, a list of applicants eligible for enrollment in the AccessTN program and other information necessary to perform the random selection processing. Contractor further agrees to process the applications for the AccessTN program in the order provided by the State or the entity acting on behalf of the State.

A.3 PREMIUM BILLING, COLLECTION AND TERMINATION FOR NONPAYMENT

A.3.1 The Contractor shall be capable of collecting the appropriate premium amounts from plan members. The State will establish a schedule of premium amounts based upon age, tobacco use and body mass index (BMI), involving no more than ten (10) age based levels.

A.3.2 The Contractor shall maintain accurate records of earned and unearned premiums received and premium refunds.

A.3.3 The Contractor shall send billing statements to members at their home address and collect all premium payments in a time and manner consistent with State policy.

A.3.4 The Contractor shall maintain the ability to receive information and funds from a premium assistance program for AccessTN members. The premium assistance program will be administered by a separate contractor and the transmittal of information concerning the recipients of the assistance will take place on a monthly basis and shall accommodate the AccessTN billing cycle.

A.3.5 The Contractor shall report premiums collected to the State on a monthly basis, and deposit all premium funds to the designated AccessTN account in a time and manner consistent with State policy and procedures

A.3.6 The Contractor shall implement a notification process concerning premiums due on a monthly basis and a process to suspend and subsequently terminate coverage for individuals who fail to pay premium in a timely fashion. The process shall assure that:

a. Premium billings are consistently generated on a date agreed upon by the State,
b. Premiums are due from members by the 1st day of each month of member coverage, unless mutually agreed upon by the Contractor and the State,
c. Medical benefit payments are suspended when members fail to pay premiums by the due date designated,
d. Pharmacy payments are suspended concurrent with the Contractor's standard corporate processes when members fail to pay premiums by the due date designated,
e. Members who do not remit premium payment in accordance with payment policies are promptly terminated effective to the last date for which premiums were paid, and
f. There is a reinstatement policy in place for members who were terminated from AccessTN coverage due to failure to pay premiums on a timely basis, subject to approval by the State.

The State may require no greater than four (4) notifications for the proper administration of premium payments and collection.

A.4 CLAIMS AJUDICATION

A.4.1 The Contractor shall by the contract start date, establish administrative claim processing and payment functions on behalf of the State from receipt of both paper and electronic claims, through final payment or denial on a fully automated claim adjudication system in a timely and accurate manner and all other necessary functions to assure timely adjudication of claims and payment of benefits to eligible members under the Plan.

A.4.2 The Contractor shall ensure the claims processing function is operated and maintained in an efficient and effective manner. The system shall have at a minimum the following capabilities:

(a) automated eligibility verification that coverage has not terminated on the date of eligible service;
(b) benefit plan information stored on the system;
(c) automatic calculation of deductibles, co-insurance out-of-pocket limits, and annual or lifetime maximum accumulations;
(d) automated calculation of cost containment provisions;
(e) identification and collection of claim overpayments and
(f) automated tracking of internal limits.

A.4.3 The Contractor shall be responsible for making available information relating to the proper manner of submitting a claim for benefits to the Plan and distributing forms upon which claim submissions shall be made, or making provision for the acceptance and processing of electronically-filed claims.

A.4.4 The Contractor shall process all medical claims in strict accordance with the AccessTN Plan Document 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.4.4.1 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.4.5 The Contractor shall, upon payment of a claim, provide an Explanation of Benefits (EOB) notice to the AccessTN plan member. The EOB shall include the name of the patient, the provider, the date(s) of service, payments to the provider and the patient's liability.

A.4.6 The Contractor shall ensure that the majority of 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.

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	National Individual Identifier
Privacy	Claims attachments
Security	National Health Plan Identifier
National Provider Identifier	Enforcement
National Employer Identifier	

The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this contract and meets the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996. The Contractor 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.4.7 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 Division of Insurance Administration and the Contractor.

A.4.8 The State shall have the sole responsibility for and authority to clarify and/or revise the AccessTN 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 AccessTN Plan Document or are not clear, the Contractor shall utilize their standard polices in adjudicating claims including medical necessity determination, and the Contractor shall advise the State 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.4.9 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide members with AccessTN 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 and approve 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 fourteen (14) calendar days from Enrollment.

A.4.10 The Contractor shall have in place a process providing for the coordination of benefits based on AccessTN as the payor of last resort.

A.4.11 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.

Additional information regarding the retention of administrative fees by the Contractor is included in Section C.3.3 of this contract.

A.4.12 The Contractor shall determine eligible expenses which 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.4.13 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.4.14 The Contractor shall notify the State, within thirty (30) days of a retroactive termination, of all claims paid on behalf of the affected plan member during the period covering the retroactivity. The State will notify the Contractor to initiate the recovery of claims.

A.4.15 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.4.16 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 inform the Division of Insurance Administration, the Division of State Audit, in the Office of the Comptroller of the Treasury and the State of Tennessee Office of inspector General. 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, the Office of the Inspector General 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 CLAIMS PAYMENT AND RECONCILIATION PROCESS

A.5.1 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.5.2 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.5.3 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 and payment amounts 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. At the specific request of the State, the Contractor shall provide in an electronic file, information which provides both payment information and claim numbers.

A.5.4 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.5.5 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 FINANCIAL TRACKING AND REPORTING

A.6.1 The Contractor shall establish a financial accounting system and/or methods employed by the Contractor that leave a clear audit trail of all financial transactions and records executed and maintained by the Contractor on behalf of the Plan. The Contractor shall maintain all financial records consistent with sound business practices and based upon generally accepted United States accounting principles, and shall clearly identify all revenue and disbursements by type of transaction. The Contractor at a minimum will be responsible for determining net written and earned premiums, other state and federal funding received by the pool, the expense of administration, the paid and incurred losses for the year and any other business conducted on behalf of the Plan and requested by the State, for each quarter and calendar year. Such information shall be reported to the State and to the State of Tennessee Comptroller of the Treasury in a form and manner prescribed by the Commissioner of Finance and Administration.

A.6.2 The Contractor will maintain a general ledger and supporting accounting records and systems for the Plan that are adequate to meet the needs of an insurance carrier of comparable size. This will include, but is not limited to:

(a) preparation and reconciliation of monthly financial statements on a cash basis in a format prescribed by the State;
(b) preparation of accrual based quarterly financial statements prepared in accordance with statutory and/or generally accepted accounting principles prescribed

A.6.3 The Contractor shall;

(a) Establish and maintain a management information reporting system that provides enrollment utilization, claims reporting, and administrative services data to the State;
(b) The Contractor shall retain and maintain all records and documents in any way relating to the Plan for **three years** after final payment by the State or any applicable statute of limitations, whichever is longer, and shall make them available for inspection and audit by authorized representatives of the State, including the State or the State's designee, at all reasonable times. All records related in any way to the Plan are to be retained for the entire time provided under this section.

A.7 GENERAL ADMINISTRATION

A.7.1 The Contractor shall by February 15, 2007, establish and provide a customer service operation that is available to plan members from at least 8:00 a.m. to 6:00 p.m. EST. Monday through Friday (excluding holidays). The customer service operation should also include a state wide, toll-free customer service line equipped with an automated voice response system that members can access directly 24 hours a day, 7 days a week, to request and receive service authorizations or other pertinent data.

A.7.2 The Contractor shall also establish and maintain a dedicated state-wide toll-free fax number for applicants to submit enrollment, and claim materials, as well as supporting documents. This toll-free fax number must receive application materials on a secured fax server. Claim forms (if required) must be mailed to members within two (2) business days from the date of request.

A.7.3 The Contractor shall provide a customer service operation that includes:

(a) Qualified staff available to answer questions on benefits, benefit levels, and claims procedures. Disabled individuals must be provided adequate access to the customer service system;
(b) An information system capable of electronically transmitting, receiving, and updating member profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.) from the Administrative Services Contractor;
(c) A toll-free line abandon rate not to exceed five percent (5%) of incoming calls (or the Contractors standard abandon rate, if so specified) in a calendar month. The abandon rate percentage shall be calculated using the hourly abandon rate averaged on a monthly basis.
(d) A toll-free busy rate not to exceed five percent (5%) of incoming calls (or the Contractors standard busy rate, if so specified) in any calendar month. The busy rate percentage shall be calculated using the hourly busy rate averaged on a monthly basis.
(e) 85 percent (85%) of incoming calls on the toll-free line will be answered by a live voice within thirty (30) seconds (or the Contractors standard live response rate and time period, if so specified) in each calendar month. Calls placed on hold within thirty (30) seconds (or the Contractors response time period) of being answered by a live voice will not be considered to meet this "live voice" performance standard. A caller must have the option to go to voicemail after three (3) minutes or continue to hold and have the call go directly to voicemail at five (5) minutes. Nothing herein shall prevent the Contractor from allowing calls to go to voicemail because of peak call times and absentees.

A.7.4 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.7.5 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 authority to review the procedure and make recommendations, where appropriate. The State sponsors an appeal process available to plan members of AccessTN PPO plan

option. The Contractor's appeal process shall meet the standards set out in Section 56-32-210 Tennessee Code Annotated.

A.7.6 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.7.7 The Contractor shall respond to all inquiries in writing from the State 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.7.8 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.7.9 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 also provide information to the State regarding the administration of the benefit, eligibility determination and enrollment, internal procedures for billing and reconciliation of transactions and the provision of health care treatment and other administrative matters.

A.7.10 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 and the staff of the Division of Insurance Administration on Contractor's administrative and benefits procedures.

A.7.11 The Contractor shall maintain AccessTN Plan-dedicated member internet pages, providing information on plan eligibility, premiums, benefits and enrollment. Information contained at this web site shall be subject to the review and approval of the Division of Insurance Administration.

A.7.12 The Contractor shall perform, following review and approval by the Division of Insurance Administration, member 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 parties and shall involve a statistically valid random sample of participants. The Division of Insurance Administration reserves the authority 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 parties shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.7.13 The Contractor shall not modify Plan PPO services or benefits provided to members during the term of this contract without the consent of the State.

A.8 **AUDIT**

A.8.1 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. 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:

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.8.1.1 Audits may commence at any time within the three (3) year period following the period being audited.

A.8.1.2 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.8.1.3 The Contractor shall not restrict the State audit sample size or sample selection methodology. The State retains the authority 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.8.1.4 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.8.1.5 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, and effective and termination dates.
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.9 MEDICAL AND CARE MANAGEMENT SERVICES

A.9.1 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.9.2 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.9.3 The Contractor shall maintain a case management/care management program for Plan members, 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.9.3.1 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.9.4 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.9.5 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.9.6 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 Utilization Review Accreditation Commission (URAC). If such accreditation is through NCQA, the Contractor shall annually submit to the State its HEDIS (Health Plan Employer Data and Information Set) report card.

A.9.7 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. 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. 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.9.7.1 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 it's benefits consultant.

A.9.7.2 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.9.7.1.

A.9.7.3 The State reserves the authority 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.9.7.4 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.10 PHARMACY

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

A.10.1 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.10.2 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's Pharmacy Benefits.
- Maintain an integrated retail and mail order electronic point-of-sale claims system that shall have edits to verify eligibility, covered drug benefits, and claim accuracy. Mail order facilities shall have the capacity to process the volume of member prescriptions.
- 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.

A.10.3 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.10.4 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.

A.10.5 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.10.6 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.10.7 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 30 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 30 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 30 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 manufactures 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 30 days of the Contractor's receipt of the final audit report.

A.10.8 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.11 DATA AND SPECIFIC REPORTING REQUIREMENTS

The Contractor shall:

A.11.1 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.11.2 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.11.3 Annually provide the State with a GeoNetworks© report showing service and geographic access. 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.11.4 The Contractor is required to transmit **plan enrollment data monthly** and medical and prescription drug claims **quarterly** to the Division of Insurance Administration'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 **Attachment E.** 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 Guarantees #7**, 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 data format similar to the format detailed in **Attachment E** 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 health and decision support system vendor no later than the last day of the month following the end of each calendar quarter **(see Contract Attachment A, Performance Guarantees #9)**.

A.11.5 Submit Management Reports as required by the State in electronic format (MSWord, MSExcel, etc.) and hard copy format, of the type, at the frequency, and containing the detail described in **Contract Attachment B Management Reporting Requirements**, shall continue for the twelve (12) month period following termination of the contract.

A.11.6 The Contractor shall participate and cooperate with the State to implement a secure, web-accessible community health record (CHR) for AccessTN members. Cooperation shall include, but may not be limited to, the provision of encounter/results data directly to an authorized CHR vendor in a time and manner approved by the State and consistent with the requirement of the CHR vendor and an executed Business Associates Agreement between the Contract and the CHR vendor. The Contractor shall require subcontractors and providers to participate and cooperate with the State and/or a CHR vendor.

A.12 **SERVICES PROVIDED BY THE STATE**

A.12.1 The State shall fund applicable accounts from which the Contractor will make claims payments during the term of the contract, and for the thirteen (13) 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 effective for the period commencing on February 13, 2007 and ending on December 31, 2009. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2 Term Extension. The State reserves the right to extend 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 Four Million Six Hundred Thousand Dollars ($4,600,000.00). 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 Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plan	$18.57	$18.57	$18.57

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

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 the rates shall be 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.3.2 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 the rates shall be 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 2010 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 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.

C.3.4 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 G 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 G. 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 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.4.1 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.5 Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.6 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.7 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.8 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.9 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 C, 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.

State further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Blue Cross Blue Shield Association nor any other Blue Cross Blue Shield licensee shall be considered to be a party to this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

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.

Contractor is responsible for providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in Attachment D, AccessTN Benefit Summary, and other duties specifically assumed by it pursuant to this Contract. Contractor does not assume any financial risk or obligation with respect to Plan claims.

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, Manager of Procurements and Contracting
Tennessee Department of Finance & Administration
Division of Insurance Administration
312 Eighth Ave. No., 13th Floor WRS Tennessee Tower
Nashville, TN 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email Address: marlene.alvarez@state.tn.us

The Contractor:

Ms. Amy Bercher, Senior Product Manager
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402
Phone: 423-535-5983
Fax: 423-535-7601
E-mail Address: amy_bercher@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 "Performance Guarantee 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 Performance Guarantee 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 Performance Guarantee Assessments represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Performance Guarantee Assessment amounts are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

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

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

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

The State may assess Performance Guarantee Assessment amounts, as applicable, against the Contractor for any failure to perform which ultimately results in a Partial Default with said Performance Guarantee Assessment 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. See Attachment 6.1.1.

E.9 Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. Seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to ***Tennessee Code Annotated***, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

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

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;
b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or grant under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
d. have not within a three (3) year period preceding this Contract had one or more public transactions (Federal, State, or Local) terminated for cause or default.

E.11 Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to

RFP # 317.40-044 (Attachment 6.3, Section B, Item B.13.) and resulting in this Contract.

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — Feb. 21, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT — **DATE**

Ronald E. Harr, Senior Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz, Jr. — 2-23-07

M. D. GOETZ, JR., CHAIRMAN — **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. — FEB 26 2007

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

Per authorized signature above

COMPTROLLER OF THE TREASURY:

John G. Morgan — 2-28-07

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 99% 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	**$800** for each full percentage point below 99% 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	**$500** for each full percentage point below 95%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: • 14 calendar days for 90% of **non-investigated (clean)** claims; and • 30 calendar days for 96% of **all** claims
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays. Any claims that include COB and subrogation will be excluded when calculating compliance with the "investigated claims" performance standard.
Assessment	**Non-Investigated Claims (clean)**: **$100** for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. **All Claims**: **$100** 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 a member services representative in 30 seconds or less.
Definition	Telephone Response Time is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Assessment	**$100** for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
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 second 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	**$5,000** for failure to attain an 85% satisfaction level for the measurement for the second calendar year

	of the contract and a 90% satisfaction level for each subsequent year of the contract. Satisfaction will be indicated by each neutral and each better than neutral response.
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. 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 Plan members will have the Access Standard indicated.
Definition	**Provider Group** / **Access Standard**
	PCPs (Endocrinologists, Internal Medicine, General or Family Practitioners) / 2 physicians within 20 miles
	Acute Care Hospitals / 1 facility within 30 miles
Assessment	**$1,000** if either of the characteristics of the network analysis are below the performance measure, as measured annually in December of each year of the contract.
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.
7. 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	*Measure* / *Benchmark*
	Gender / Data missing for </= (less than or equal to) 3% of claims
	Date of birth / Data missing for </= 3% of claims
	Outpatient diagnosis coding / Data invalid or missing for </= 5% of outpatient claims
	Outpatient provider type missing / Data missing for </= 1.5% of outpatient claims
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.)
8. Member Handbooks, Provider Network Directories and Member ID Card Distribution	
Guarantee	Member Handbooks, Porvider Network Directories and Member ID cards must be distributed (defined as "mailed") to a minimum of 99% of plan members within 14 calendar days of Enrollment.
Definition	The actual distribution to a minimum of 99% of plan members by the specified dates.
Assessment	Should the above standard not be met, the total amount shall be **$500** per year in which the standard is not met.
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.
9. 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 **$3,000** per quarter.
Compliance report	Compliance reporting submitted by MedStat upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.
10. Disease Management Program	
Guarantee	Establish a disease management program as specified in item A.9.7 of the contract by the conclusion of the first four months of the contract and maintain a compliant program for each calendar year of the contract.

Definition	The operation of a qualified disease management program by the fourth month of the contract and during each of the calendar years of the contract, thereafter.
Assessment	Should the standard not be met by the fourth month of the contract, **$10,000** and during each of the subsequent calendar years of the contract, **$10,000** annually as reported by the contractor each December.
Compliance report	Submitted by the contractor, subject to examination of program content and participation by the State or the State's designee.

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 in hard copy format, 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.
   - Number of Member Months
   - Total Paid Medical Expenses
   - Inpatient data:
     - Admissions per 1,000 members, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Days per 1,000 Members, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Average Length of Stay
   - Outpatient data:
     - Distribution of Dollars paid for Outpatient Services (expressed as percentages), for:
       - Medical
       - Surgery/ Diagnostic/Therapeutic
       - Anesthesia
       - Other
       - Total
   - Enrollment analysis, indicating:
     - Month 1, Month 2, Month 3 of the current quarter, and YTD, for:
       - Number of Members
       - Number of Patients
       - Average Age of Member
   - Prescription drug utilization- Retail and Mail Order:
     - Number of Prescriptions
     - Total Cost
     - Average Cost per Prescription
     - Average Cost per member per month
   - Top 10 Drugs by Number of Claims, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit
   - Top 10 Drugs by Cost, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit

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

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	**FA-**
CONTRACTOR LEGAL ENTITY NAME:	**BlueCross BlueShield 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: Ronald E. Harr, Feb. 21, 2007

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

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
This listing is for illustration only; plan documents shall control.	**Note: Benefits are subject to change by the AccessTN Board of Directors. Plan 500 'not currently offered.**	
PREVENTIVE CARE (first dollar- prior to deductible)	$300	$300
DEDUCTIBLES Individual Maximum Deductible per Plan Year – In network Out-of-network	$1,000 $2,000	$5,000 $10,000
Covered Expenses, as specified plan document , subject to maximum allowable charge	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Pre-Existing Conditions Period- except as stated for specific benefits, to be determined by Board of Directors	Underwritten based on 12 months	Underwritten based on 12 months
Prescription Drugs - Pharmacy does not apply to out of pocket maximum except for Plan 2,500 – HSA	No deductible for outpatient drugs	No deductible for outpatient drugs
[In addition to retail prices below, mail order program may offer incentive pricing, also to include willing network retail providers who contract to supply on same terms]	Copayment or coinsurance to be determined	Copayment or coinsurance to be determined
Generic	$10 copayment (or cost if less)	$15 copayment (or cost if less)
Preferred Brand Drugs	25% coinsurance subject to a min. of $25, max. of $50	30% coinsurance subject to a min. of $30, max. of $75
Non-Preferred Brand-	50% coinsurance subject to a min. of $50, max. of $100	60% copayment subject to a min. of $60, max. of $150
Non-covered Drugs	as identified by formulary	as identified by formulary
Maximum Out-of-Pocket Expense **(see criteria next page)**	$5,000	$10,000
Maximum Annual Benefits, except for supplemental **Organ Transplants as below**	$120,000	$100,000
Supplemental Maximum Benefit for Transplants	$100,000	$100,000
Maximum Lifetime Benefits Subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000
Maximum Out-of-Pocket Expense No out of pocket maximum for out-of-network services No out of pocket maximum for pharmacy, except for Plan 2500, according to HSA regulations. No out of pocket max. for copays- emergency room visits	$5,000	$10,000
Covered Services includes		
Inpatient services- non-emergent service must be preauthorized	80% in-network 60% out-of-network	80% in-network 60% out-of-network

	Surgical Procedures Diagnostic Lab and Imaging Services Physician office visits Preventive care after first dollar allowance above Chemotherapy and Radiation Therapy Organ Transplant (designated procedures)	80% in-network 60% out-of-network	80% in-network 60% out-of-network
	Maternity benefits- Covered only under optional rider.	Not Covered	Not Covered

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
Approved/Accredited Rehabilitation Facility		
Covered services listed below	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Inpatient Rehabilitation Facility		
Outpatient Rehabilitation Facility	Limited to 45 days per year	Limited to 45 days per year
Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)	Limited to 45 days per year	Limited to 45 days per year
Home Health Care	30 visits per year	30 visits per year
Non-Hospital & Non-Physician Services		
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Non-Contracted Providers (Varies based on the network/services area outside of Tennessee)		
Emergency Services (in-state or out-of-state)		
Emergency services (in -network or out-of-network) Note: Out-of-network benefits will be reduced to non-PPO levels if the claims administrator determines the situation was not an emergency.	80% of reasonable charges	80% of reasonable charges
Emergency Room Visit Copayment – waived if admitted ; Note: copayment required even if out-of-pocket expenses have been met, except HSA)	$50 copayment per visit	$75 copayment per visit
Non-Emergent Care		
Urgent Care Situations Urgent Care received at a walk-in clinic	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Urgent Care received through hospital emergency room (in addition to ER copay)	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Appliances & Equipment Durable Medical Equipment	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max
EXCLUSIONS **(This is a partial list- includes any services not medically necessary, etc.; see plan document for complete listing of exclusions.)**	**Cosmetic procedure** **Human Growth Hormone** **Hearing aids,** **Eyeglasses, contacts, etc.** **Dental services** **Routine foot care** **Maternity coverage, including routine newborn care**	

		Assisted reproductive technology, including fertility drugs **Services or supplies related to obesity, including surgical or other treatment for morbid obesity**

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
SCHEDULE OF PPO MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS		
DEDUCTIBLES- No separate Mental Health deductible	Outpatient services not subject to plan deductible	Outpatient services not subject to plan deductible
COINSURANCE **for MENTAL HEALTH/ SUBSTANCE ABUSE**	See below	See below
Inpatient – Including Intermediate Care Services (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 80/60% levels)	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days
Outpatient- In- Network Out-of-Network, subject to MAC [Note- Outpatient therapy sessions are NOT subject to plan deductible; Inpatient above and intermediate levels below are subject to deductible.]	80% in-network 60% out-of-network 30 sessions	80% in-network 60% out-of-network 30 sessions
Expenses determined not to be medically necessary by the utilization review organization	$0	$0

Intermediate Care
All intermediate levels of care will be counted as inpatient for purposes of plan limitations.

- Residential Treatment: defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. 1.5 residential treatment days = 1 inpatient day
- Partial Hospitalization: defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often.
  2 partial hospitalization days = 1 inpatient day
- Intensive Outpatient: defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often.
- 5 structured outpatient days = 1 inpatient day

Substance Abuse Limitations

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay. A stay is any substance treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 28 inpatient days.
- Lifetime maximum: Two inpatient stays for detoxification – maximum of 5 days per stay. A stay is any detox treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 5 inpatient days.

Additional Mental Health Limitations

- Inpatient care limit of 30 days per plan year (intermediate levels of care will be considered inpatient treatment for purposes of this limitation).
- Outpatient care limit of 30 visits per plan year is for mental health/substance abuse combined.

Payment is based on the MAC. Covered persons will be responsible for the deductible and any applicable copayment or coinsurance amounts. If non-network providers are used, covered persons will also be responsible for payment of charges above the Maximum allowable charge.

MEDSTAT STANDARD ELIGIBILITY FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly eligibility file for plan participants administered through **<Data Supplier>**.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, if a project requires 36 months of historical data, Medstat will expect to receive 36 records for each member, one for each month. Ongoing file submissions would include one record for each member for the latest month only.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a monthly basis.

TIMING OF SUBMISSION

Monthly files should be submitted on or before the 15th of the month following the close of each month.

SELECTION CRITERIA

Members and their dependents who are eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage, as well as employees who have opted-out of coverage should be included. This includes one record for each participant and one record for each dependent for the reporting month. A record should be created if the person was eligible/enrolled at any time within the month (e.g. If an employee was terminated, there should be a record in the month of termination, but not in the subsequent month. The exception to this would be an employee who terminates but continues company-paid benefits under a severance plan).

Data should include:

- Covered active members and their covered dependents including retirees, surviving spouses/beneficiaries, LOA, LTD, STD, Permanent Disability, Military Leave, and FMLA.
- Employees who have opted-out of coverage

- Employees who have terminated but retain medical coverage through a severance plan paid by the company.
- COBRA enrollee information (if this information is being provided from this data supplier for the client).

Data need not include:

- It is not necessary to include employees and dependents who are not eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage.
- Medstat would not want to receive information on terminated employees who do not continue company-paid benefits beyond the month of termination.
- If COBRA enrollee information will be supplied from a 3rd party, Medstat would ***NOT*** want to receive two records for one person.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal).

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Family ID and Employee Status, we would like to have information copied down from the employee to the dependent record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person. For financial

or quantity fields, (e.g. Employee Medical Contribution), to avoid over-counting, we would only want to see this information on the employee record.

For each field, Medstat has noted one of the three values below in the right-most column.

Member-specific = information relevant to the member (e.g. Date of Birth, Medstat would like each member's date of birth). Please populate on each record with the information specific to that member.

Employee-specific = information relevant to the employee/contract holder, but also **"copied down" to the dependent's record** (e.g. Family ID, Medstat would like the SSN of the employee also copied to each dependent's record).

Employee/Contract-Holder Only = information relevant to the employee/contract holder that Medstat would like on the **employee record or contract holder only**, i.e. not copied onto the dependent's records.

ELIGIBILITY LAYOUT – Detail Records

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	Population of Employee/ Dependent Records
Standard Medstat Fields								
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'D'	Member-Specific
2	Business Unit Code	2	5	4	Character	Client-specific code for the business unit.	Business Unit values will be identified in the **Data Dictionary**.	Employee-Specific
3	Coverage Indicator Dental	6	6	1	Character	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
4	Coverage Indicator Drug	7	7	1	Character	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
5	Coverage Indicator Hearing	8	8	1	Character	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
6	Coverage Indicator Medical	9	9	1	Character	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
7	Coverage Indicator MHSA	10	10	1	Character	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
8	Coverage Indicator Vision	11	11	1	Character	Indicator of Vision Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
9	Coverage Tier Code	12	15	4	Character	Medical Coverage Tier Code	Customer-specific values.	Member-Specific
10	Date of Birth	16	25	10	Date	Birth date of the person	MM/DD/CCYY format	Member-Specific
11	Date of Eligibility Month	26	35	10	Date	First day of eligibility month	MM/DD/CCYY Format	Member-Specific
12	Employee Status Code	36	40	5	Character	Client-specific values of employee status.	Employee Status code values will be identified in the **Data Dictionary**.	Employee-Specific
13	Family ID	41	49	9	Character	Employee SSN		Employee-Specific
14	Gender	50	50	1	Character	Gender of the person.	M or F	Member-Specific
15	Employee Medicare Eligible Indicator	51	51	1	Character	A code indicating whether an employee is Medicare eligible.	Y = Yes N = No	Employee-Specific

16	Part-Time/Full-time Indicator	52	52	1	Character	A code indicating whether an employee is full-time or part-time.	P = Part-time F = Fulll-time	Employee-Specific
17	PCP Type Code	53	53	1	Character	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	PCP Type code values will be identified in the **Data Dictionary**.	Member-Specific
18	PCP ID	54	66	13	Character	The provider identifier of the Primary Care Physician.	The Tax ID number for the provider is preferred.	Member-Specific
19	Plan Code	67	72	6	Character	The code for the medical plan in which the member is enrolled.	Plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "***Opt-outs***".	Member-Specific
20	Race Code	73	73	1	Character	A code specifying the race or ethnicity of the person.	Race code values will be identified in the **Data Dictionary.**	Member-Specific
21	Region Code	74	78	5	Character	Client-specific code for the geographic region of the person.	Region code values will be identified in the **Data Dictionary**.	Member-Specific
22	Relationship Code	79	83	5	Character	Client-specific values that specify the relationship of the member to the subscriber.	Relationship code values will be identified in the **Data Dictionary**.	Member-Specific
23	Salaried Indicator	84	84	1	Character	An indicator of whether the employee status is salaried or hourly.	Y = Salaried N = Hourly	Employee-Specific
24	Union Worker Indicator	85	85	1	Character	An indicator that the employee belongs to a union.	Y = Union N = Non-Union	Employee-Specific
25	Zip Code	86	95	10	Character	The zip code of the residence of the member at the time of the eligibility month.		Member-Specific
26	Monthly Employee Medical Contribution	96	105	10	Numeric	The monthly amount contributed by the employee for their medical benefits	Format 9(7)v99 (2 – digit, implied decimal) Only recorded on employee record (zero-filled on dependent records). Zero-filled for opt-outs.	Employee/Contract Holder Only
27	Monthly Medical Premium	106	115	10	Numeric	The employer-paid monthly premium for medical benefits (fully-insured plans)	Format 9(7)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid ***by the employer*** for fully-insured plans and not premium equivalents. ***<It should not be the net amount (minus employee contrib) as this will be calculated within the Medstat product.*** It should be populated only on employee records for those employees enrolled in fully-insured medical plans. On all other records	Employee/Contract Holder Only

							this field should be zero filled.	
28	Monthly Medical Admin Fees	116	125	10	Numeric	The employer-paid monthly admin/ASO fees for medical benefits (self-insured plans)	Format 9(7)v99 (2 – digit, implied decimal) This field is to be populated on employee records only for those employees enrolled in self-insured medical plans. For all other records, this field should be zero filled.	Employee/Contract Holder Only
Field Number	**Field Name**		**End**	**Length**	**Type**	**Data Element Description**	**Data Supplier Instructions/Notes**	**Population of Employee / Dependent Records**
Customer-specific fields								
<Add any Customer-specific fields here and adjust the field numbering and start/end positions accordingly>								
40	Filler1	178	299	122	Character	Reserved for future use	Fill with blanks	
41	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

ELIGIBILITY LAYOUT – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes	Population of Employee/ Dependent Records
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'T'	N/A – only 1 trailer record will be provided.
2	Eligibility Start Date	2	11	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.	
3	Eligibility End Date	12	21	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.	
4	Record Count	22	31	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record	
5	Filler	32	299	268	Character	Filler	Fill with Blanks	
6	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

MEDSTAT STANDARD MEDICAL CLAIMS FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Medical claims file for plan participants administered through **<Data Supplier>**.
The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Medical Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Medical Claims / Encounter Records

Definitions:

- **Fee-for-service claims** – Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records** – Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data** – Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-92 claim form.
- **Professional Data** – Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents** – Financial amounts for services rendered under a capitated arrangement found within encounter records.

Items for discussion

General

- If both fee-for-service claims and encounter records are included on the data file, Medstat will rely on the data supplier to explain how to differentiate them.
- Medstat prefers to receive the facility, professional and capitation data (if applicable) in one file. We will rely on the data supplier to explain how to differentiate facility, professional and capitation services in their data.
- If encounter records contain fee-for-service equivalents, it is essential for Medstat to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Medstat will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG.
- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields

Medstat defines the relationship among financial fields as follows:

Charge Submitted
– Not Covered Amount*
= Charge Covered*
– Discount Amount
= Allowed Amount
– Coinsurance
– Copayment
– Deductible
– Penalty/Sanction Amount*
– Third Party Amount
= **Net Payment**

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement
A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.
The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments
A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.
The original and adjustment need not appear in the same file.
Example: After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Facility Record Content

- The standard UB-92 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One facility claim with three service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Rev Cd	Svc Cnt	Net Pay
11111	121212121	25	1	120	2	2000.00
11111	121212121	25	2	250	1	100.00
11111	121212121	25	3	720	10	1532.00

Professional Record Content

- Medstat does not store separate header/claim-level and detail/service-level information for professional claims. Medstat requires the following:
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim.)
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One professional claim with two service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Proc Cd	Svc Cnt	Net Pay
13331	621262121	51	1	99201	1	100.00
13331	621262121	51	2	99175	1	150.00

Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

Data Type: Capitation Data

Definition

1 Capitation data contains information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record will be found in the medical claims data.

Items for Discussion

- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Medical Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
3	Bill Type Code UB	12	14	3	Character	The UB-92 standard code for the billing type, indicating type of facility, bill	Bill Type values will be identified in the **Data Dictionary.**
4	Capitated Service Indicator	15	15	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
5	Charge Submitted	16	25	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
6	Claim ID	26	40	15	Character	The client-specific identifier of the claim.	
7	Claim Type Code	41	42	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
8	Co-Insurance	43	52	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	Copayment	53	62	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
10	Date of Birth	63	72	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.

11	Date of First Service	73	82	10	Date	The date of the first service reported on the claim or authorization record.	MM/DD/CCYY format
12	Date of Last Service	83	92	10	Date	The date of the last service reported on the claim or authorization record.	MM/DD/CCYY format
13	Date of Service Facility Detail	93	102	10	Date	The date of service for the facility detail record.	MM/DD/CCYY format
14	Date Paid	103	112	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
15	Days	113	118	6	Numeric	The number of inpatient days for the facility claim.	
16	Deductible	119	128	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
17	Diagnosis Code Principal	129	133	5	Character	The first or principal diagnosis code for a service, claim or lab result.	No decimal point.
18	Diagnosis Code 2 UB	134	138	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
19	Diagnosis Code 3 UB	139	143	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
20	Diagnosis Code 4 UB	144	148	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
21	Diagnosis Code 5 UB	149	153	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
22	Diagnosis Code 6 UB	154	158	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
23	Diagnosis Code 7 UB	159	163	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
24	Diagnosis Code 8 UB	164	168	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
25	Diagnosis Code 9 UB	169	173	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
26	Diagnosis Code 10 UB	174	178	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
27	Diagnosis Code 11 UB	179	183	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
28	Diagnosis Code 12 UB	184	188	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
29	Diagnosis Code 13 UB	189	193	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.

30	Discharge Status Code UB	194	195	2	Numeric	The UB-92 standard patient status code, indicating disposition at the time of billing.	
31	Discount	196	205	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
32	Family ID	206	214	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
33	Gender Code	215	215	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
34	Line Number	216	217	2	Numeric	The detail line number for the service on the claim	
35	Net Payment	218	227	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
36	Network Paid Indicator	228	228	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level	"Y" or "N"
37	Network Provider Indicator	229	229	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs	"Y" or "N"
38	Ordering Provider ID	230	242	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.	The ID should be the physician's Federal Tax ID (TIN).
39	PCP Responsibility Indicator	243	243	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
40	Place of Service Code	244	245	2	Character	Client-specific code for the place of service.	Place of Service values will be identified in the Data **Dictionary.**
41	Procedure Code	246	250	5	Character	The procedure code for the service record.	CPT/HCPCS codes.
42	Procedure Code UB Surg 1	251	255	5	Character	The primary surgical procedure code (1) on the facility claim.	ICD-9 Surgical procedure codes.
43	Procedure Modifier Code 1	256	257	2	Character	The 2-character code of the first procedure code modifier on the professional claim	

44	Provider ID	258	270	13	Character	The identifier for the provider of service.	This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOSP)
45	Provider Type Code Claim	271	273	3	Numeric	Client-specific code for the provider type on the claim record	Provider Type codes are further defined in the **Data Dictionary**
46	Provider Zip Code	274	278	5	Numeric	The 5-digit zip code corresponding to the Provider ID	Provider Location zip code
47	Revenue Code UB	279	282	4	Numeric	The CMS standard revenue code from the facility claim	This field must be at the service/detail level.
48	Third Party Amount	283	292	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Units of Service	293	296	4	Numeric	Client-specific quantity of services or units	
50	Provider Name	297	326	30	Character	The description or name corresponding to the Provider ID.	
51	Financial Cost Amount	327	336	10	Numeric	The amount of payments contributing to total cost of coverage, but received as a standard claim.	Format 9(7)v99 (2 – digit, implied decimal) Usually used for capitation payments.
52	Capitation Type Code	337	338	2	Numeric	Client-specific code for the type of capitation payment	
53	Funding Type Code	339	340	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
54	Account Structure	341	348	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
55	Provider NPI Number	349	358	10	Character	The National Provider ID number for the provider.	
56	Provider Address 1	359	408	50	Character	The current street address1 of the provider of service.	
57	Provider Address 2	409	458	50	Character	The current street address2 of the provider of service.	
58	HRA Amount	459	458	10	Numeric	The amount paid from the HRA as a result of this claim.	
58	Filler1	469	599	131	Character	Reserved for future use	Fill with blanks
59	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'D'

Medical Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	599	555	Character	Filler	Fill with Blanks
6	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'T'

MEDSTAT STANDARD DRUG FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Prescription Drug claims file for plan participants administered through **<Data Supplier>**.
The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Drug Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Drug Claims

Definitions:

- Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.

Items for discussion

General

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields

Medstat defines the relationship among financial fields as follows:

Charge Submitted
– Not Covered Amount*
= Charge Covered*
– Discount Amount
= Allowed Amount
– Coinsurance
– Copayment
– Deductible
– Penalty/Sanction Amount*
– Third Party Amount
= **Net Payment**

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement
A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.
The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments
A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.
The original and adjustment need not appear in the same file.
Example: After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Denied Claims
Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Drug Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.	
6	Claim Type Code	38	39	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
7	Co-Insurance	40	49	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
8	Copayment	50	59	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
9	Date of Birth	60	69	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
10	Date of Service	70	79	10	Date	The date of service for the drug claim.	MM/DD/CCYY format

11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
12	Days Supply	90	93	4	Numeric	The number of days of drug therapy covered by the prescription.	
13	Deductible	94	103	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal)
14	Dispensing Fee	104	113	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
15	Family ID	114	122	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
16	Formulary Indicator	123	123	1	Character	An indicator that the prescription drug is included in the formulary.	"Y" or "N"
17	Gender Code	124	124	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
18	Ingredient Cost	125	134	10	Numeric	The charge or cost associated with the pharmaceutical product.	Format 9(7)v99 (2 – digit, implied decimal)
19	Metric Quantity Dispensed	135	145	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.	
20	NDC Number Code	146	156	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Please leave out the dashes.
21	Net Payment	157	166	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal)
22	Network Paid Indicator	167	167	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.	"Y" or "N"
23	Network Provider Indicator	168	168	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.	"Y" or "N"
24	Ordering Provider ID	169	181	13	Character	The ID number of the provider who prescribed the drug.	The ID should be the physician's Federal Tax ID (TIN).

25	PCP Responsibility Indicator	182	182	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
26	Provider ID	183	195	13	Character	The identifier for the provider of service.	This must be the National Association of Boards of Pharmacy (NABP) number.
27	Rx Dispensed as Written Code	196	196	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.	
28	Rx Mail or Retail Code	197	197	1	Numeric	The Medstat standard code indicating the purchase place of the prescription.	"M" for Mail, "R" for Retail
29	Rx Payment Tier	198	198	1	Character	Client-specific description for the payment tier of the drug claim.	Data Supplier will help Medstat understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary
30	Rx Refill Number	199	202	4	Numeric	A number indicating the original prescription or the refill number.	This is the refill number, not the number of refills remaining.
31	Sales Tax	203	212	10	Numeric	The amount of sales tax applied to the cost of the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
32	Third Party Amount	213	222	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal)
33	Discount	223	232	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal)
34	Provider NPI Number	233	242	10	Numeric	The National Provider Identifier for the pharmacy.	
35	Funding Type Code	243	244	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
36	Account Structure	245	252	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
37	HRA Amount	253	262	10	Numeric	The amount paid from the HRA to pay the provider.	
38	Filler1	263	399	147	Character	Reserved for future use	Fill with blanks
39	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'D'

Drug Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	399	355	Character	Filler	Fill with Blanks
6	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'T'

ATTACHMENT F

HIPAA BUSINESS ASSOCIATE AGREEMENT TO COMPLY WITH PRIVACY AND SECURITY RULES

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

BACKGROUND

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

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

- contract number(s) TBD

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 fifteen (15) days 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 thirty (30) 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 and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least fifteen (15) 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.
Title: Chairman, Access Tennessee Board of Directors
Address: 312 8th Avenue, North
Nashville, Tennessee 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email: dave.goetz@state.tn.us

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

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

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

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this

Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

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

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

IN WITNESS WHEREOF,

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Tena Roberson 2/21/07

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

ACCESS TENNESSEE BOARD OF DIRECTORS

M.D. Goetz, Jr. 2-23-07

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

Contract Attachment G
BLUECARD PPO PROGRAM

G.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."

G.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.")

G.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.

G.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.

G.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.

G.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:

G.2.2.1 the actual price the Host Plan paid to the health care provider ("Actual Price"); or

G.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

G.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.

G.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.

G.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.

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

G.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

G.2.5.2 add a surcharge.

G.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.

G.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.

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

G.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

G.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.

G.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.

G.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.

G.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.

G.5 Administrative Expense Allowance Fees. 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:

Type of Claim	State's cost per Claim	
	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.

G.6 Access Fees. 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.

G.7 BlueCard Worldwide. 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.