

CONTRACT #12
RFS # 317.86-00104
FA # 11-33180
Edison # 22046

**Department of Finance and
Administration
Benefits Administration**

VENDOR:
**Cigna Health and Life
Insurance Company – West
(formerly Connecticut General
Life Insurance Company)**



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION

312 Rosa L. Parks Avenue
Suite 1900 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-4517 or (866) 576-0029
FAX (615) 253-8556

Larry B. Martin
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

TO: Lucian Geise, Executive Director, Fiscal Review Committee

FROM: Laurie Lee *LL*

DATE: August 7, 2013

RE: **Cigna Health and Life Insurance Company Amendment # 1, Edison # 22047 - West**

This request for amendment # 1 comes to the Fiscal Review Committee with an October 21, 2013 effective date.

As detailed in the Non-Competitive Amendment request accompanying this correspondence, the current contractor, Cigna Health and Life Insurance Company, is providing the State with medical claims administration services for the public sector plans. This amendment will effect a Vendor name change, add funding to complete the term of the contract, amend the subrogation process language in the original contract, correct a county division assignment, and update Attachment D of the contract to reflect the subrogation process change.

The original contract is included for review. Thank you for your consideration of this request.

Supplemental Documentation Required for
Fiscal Review Committee

*Contact Name:	Sylvia Chunn	*Contact Phone:	615-253-8358		
*Original Contract Number:	FA-11-33180	*Original RFS Number:	31786-00104		
Edison Contract Number: <i>(if applicable)</i>	22047	Edison RFS Number: <i>(if applicable)</i>			
*Original Contract Begin Date:	8/27/2010	*Current End Date:	12/31/2015		
Current Request Amendment Number: <i>(if applicable)</i>		One (1)			
Proposed Amendment Effective Date: <i>(if applicable)</i>		October 21, 2013			
*Department Submitting:		Finance and Administration			
*Division:		Benefits Administration			
*Date Submitted:		August 7, 2013			
*Submitted Within Sixty (60) days:		Yes			
<i>If not, explain:</i>					
*Contract Vendor Name:		Cigna Health and Life Insurance Company (formerly Connecticut General Life Insurance Company) – West			
*Current Maximum Liability:		\$21,652,236.00			
*Current Contract Allocation by Fiscal Year: <i>(as Shown on Most Current Fully Executed Contract Summary Sheet)</i>					
FY:2011	FY:2012	FY:2013	FY:2014	FY:2015	FY:2016
\$1,956,926.00	\$4,013,236.00	\$4,215,936.00	\$4,428,899.00	\$4,653,256.00	\$2,383,983.00
*Current Total Expenditures by Fiscal Year of Contract: <i>(attach backup documentation from STARS or FDAS report)</i>					
FY:2011	FY:2012	FY:2013	FY:2014	FY:2015	FY:2016
\$3,699,905.00	\$7,354,951.56	\$7,549,285.53	\$	\$	\$
IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:					
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:					
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:			Contract Per Member Per Month (PMPM) actual expenditures are based on payroll deduction of member premiums. Actual membership may vary from the original estimates during the term of each contract, and therefore funding needs may vary. Monthly funding of contract expenditures is obtained,		

Supplemental Documentation Required for
Fiscal Review Committee

		on an as needed basis, from each separate plan funds (State Fund 55, Local Education Fund 56, and Local Government Fund 58). Plan fund revenues are obtained primarily from employer and employee premiums, which are annually set by the committees, and utilized for paying all health plan fund expenses (claims, and administrative expenses, etc.), and can only be utilized for that purpose.	
*Contract Funding Source/Amount:	State:		Federal:
Interdepartmental:		\$21,652,236.00	Other:
If "other" please define:			
Dates of All Previous Amendments or Revisions: <i>(if applicable)</i>		Brief Description of Actions in Previous Amendments or Revisions: <i>(if applicable)</i>	
n/a			
Method of Original Award: <i>(if applicable)</i>		RFP	
*What were the projected costs of the service for the entire term of the contract prior to contract award?		\$25,000,000.00	

Supplemental Documentation Required for
Fiscal Review Committee

<p>For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.</p> <p>If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.</p>					
<p>Planned expenditures by fiscal year by deliverable. Add rows as necessary to indicate all estimated contract expenditures.</p>					
Deliverable description:	FY:	FY:	FY:	FY:	FY:
n/a					
<p>Proposed savings to be realized per fiscal year by entering into this contract. If amendment to an existing contract, please indicate the proposed savings to be realized by the amendment. Add rows as necessary to define all potential savings per deliverable.</p>					
Deliverable description:	FY:	FY:	FY:	FY:	FY:
n/a					
<p>Comparison of cost per fiscal year of obtaining this service through the proposed contract or amendment vs. other options. List other options available (including other vendors), cost of other options, and source of information for comparison of other options (e.g. catalog, Web site). Add rows as necessary to indicate price differentials between contract deliverables.</p>					
Proposed Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:

Cigna West

Contract # 22047

Vendor # 5518

Reports Pulled: 7/8/2013

<u>FY</u>	<u>Payments</u>
2011	3,699,905.00
2012	7,354,951.56
YTD 2013	<u>7,549,285.53</u>
Total	18,604,142.09

TN_PU_CN026 - Payments Not on Contract

Report Date: 7/8/2013

Payments	0						
Unit	Sum Amount	Edison Contract ID	Vendor ID	Vendor Name	PO_ID	D.VOUCHER_ID	Year

Contract Reconciliation as of 7/8/2013

Maximum Liability	\$ 21,652,236.00	
Less: Payments	\$ 18,604,142.09	From Reports CN-021 and CN-026
Remaining Balance	\$ 3,048,093.91	
Line Released	\$ 20,884,142.09	From Edison as of 7/8/2013
Diff. B/T Line Released and Payments	\$ 2,280,000.00	
Accrual PO 984 (See Edison CN-028)		
Total PO amount	\$ 2,280,000.00	
Total Paid	\$ -	
Difference	\$ 2,280,000.00	
Difference b/t B11 and B16	\$ -	should be zero

Contract Reconciled as of 7/8/2013

Remaining Contract Balance \$ 3,048,093.91

POs by Contract ID	316									
Unit	PO No.	PO Status	Budget	PO Line	Vendor	Name	Sum PO Amount	Sum Voucher Amount	Contract	Contract Line
31786	000000984	Approved	Valid	1	000005518	Cigna Healthcare	49000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	2	000005518	Cigna Healthcare	20500.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	3	000005518	Cigna Healthcare	1000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	4	000005518	Cigna Healthcare	183000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	5	000005518	Cigna Healthcare	151000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	6	000005518	Cigna Healthcare	63000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	7	000005518	Cigna Healthcare	88000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	8	000005518	Cigna Healthcare	46500.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	9	000005518	Cigna Healthcare	2000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	10	000005518	Cigna Healthcare	967000.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	11	000005518	Cigna Healthcare	535500.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	12	000005518	Cigna Healthcare	139500.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	13	000005518	Cigna Healthcare	500.000	0.000	0000000000000000000220	1
31786	000000984	Approved	Valid	14	000005518	Cigna Healthcare	33500.000	0.000	0000000000000000000220	1
31786	000000940	Dispatched	Valid	1	000005518	Cigna Healthcare	80859.240	80859.240	0000000000000000000220	1
31786	000000940	Dispatched	Valid	2	000005518	Cigna Healthcare	33895.540	33895.540	0000000000000000000220	1
31786	000000940	Dispatched	Valid	3	000005518	Cigna Healthcare	845.930	845.930	0000000000000000000220	1
31786	000000940	Dispatched	Valid	4	000005518	Cigna Healthcare	309056.150	309056.150	0000000000000000000220	1
31786	000000940	Dispatched	Valid	5	000005518	Cigna Healthcare	256637.660	256637.660	0000000000000000000220	1
31786	000000940	Dispatched	Valid	6	000005518	Cigna Healthcare	105449.550	105449.550	0000000000000000000220	1
31786	000000940	Dispatched	Valid	7	000005518	Cigna Healthcare	144624.860	144624.860	0000000000000000000220	1
31786	000000940	Dispatched	Valid	8	000005518	Cigna Healthcare	77300.500	77300.500	0000000000000000000220	1
31786	000000940	Dispatched	Valid	9	000005518	Cigna Healthcare	2362.770	2362.770	0000000000000000000220	1
31786	000000940	Dispatched	Valid	10	000005518	Cigna Healthcare	1651517.890	1651517.890	0000000000000000000220	1
31786	000000940	Dispatched	Valid	11	000005518	Cigna Healthcare	914304.480	914304.480	0000000000000000000220	1
31786	000000940	Dispatched	Valid	12	000005518	Cigna Healthcare	235635.260	235635.260	0000000000000000000220	1
31786	000000940	Dispatched	Valid	13	000005518	Cigna Healthcare	320.870	320.870	0000000000000000000220	1
31786	000000940	Dispatched	Valid	14	000005518	Cigna Healthcare	55189.640	55189.640	0000000000000000000220	1
31786	000000915	Dispatched	Valid	1	000005518	Cigna Healthcare	56688.330	56688.330	0000000000000000000220	1
31786	000000915	Dispatched	Valid	2	000005518	Cigna Healthcare	24732.090	24732.090	0000000000000000000220	1
31786	000000915	Dispatched	Valid	3	000005518	Cigna Healthcare	679.920	679.920	0000000000000000000220	1
31786	000000915	Dispatched	Valid	4	000005518	Cigna Healthcare	212050.050	212050.050	0000000000000000000220	1
31786	000000915	Dispatched	Valid	5	000005518	Cigna Healthcare	164229.010	164229.010	0000000000000000000220	1
31786	000000915	Dispatched	Valid	6	000005518	Cigna Healthcare	72128.180	72128.180	0000000000000000000220	1
31786	000000915	Dispatched	Valid	7	000005518	Cigna Healthcare	90401.030	90401.030	0000000000000000000220	1
31786	000000915	Dispatched	Valid	8	000005518	Cigna Healthcare	50399.070	50399.070	0000000000000000000220	1
31786	000000915	Dispatched	Valid	9	000005518	Cigna Healthcare	1869.780	1869.780	0000000000000000000220	1
31786	000000915	Dispatched	Valid	10	000005518	Cigna Healthcare	1031778.600	1031778.600	0000000000000000000220	1
31786	000000915	Dispatched	Valid	11	000005518	Cigna Healthcare	568753.080	568753.080	0000000000000000000220	1
31786	000000915	Dispatched	Valid	12	000005518	Cigna Healthcare	151027.230	151027.230	0000000000000000000220	1
31786	000000915	Dispatched	Valid	13	000005518	Cigna Healthcare	36.000	0.000	0000000000000000000220	1
31786	000000915	Dispatched	Valid	14	000005518	Cigna Healthcare	34165.980	34165.980	0000000000000000000220	1
31786	000000899	Compl	Valid	1	000005518	Cigna Healthcare	14249.990	14249.990	0000000000000000000220	1
31786	000000899	Compl	Valid	2	000005518	Cigna Healthcare	6232.600	6232.600	0000000000000000000220	1
31786	000000899	Compl	Valid	3	000005518	Cigna Healthcare	169.980	169.980	0000000000000000000220	1
31786	000000899	Compl	Valid	4	000005518	Cigna Healthcare	54308.610	54308.610	0000000000000000000220	1
31786	000000899	Compl	Valid	5	000005518	Cigna Healthcare	41588.440	41588.440	0000000000000000000220	1
31786	000000899	Compl	Valid	6	000005518	Cigna Healthcare	17422.950	17422.950	0000000000000000000220	1
31786	000000899	Compl	Valid	7	000005518	Cigna Healthcare	22295.710	22295.710	0000000000000000000220	1
31786	000000899	Compl	Valid	8	000005518	Cigna Healthcare	11473.650	11473.650	0000000000000000000220	1
31786	000000899	Compl	Valid	9	000005518	Cigna Healthcare	339.960	339.960	0000000000000000000220	1
31786	000000899	Compl	Valid	10	000005518	Cigna Healthcare	257009.760	257009.760	0000000000000000000220	1
31786	000000899	Compl	Valid	11	000005518	Cigna Healthcare	140431.810	140431.810	0000000000000000000220	1
31786	000000899	Compl	Valid	12	000005518	Cigna Healthcare	36913.990	36913.990	0000000000000000000220	1
31786	000000899	Compl	Valid	13	000005518	Cigna Healthcare	8215.700	8215.700	0000000000000000000220	1
31786	000000882	Compl	Valid	1	000005518	Cigna Healthcare	14448.300	14448.300	0000000000000000000220	1
31786	000000882	Compl	Valid	2	000005518	Cigna Healthcare	6317.590	6317.590	0000000000000000000220	1
31786	000000882	Compl	Valid	3	000005518	Cigna Healthcare	169.980	169.980	0000000000000000000220	1
31786	000000882	Compl	Valid	4	000005518	Cigna Healthcare	54988.530	54988.530	0000000000000000000220	1
31786	000000882	Compl	Valid	5	000005518	Cigna Healthcare	41843.410	41843.410	0000000000000000000220	1
31786	000000882	Compl	Valid	6	000005518	Cigna Healthcare	17536.270	17536.270	0000000000000000000220	1
31786	000000882	Compl	Valid	7	000005518	Cigna Healthcare	22012.410	22012.410	0000000000000000000220	1
31786	000000882	Compl	Valid	8	000005518	Cigna Healthcare	11671.960	11671.960	0000000000000000000220	1
31786	000000882	Compl	Valid	9	000005518	Cigna Healthcare	368.290	368.290	0000000000000000000220	1
31786	000000882	Compl	Valid	10	000005518	Cigna Healthcare	256868.110	256868.110	0000000000000000000220	1
31786	000000882	Compl	Valid	11	000005518	Cigna Healthcare	140431.810	140431.810	0000000000000000000220	1
31786	000000882	Compl	Valid	12	000005518	Cigna Healthcare	36913.990	36913.990	0000000000000000000220	1
31786	000000882	Compl	Valid	13	000005518	Cigna Healthcare	8159.040	8159.040	0000000000000000000220	1
31786	000000858	Compl	Valid	1	000005518	Cigna Healthcare	14788.260	14788.260	0000000000000000000220	1
31786	000000858	Compl	Valid	2	000005518	Cigna Healthcare	6232.600	6232.600	0000000000000000000220	1
31786	000000858	Compl	Valid	3	000005518	Cigna Healthcare	169.980	169.980	0000000000000000000220	1
31786	000000858	Compl	Valid	4	000005518	Cigna Healthcare	55243.500	55243.500	0000000000000000000220	1
31786	000000858	Compl	Valid	5	000005518	Cigna Healthcare	42693.310	42693.310	0000000000000000000220	1
31786	000000858	Compl	Valid	6	000005518	Cigna Healthcare	17507.940	17507.940	0000000000000000000220	1
31786	000000858	Compl	Valid	7	000005518	Cigna Healthcare	21870.760	21870.760	0000000000000000000220	1
31786	000000858	Compl	Valid	8	000005518	Cigna Healthcare	11388.660	11388.660	0000000000000000000220	1
31786	000000858	Compl	Valid	9	000005518	Cigna Healthcare	396.620	396.620	0000000000000000000220	1
31786	000000858	Compl	Valid	10	000005518	Cigna Healthcare	256924.770	256924.770	0000000000000000000220	1
31786	000000858	Compl	Valid	11	000005518	Cigna Healthcare	141819.980	141819.980	0000000000000000000220	1
31786	000000858	Compl	Valid	12	000005518	Cigna Healthcare	36772.340	36772.340	0000000000000000000220	1
31786	000000858	Compl	Valid	13	000005518	Cigna Healthcare	7535.780	7535.780	0000000000000000000220	1
31786	000000843	Compl	Valid	1	000005518	Cigna Healthcare	14901.580	14901.580	0000000000000000000220	1
31786	000000843	Compl	Valid	2	000005518	Cigna Healthcare	6260.930	6260.930	0000000000000000000220	1
31786	000000843	Compl	Valid	3	000005518	Cigna Healthcare	169.980	169.980	0000000000000000000220	1
31786	000000843	Compl	Valid	4	000005518	Cigna Healthcare	56178.390	56178.390	0000000000000000000220	1
31786	000000843	Compl	Valid	5	000005518	Cigna Healthcare	42721.640	42721.640	0000000000000000000220	1
31786	000000843	Compl	Valid	6	000005518	Cigna Healthcare	18471.160	18471.160	0000000000000000000220	1
31786	000000843	Compl	Valid	7	000005518	Cigna Healthcare	21814.100	21814.100	0000000000000000000220	1
31786	000000843	Compl	Valid	8	000005518	Cigna Healthcare	11388.660	11388.660	0000000000000000000220	1
31786	000000843	Compl	Valid	9	000005518	Cigna Healthcare	396.620	396.620	0000000000000000000220	1
31786	000000843	Compl	Valid	10	000005518	Cigna Healthcare	256443.160	256443.160	0000000000000000000220	1
31786	000000843	Compl	Valid	11	000005518	Cigna Healthcare	142074.950	142074.950	0000000000000000000220	1
31786	000000843	Compl	Valid	12	000005518	Cigna Healthcare	38018.860	38018.860	0000000000000000000220	1
31786	000000843	Compl	Valid	13	000005518	Cigna Healthcare	7649.100	7649.100	0000000000000000000220</	

Non-Competitive Amendment Request

NOT required for a contract with a federal, Tennessee, or Tennessee local government entity or a grant.

Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@state.tn.us

APPROVED

COMMISSIONER OF FINANCE & ADMINISTRATION

Request Tracking #	31786-00104	
1. Procuring Agency	Department of Finance and Administration, Division of Benefits Administration	
2. Contractor	Cigna Health and Life Insurance Company - West	
3. Contract #	FA-11-33180	
4. Proposed Amendment #	1	
5. Edison ID #	22047	
6. Contract Begin Date	8/27/2010	
7. Current Contract End Date – with ALL options to extend exercised	12/31/2015	
8. Proposed Contract End Date – with ALL options to extend exercised	12/31/2015	
9. Current Maximum Contract Cost – with ALL options to extend exercised	\$ 21,652,236	
10. Proposed Maximum Contract Cost – with ALL options to extend exercised	\$ 38,972,236	
11. Office for Information Resources Endorsement – information technology service (N/A to THDA)	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
12. eHealth Initiative Support – health-related professional, pharmaceutical, laboratory, or imaging	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
13. Human Resources Support – state employee training service	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Attached	
14. Explanation Need for the Proposed Amendment	<p>This amendment will effect a Vendor name change, add funding to complete the term of the contract, amend the subrogation process language in the original contract, correct a county division assignment, and update Attachment D of the contract to reflect the subrogation process change.</p>	
15. Name & Address of the Contractor's Principal Owner(s) – NOT required for a TN state education institution		

Request Tracking #	31786-00104
<p>Tim Cullen, Account Manager Cigna 1000 Corporate Centre Drive, Suite 500 Franklin, TN 37067</p>	
<p>16. Evidence Contractor's Experience & Length Of Experience Providing the Service</p> <p>The current contractor, Cigna Health and Life Insurance Company, is providing the State with medical claims administration services for the public sector plans, and has held a contract with the State for the past 8 years providing these services.</p>	
<p>17. Efforts to Identify Reasonable, Competitive, Procurement Alternatives</p> <p>N/A</p>	
<p>18. Justification – <i>specifically explain why non-competitive negotiation is in the best interest of the state</i></p> <p>This amendment adds funding to complete the initial contract term and updates to contract language to match current division assignments and subrogation processes.</p>	
<p>Agency Head Signature and Date – <i>MUST be signed by the ACTUAL agency head as detailed on the current Signature Certification. Signature by an authorized signatory is acceptable only in documented exigent circumstances</i></p>	



CONTRACT AMENDMENT

Agency Tracking # 31786-00104	Edison ID 22047	Contract # Cigna - West	Amendment # 1		
Contractor Legal Entity Name Cigna Health and Life Insurance Company (CHLIC)			Edison Vendor ID 5518		
Amendment Purpose & Effect(s) Vendor Name Change, Subrogation Process Language Change, Change County Division Location, and Update Attachment D					
Amendment Changes Contract End Date: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		End Date: December 31, 2015			
TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A):			\$ 17,320,000.00		
Funding —					
FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2011			\$1,956,926.00		\$1,956,926.00
2012			\$4,013,236.00		\$4,013,236.00
2013			\$4,215,936.00		\$4,215,936.00
2014			\$13,088,899.00		\$13,088,899.00
2015			\$13,313,256.00		\$13,313,256.00
2016			\$2,383,983.00		\$2,383,983.00
TOTAL:			\$38,972,236.00		\$38,972,236.00
American Recovery and Reinvestment Act (ARRA) Funding: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.			<i>OCR USE</i>		
Speed Chart (optional) Multiple Funds Apply		Account Code (optional) 78901000			

**AMENDMENT ONE
OF CONTRACT EDISON # 22047**

This Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee hereinafter referred to as the "State" and Cigna Health and Life Insurance Company, 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. Contract section A.22.hh is deleted in its entirety and replaced with the following:

A.22. Definitions.

hh. PPO Grand Division: A defined geographical area that includes specified counties in the State of Tennessee. The Contractor shall serve an entire PPO Grand Division. The following counties constitute the PPO Grand Divisions in Tennessee for this Contract:

East PPO Grand Division – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle PPO Grand Division – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Franklin, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West PPO Grand Division – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

2. Contract section C.1 is deleted in its entirety and replaced with the following:

C.1 Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty Eight Million Nine Hundred Seventy Two Thousand Two Hundred Thirty Six Dollars (\$38,972,236.00). The payment 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 payment 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 payment 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. Contract section C.3.f is deleted in its entirety and replaced with the following:

C.3. Payment Methodology

f. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received, provided that the Contractor shall comply with the State's requirements regarding subrogation, as specified in Contract Section A.9. and Contract Attachment D. However, if the Contractor subcontracts the subrogation function to a subcontractor that is not an organizational unit, affiliate, subsidiary, or parent company, then the Contractor may instead request reimbursement from the State for the subcontracted costs incurred for subrogation activities for the public sector plans. Such reimbursement shall be in lieu of rather than in addition to the five percent (5%) retention allowance described above.

4. The following is added as Contract section E.21.:

E.21. Contractor Name. All references to "Connecticut General Life Insurance Company (CGLIC)" shall be deleted and replaced with "Cigna Health and Life Insurance Company (CHLIC)."

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

Required Approvals. The State is not bound by this Amendment until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

Amendment Effective Date. The revisions set forth herein shall be effective October 21, 2013. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CONTRACTOR/GRANTEE LEGAL ENTITY NAME:

SIGNATURE

DATE

PRINTED NAME AND TITLE OF SIGNATORY (above)

STATE AGENCY NAME:

AGENCY HEAD NAME & TITLE

DATE

CONTRACT ATTACHMENT D SUBROGATION REQUIREMENTS

As required by Contract Section A.9, the Contractor shall comply with the State's requirements regarding subrogation.

Identification of Subrogation Claims

The Contractor shall maintain a process to screen medical claims through a detection procedure that reviews both occurrence codes and diagnostic codes. The Contractor shall identify claims with subrogation potential within twenty (20) days of claim payment. Of particular significance are claims related to workplace accidents and illnesses, injuries attributable to automobile accidents and expenses covered by property and casualty insurance maintained by homeowners and businesses.

The Contractor shall accept subrogation information from the State's Pharmacy Benefits Manager (PBM) and Employee Assistance Program (EAP)/Behavioral Health Organization (BHO) vendor.

The Contractor shall recognize an allowable expense threshold of one thousand five hundred dollars (\$1,500) for the identification of cases to pursue. In instances where claims are below the threshold, the Contractor shall establish and monitor an accumulator related to the member and the medical event. The Contractor shall continue the monitoring activity for specific instances (medical events) for twelve (12) months after the incident (date of the event which resulted in the first claim for medical services).

The Contractor shall resolve cases with a benefits paid value equal to or less than \$5,000 and submit a case summary to the State regarding the disposition of the issue(s).

Procedural Requirements

Upon identification of claims with recovery potential, the Contractor shall provide a minimum of two incident notices and request for pertinent information to the head-of-contract with an explanation of the State's requirements related to the recovery of benefit payments through a subrogation process. The Contractor's inquiry shall explain the member's responsibilities and procedures for the member to contact the Contractor. The Contractor shall report all non-responses to the Division of Benefits Administration on a monthly basis. The Division of Benefits Administration shall provide an additional incident notice and questionnaire to the head-of-contract requesting pertinent information. If the head-of-contract fails to respond, the case information may be forwarded to the state collection agency. In addition to the inquiry process, the Contractor shall evaluate questionnaires submitted by members and complete tasks related to collecting additional data, particularly settlement information, from health care providers, attorneys, court records and liability carriers. Data collection by the Contractor can be completed in writing or telephonically. The Contractor shall re-open any case from Benefits Administration upon receipt of a completed questionnaire by a head-of-contract. The Contractor shall prepare a brief summary for each case with a benefit paid value of greater than \$5,000 and provide it to the Division of Benefits Administration for review. The case summary shall include: member name, member identification number, a case number (if assigned), amount of benefit paid, date of incident, Public Sector Plan name and benefits option, recitation of facts, and review of the relevant issues. The Contractor shall also provide a specific recommendation concerning the disposition of the case. In addition to providing case summaries, the Contractor shall provide monthly and quarterly Subrogation Reports detailing the claims reviews it has completed with the disposition and a "Non-Response Report" detailing cases where responses from members are pending. The formats of both reports will be determined by the Contractor and Benefits Administration.

Contractor Ownership/Control

African American

Person w/ Disability

Hispanic

Small Business

Government

Asian

Female

Native American

NOT Minority/Disadvantaged Other

Contractor Selection Method

RFP

Competitive Negotiation *

Alternative Competitive Method *

Non-Competitive Negotiation *

Other *

***Procurement Process Summary**

**CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE,
AND
CONNECTICUT GENERAL LIFE INSURANCE COMPANY (CGLIC)**

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee, hereinafter referred to as the "State" and Connecticut General Life Insurance Company (CGLIC), hereinafter referred to as the "Contractor," is for the provision of medical claims administration services for the State's Public Sector Plans for the WEST PPO Grand Division of Tennessee, as further defined in the "SCOPE OF SERVICES."

The Contractor is a corporation. The Contractor's address is:

Connecticut General Life Insurance Company
Two Liberty Place
1601 Chestnut Street
Philadelphia, Pennsylvania 19192

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

The Contractor's Federal Employee Tax Identification Number is 06-0303370.

A. SCOPE OF SERVICES

A.1. General.

- a. The Contractor shall provide all service and deliverables as required, described, and detailed by this Scope of Services and shall meet all service and delivery timelines specified in the Scope of Services section or elsewhere in this Contract.
- b. PPO Grand Division Service Area for this Contract (refer to Contract Section A.22): WEST.
- c. The Contractor shall provide administrative services for the State's Public Sector Plans for eligible individuals who elect to enroll in one of the options offered by the Contractor, hereinafter referred to as "members", in accordance with this Contract.
- d. The State may adjust the premium that it charges members to enroll with the Contractor in order to account for changes in the Contractor's provider payment terms and other factors as the State deems appropriate. Such adjustments may vary by third party administrator for medical services. Similarly, the State may elect to adjust the State contribution for State and higher education employees based on these and other factors. The State's decisions on these issues are final and not subject to appeal.

A.2. Implementation.

- a. The Contractor's call center and other information systems, including but not limited to its claims management system, shall be fully operational on the date specified in Contract Section A.21.
- b. The Contractor shall implement the information systems and other processes required to process all medical claims and perform all other services described herein. The Contractor shall work with the State to ensure that the Contractor satisfies applicable

requirements of this Contract, including requirements in the State Plan, Local Education Plan, and Local Government Plan Documents (referred to as the "Plan Documents" and which are located on the State's website at www.tn.gov/finance/ins/publications.html) and State and Federal law.

- c. The Contractor shall have a dedicated full-time implementation team. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of claims administration services for at least one other large employer (i.e., employer with medical plans covering at least 30,000 lives). The Contractor's implementation team shall include a full-time Account Manager dedicated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of this Contract. Also, the Contractor shall assign an Information Systems Project Coordinator (i) to serve as backup to the Account Manager and (ii) to coordinate activities among the Contractor and the State's existing vendors and all the internal and external participating and affected entities. The Account Manager should be dedicated full-time to this implementation project through sixty (60) days after the go-live date. All other implementation team members that the Contractor referenced in its proposal response to Question C.1. of RFP Attachment 6.2, Section C (Technical Proposal) shall be available as needed during the implementation but should be dedicated full-time to this project at least two (2) months prior to the go-live date specified in Contract Section A.21. and thirty (30) days after the go-live date.
- d. All key Contractor project staff shall attend a project kick-off meeting at the State of Tennessee offices in Nashville, TN within the first thirty (30) days after the Contract start date. State project staff shall provide access and orientation to the Public Sector Plans and system documentation, as requested by the Contractor.
- e. The Contractor shall provide a project implementation plan to the State no later than thirty (30) days after the Contract start date. The plan shall be electronically maintained, daily, in Microsoft Excel or Microsoft Project. The plan shall comprehensively detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily implement all medical claims administrative services no later than the go-live date specified in Contract Section A.21. and a description of the members on the implementation team and their roles with respect to each item/task/function. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:
 - (1) identification and timing of significant responsibilities and tasks;
 - (2) names and titles of key implementation staff;
 - (3) identification and timing of the state's responsibilities;
 - (4) data requirements (indicate type and format of data required);
 - (5) identification and timing for the testing, acceptance and certification of receipt of the State's enrollment information through the Edison system;
 - (6) identification and timing for testing and certification of claims processing and payment and the reconciliation process;
 - (7) member communications;
 - (8) schedule of in-person meetings and conference calls;
 - (9) transition requirements with the incumbent claims administrators; and
 - (10) staff assigned to attend and present (if required) at annual transfer/ educational sessions.
- f. The Contractor shall provide for a comprehensive operational readiness review (pre implementation audit) by the State, and/or its authorized representative, at least sixty (60) days prior to the go-live date. Such review by the State, and/or its authorized representative, may include, but not be limited to, an onsite review of the Contractor's

operational readiness for all services required in this Contract (e.g., claims processing and payment, member services, training, and website development). The review may also include desk reviews of documentation that includes but is not limited to:

- (1) policy and procedures manual;
 - (2) call center scripts;
 - (3) information systems documentation; and
 - (4) the ability to provide and the process governing the preparation of any and all deliverables required under this Contract.
- g. At its discretion, the State may conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the information systems requirements of this Contract. Such review by the State, and/or its authorized representative, may include both onsite and desk reviews, including but not limited to staff interviews, system demonstrations, systems testing, and document review.
- h. During onsite visits as part of readiness review or a pre-implementation review, the Contractor shall provide onsite workspace and access to a telephone, fax, printer, copy machine, and Internet connection. The Contractor's staff members shall be freely available to the State officials to answer question during this visit.
- i. The Contractor shall conduct status meetings concerning project development, project implementation and Contractor performance at least twice a week during implementation and daily for the two weeks prior to and the first month following the go-live date, unless otherwise approved by the State. Thereafter, all ongoing operational meetings shall be conducted on a State-specified schedule, but shall occur no less than once a month. Such meetings shall be either by phone or onsite at the offices of the State, as determined by the State, and shall include the Account Manager and appropriate systems staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor.
- j. No later than forty-five (45) days post-implementation, the State will complete an Implementation Performance Assessment, which will be provided to the Contractor. This assessment will be used to document the State's satisfaction with the implementation process and identify any necessary corrective action(s). The Contractor shall comply with all recommendations/requirements made in writing by the State within the timeframes specified by the State.

A.3. Provider Network.

- a. The Contractor shall maintain a provider network in the PPO Grand Division covered by this Contract that provides high quality, cost effective medical services, and provides adequate geographic and service access to members. The Contractor shall contract with medical providers including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, nurse midwives, hospitals (all levels - primary, secondary and tertiary), skilled nursing facilities, urgent care facilities, convenience clinics, state employee onsite clinics, laboratories, and all other medical facilities, services and providers necessary to provide covered benefits. If the State elects to cover nutrition counseling, the Contractor's provider network shall include registered dietitians/nutritionists and the Contractor must have this network within six (6) months of the State making this decision.
- b. The Contractor's provider network shall meet, at minimum, the geographic access standards specified in Contract Attachment B, Liquidated Damages, Liquidated Damage Number 24.

- c. The Contractor shall maintain a sufficiently extensive and accessible provider network such that members are able to receive appointments from a geographically-accessible provider within the following appointment standards:
- (1) urgent visit: twenty-four (24) hours
 - (2) wellness visit: two (2) months
 - (3) primary care routine visit: fourteen (14) days
 - (4) specialty care routine visit: thirty (30) days
- d. The Contractor shall submit a semi-annual report to the State regarding appointment standards, including monitoring activities, findings, and corrective actions (refer also to Contract Attachment C, Reporting Requirements).
- e. When requested by the State in writing, the Contractor shall, within ten (10) business days and in writing, report to the State any actions it intends to take to correct any access deficiencies highlighted by reports to the State or otherwise identified by the State (refer also to Contract Attachment C, Reporting Requirements).
- f. As directed by the State, the Contractor shall develop and implement a high performance network of specialty providers and inpatient hospitals as measured by their adherence to evidence-based clinical protocols and cost efficiency (e.g., cost per episode). Notwithstanding the foregoing, the Contractor may develop a high performance network of primary care providers without State direction. Before implementing a high performance network, the Contractor shall submit its plan for developing and implementing a high performance network to the State, and the plan shall be approved in writing by the State. The Contractor's plan shall include the information specified by the State, including at minimum the (1) quality and cost efficiency measures that the Contractor will use to determine whether a providers satisfies the criteria to be a high performance provider; and (2) proposed member cost-sharing incentives (e.g., lower rates of co-insurance, co-payment in lieu of co-insurance, waiver of or provision of lower deductible amounts) or other incentives for members who receive covered benefits from high performance providers. The State may approve the Contractor's use of such member incentives regardless of whether other third party administrator for medical services have implemented such member incentives.
- g. The Contractor shall include in its provider network transplant centers that are Medicare-approved transplant programs. The State considers Medicare-approved transplant programs to be Centers of Excellence for each program type (e.g., heart/lung, heart-only, kidney-only) approved by Medicare. The Contractor shall only authorize and pay for organ transplants performed by a transplant program that is approved by Medicare for the applicable transplant (e.g., heart/lung, heart-only, kidney-only). The Contractor may require additional criteria on their network providers over and above the requirements listed above.
- h. As directed by the State, the Contractor shall maintain a network of Centers of Excellence for each of the following: bariatric surgery, orthopedic surgery, oncology/cancer surgery, and cardiology/cardiac surgery. For bariatric surgery, Centers of Excellence are those bariatric surgery centers designated as Centers of Excellence either by the American College of Surgeons or the American Society for Metabolic and Bariatric Surgery. For the other services, the criteria for Centers of Excellence shall be specified by the State. As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence. Additionally, and as directed by the State, the Contractor shall provide incentives to members to use Centers of Excellence for the specified services (including but not limited to lower member deductibles and co-insurance for procedures performed at such facilities). The Contractor may require additional criteria on their network providers over and above the requirements listed above.

- i. As directed and funded by the State, the Contractor shall pay incentive payments, enhanced reimbursement, or per member per month capitation payments to providers based on a disease management flag or other indicator reported to the Contractor by the State or its authorized representative. (See Contract Section A.8.i. for related member incentives.)
- j. As directed and funded by the State, the Contractor shall pay incentive payments, enhanced reimbursements, or per member per month capitation payments to providers with credentialed/accredited "medical homes" as defined by the State. To date, the State has no formal designation of "medical home," but we continue to explore this option and are considering the National Committee for Quality Assurance- (NCQA-) accredited medical home model and others.
- k. Covered benefits received through network providers located in states contiguous to the State of Tennessee shall be consistent with covered benefits provided through network providers located in Tennessee. The Contractor shall include in its provider network providers, including but not limited to physicians and hospitals, located in states contiguous to the PPO Grand Division covered by this Contract.

If the East PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Huntsville/Decatur Combined Statistical Area and Florence-Muscle Shoals Metropolitan Statistical Area (MSA)
- Georgia – Chattanooga/Cleveland/Athens Combined Statistical Area
- North Carolina – Asheville/Brevard Combined Statistical Area
- Virginia – Johnson City/Kingsport/Bristol Combined Statistical Area

If the Middle PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Huntsville/Decatur Combined Statistical Area and Florence-Muscle Shoals MSA
- Kentucky – Clarksville MSA

If the West PPO Grand Division is covered by this Contract, the Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Florence-Muscle Shoals MSA
- Mississippi and Arkansas – Memphis Metropolitan Statistical Area (MSA)
- Kentucky – Union City, TN - KY Micropolitan Statistical Area

- l. The Contractor shall submit a quarterly network changes update report to the State within five (5) business days of the end of each Contract quarter that includes any changes in the Contractor's provider network (refer also to Contract Attachment C, Reporting Requirements).
- m. The Contractor shall notify the State in writing of any termination of a hospital or physician group of twenty (20) or more, regardless of whether the termination is initiated by the Contractor or the provider, within one (1) business day of becoming aware of the termination. The Contractor shall also provide written notice to members who received treatment from the hospital or physician group within the last six (6) months. The Contractor shall mail the notice to members no less than thirty (30) calendar days prior to the effective date of the termination.

- n. The Contractor shall notify the State in writing if any physician group is not accepting members as new patients. The Contractor shall provide such notice within one (1) business day of becoming aware of the restriction.
- o. The Contractor shall not take action to disenroll network primary care providers or hospital providers except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/recredentialing process; non-compliance with provider agreement 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; or request by the State.
- p. Following review and approval by the State, the Contractor shall annually update and print provider directories. During the first calendar year of this Contract, the Contractor shall mail a provider directory to each member who is also the head-of-contract at his/her home address no later than twenty-one (21) days prior to the go-live date. The provider directory shall include provider name, specialty, address and phone number and be organized by county. After the first calendar year of this Contract, the Contractor shall mail a provider directory to each new member who is also the head-of-contract within ten (10) days of the Contractor's receipt of the member's enrollment information. Throughout the term of this Contract the Contractor shall, at a member's request, mail a copy of the current provider directory to the member within ten (10) days of receiving the member's request to have a copy and shall, upon the State's request, distribute provider directories to Agency Benefits Coordinators within fifteen (15) days of the State's request to provide copies. Notwithstanding the foregoing, after the first calendar year of this Contract, the Contractor shall produce and distribute provider directories to all existing members if requested by the State. (In all instances, the reimbursement of actual costs pursuant to Contract Section C.3.e., shall be applicable.)
- q. The Contractor shall maintain the capability to respond to inquiries from members concerning participation by providers in the network, by specialty and by county. Such capability shall be through the call center (see Contract Section A.12.) and an up-to-date internet-based directory of providers on its website (see Section A.14.) that includes provider search capability deemed acceptable by the State. The internet-based provider directory shall accurately reflect network providers who have joined or ceased participation in the network in the past fifteen (15) calendar days and whether or not the provider is accepting members as new patients. The Contractor shall provide the internet-based provider directory on its website on or before the date specified in Contract Section A.21.
- r. The Contractor shall provide the State with GeoNetworks® reports on a semi-annual basis showing service and geographic access (refer also to Contract Attachment C, Reporting Requirements). For the first report, and subsequent reports if so directed by the State, the Contractor shall submit two versions of the reports; one mapping to all network providers and one mapping to network providers that are accepting members as new patients. The State shall review the reports and inform the Contractor in writing of any deficiencies. The Contractor shall develop and implement an action plan to correct deficiencies. The State reserves the right to review the action plan and require changes, where appropriate.
- s. The Contractor shall submit to the State an annual provider turnover report that includes the Contractor's voluntary and involuntary turnover rate by provider type (refer also to Contract Attachment C, Reporting Requirements).
- t. The Contractor shall exercise due diligence and reasonable care in its selection, credentialing, recredentialing, and retention of each network provider. The Contractor shall contract only with providers who are duly licensed to provide such medical services

and 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 that assures the quality of network providers. The Contractor shall complete processes necessary to reconfirm the licensure, accreditations, credentials, and standing of network providers no less frequently than every three (3) years.

- u. The Contractor shall maintain face-to-face, telephonic, and written communication with providers to ensure a high degree of continuity in the provider network and ensure that the providers are familiar with applicable requirements.
- v. The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management and other procedures as required for participation in the Contractor's provider network.
- w. The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of members.
- x. The Contractor shall identify and sanction network providers who fail to meet pre-determined, minimum standards relating to referrals to out-of-network providers.
- y. As a means to "doctor shopping" and mitigate risks relating to fraud, waste, and abuse, the Contractor shall maintain the ability, as may be deemed necessary, to "lock in" or otherwise restrict selected members to one or more specific network providers or group of providers for accessing covered services.
- z. Any pay-for-performance (P4P) arrangements between the Contractor and a network provider must be prior approved in writing by the State.
- aa. The Contractor shall notify the State in writing, in a format prior approved by the State in writing, at least thirty (30) days prior to any adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State.
- bb. If the Contractor is unable to deliver covered benefits through network providers, the Contractor shall arrange and pay for such services to be rendered by out-of-network providers. When the Contractor arranges for covered benefits to be provided through an out-of-network provider, the member's financial liability shall be limited to any cost-sharing that would have applied had the service been rendered by a network provider (e.g., in-network co-insurance percentage and in-network deductible amount). Balance billing is prohibited. The Contractor shall report to the State on a monthly basis all unique care exception requests and whether they were granted or denied (refer also to Contract Attachment C, Reporting Requirements).
- cc. In no case shall network providers balance bill for covered benefits. Rather, the member's liability shall be limited to the allowable member cost-sharing.
- dd. If the Contractor signs a provider agreement with an inpatient hospital that limits the Contractor's ability to negotiate or sign a provider agreement with another inpatient hospital, the Contractor shall require the network hospital to participate in the annual Leapfrog Hospital Survey (see Contract Section A.22.w.).

A.4. Utilization Management.

- a. Unless otherwise directed by the State, the Contractor shall maintain a utilization management function designed to help individual members secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness and medical necessity of inpatient hospital care, skilled nursing facility stays, inpatient rehabilitative care, and other levels of care as specified by the State and for prior authorizing these and other covered benefits.
- b. The Contractor shall have in place an effective process that identifies and manages members in need of inpatient hospital care. This shall include:
- (1) Identification of patients in need of inpatient hospital care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall include admission review, or the pre-certification/authorization of an inpatient stay.
 - (2) Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management staff coordinate care with the hospital staff and patients' physicians; this shall include review of the continued hospitalization of patients and identification of medical necessity for stays as well as available alternatives.
 - (3) Discharge planning, providing a process by which the Contractor's utilization management staff work with the hospital, patient's physicians, the State's Health Management/Wellness (HM/W) vendor, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.
 - (4) Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.
- c. The Contractor shall have in place an effective process that identifies and manages members in need of skilled nursing facility care. This shall include:
- (1) Identification of patients in need of skilled nursing care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall include admission review, or the pre-certification/authorization of a skilled nursing facility stay.
 - (2) Concurrent review during the course of a patient's skilled nursing facility stay, where qualified medical management staff coordinate care with the skilled nursing facility staff and patients' physicians; this shall include review of the continued skilled nursing facility stay of patients and identification of medical necessity for stays as well as available alternatives.
 - (3) Discharge planning, providing a process by which the Contractor's utilization management staff work with the skilled nursing facility, patient's physicians, HM/W vendor, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.
- d. The Contractor shall not require pre-admission certification for inpatient hospital admissions for the normal delivery of children.
- e. The Contractor shall collaborate with the State and its vendors to develop a discharge planning and notification protocol. Consistent with this protocol, the Contractor may by January 1, 2012 ensure that network providers: (i) complete a written discharge plan (including the dates of admission and discharge, follow-up care required, current medications, etc.) prior to the discharge of, at a minimum, any member who is being discharged from a hospital to a skilled nursing facility, a rehabilitative facility, or a

psychiatric facility or who will receive home health services, and (ii) transmit a copy of the discharge plan to the HM/W vendor as specified in Contract Section A.8.g.

- f. The Contractor shall require prior authorization of (i) outpatient high-technology diagnostic imaging, including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET) scans, and nuclear cardiac imaging studies; (ii) same-day surgery procedures, including procedures at an ambulatory surgical center, and (iii) other services specified by the State. Subject to State approval, the Contractor may require prior authorization of other services.
- g. Unless otherwise directed by the State, the Contractor shall adhere to the following standards for timeliness of utilization management (UM) decision making:
 - (1) For non-urgent pre-certification or prior authorization decisions, the Contractor shall make the decision within fifteen (15) calendar days of receipt of the request;
 - (2) For urgent prior authorization decisions, the Contractor shall make the decision within seventy-two (72) hours of receipt of the request
 - (3) For urgent pre-certification or concurrent review decisions, the Contractor shall make the decision within twenty-four (24) hours of receipt of the request;
 - (4) For retroactive decisions, the Contractor shall make the decision within thirty (30) calendar days of receipt of the request.
- h. If the Contractor is missing any information necessary to make a pre-certification, prior authorization, or concurrent review decision, the Contractor shall immediately contact the provider to obtain the missing information. If the information is still missing one (1) business day after contacting the provider, the Contractor shall make at least one follow-up contact to obtain the missing information.
- i. Any appeals of denied requests for continued hospitalization shall be promptly processed (see Contract Section A.11.i) and shall involve physician-to-physician consultation between the Contractor's staff and attending physician.
- j. The Contractor shall have an electronic utilization management system that contains complete (*i.e.*, sufficient to accurately portray the events of the review during an independent medical audit of the utilization management record) documentation of the review process by capturing administrative and clinical data as well as clinical notes by the UM staff.
- k. The Contractor shall use protocols that are diagnosis/procedure specific, consistent with efficient medical practices, and that provide nurse reviewers with guidelines regarding the type of care that is indicated during each day of treatment. Physician reviewers shall be actively involved in the review process in accordance with industry standards. Any provision of the Plan Documents and any protocol adopted by the Benefits Administration Division shall take precedence over any protocol used by the Contractor.
- l. The Contractor shall maintain a comprehensive internal audit program for utilization management services and shall take prompt corrective action to correct any deficiencies or quality of care issues.
- m. The Contractor shall submit to the State, at least two (2) months prior to the go-live date, two (2) written copies describing its utilization management program, evaluation methodology, and audit plan. The State reserves the right to review these documents and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its utilization management program. The State reserves the right to review the change and require changes, where appropriate.

- n. The Contractor shall provide a written report to the State on a quarterly basis regarding the utilization of services and the demonstrated effectiveness of its utilization management program (refer also to Contract Attachment C, Reporting Requirements).
- o. The State reserves the authority to "carve-out" all or part of the utilization management functions during the term of this Contract upon a one hundred and twenty (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 utilization management up to the effective date of the carve-out of any or all of the utilization management functions. In the event of a carve-out of all or part of the utilization management functions, the Contractor shall assist the State in transitioning the specified utilization management functions to the vendor identified by the State. This shall include but not be limited to transferring all relevant data to enable the vendor to perform its functions, providing transition support in-person and via telephone, and implementing a process for referral and warm transfer of members between the Contractor and the vendor with associated tracking and reporting. If, as part of the carve-out, as determined by the State, the Contractor retains part of the utilization management functions, the Contractor shall coordinate with the vendor as necessary for the Contractor and the vendor to perform each of its functions.
- p. Unless otherwise directed by the State, the Contractor shall identify members with high-risk conditions such as terminal illness, severe injury, major trauma, cognitive or physical disability, or transplants as identified through prior authorization, medical data and claims data. Registered nurse case managers shall work with the member, health care providers, primary caregivers and appropriate vendors to coordinate the most appropriate, cost-effective care settings. This shall include transition to designated vendors for continued follow-up and ongoing management, as designated by the State, as well as clinical management and oversight of activities to ensure timely and effective transition to appropriate vendors. For the duration of the period during which the Contractor provides such case management services, the State acknowledges that it is not administratively possible to carve out utilization management functions pursuant to Section A.4.o.

A.5. Quality Assurance Program.

- a. The Contractor shall maintain a comprehensive quality assurance program that prospectively, concurrently and retrospectively ensures the quality of care provided by network providers as well as the quality of services provided by both network providers and the Contractor.
- b. The Contractor shall establish a quality assurance committee comprised of qualified medical experts, including adequate representation of medical specialties, which shall meet at least quarterly. The quality assurance committee shall be responsible for evaluating the quality of care provided by network providers. Any person employed by the Contractor who identifies a potential quality of care issue involving a network provider shall submit it for investigation by the quality assurance committee. The committee shall promptly investigate any potential quality of care issues.
- c. The Contractor shall review and assess the practice patterns of network providers, share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.
- d. Unless otherwise directed by the State, the Contractor shall ensure that its network hospitals complete the Leapfrog Hospital Survey by no later than June 30, 2012 and every year thereafter.
- e. The Contractor shall collaborate with the State and other stakeholders to identify the appropriate depression screening and referral protocols in primary care environments.

Beginning January 1, 2013, unless otherwise directed by the State, the Contractor shall deny payment for an adult wellness visit/physical that does not include a depression screening (which the provider documented in the medical chart) that the provider performs with a nationally-recognized, validated, reliable screening instrument. Such instrument must be prior approved in writing by the State. The Contractor shall also include depression screening in an adult wellness visit/physical as an element in any chart reviews that it conducts beginning in the same year and amend its provider agreements (at time of their renewal) to incorporate this requirement.

- f. Unless otherwise directed by the State, the Contractor shall complete the eValue8 (see Contract Section A.22.r.) process every year. This shall include but not be limited to completing the request for information survey, submitting the survey to the National Business Coalition on Health and/or other entity as directed by the State, participating in the validation process, and participating in any onsite visits with the State to discuss the results and identify areas for improvement.
- g. The Contractor shall adopt and implement evidence-based clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. Any provision of the Plan Documents and any guideline, protocol, or pathway adopted by the Benefits Administration Division shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.14.) shall contain all such guidelines, protocols, or pathways that are applicable to the Public Sector Plans.
- h. The Contractor shall maintain standards and protocols for tracking all incidents/potential issues with network providers (e.g., member complaints, irregular billing practices, and quality of care issues). In addition to responding to each incident/issue, the Contractor shall initiate a provider review when the number of incidents/issues reaches a threshold defined in advance by the Contractor. The Contractor shall specify the content of this review, which may range from medical chart audits to an outcomes analysis.
- i. Whenever the Contractor identifies a potential quality of service or quality of care issue, the Contractor shall conduct appropriate follow-up, including taking corrective action as necessary to remedy a deficiency.
- j. The Contractor shall submit to the State, at least one (1) month prior to the go-live date, a summary of its quality assurance program, which shall address each of the requirements in this Contract Section A.5. The State reserves the right to review the procedure and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its quality assurance program. The State reserves the right to review the change and require changes, where appropriate.
- k. Unless otherwise directed by the State, qualified members of the Contractor's clinical staff shall participate in weekly conference calls with the State to address issues or concerns regarding individual members, particularly members with complex needs. In preparation for each call, the Contractor shall identify members and their issues/concerns, provide applicable documentation, including clinical information, to the State, and develop recommendations for resolving the issue/concern. The PBM, EAP/BHO vendor, HM/W vendor and/or the State may also identify members, and the call may, in addition to the Contractor and the State, include representatives from the PBM, EAP/BHO vendor, and/or the HM/W vendor.
- l. Unless otherwise directed by the State, qualified members of the Contractor's staff shall participate in monthly conference calls with the State and representatives from the other third party administrator for medical services, the PBM, the EAP/BHO vendor, and/or the HM/W vendor to improve coordination of their services to members.

- m. Unless otherwise directed by the State, qualified members of the Contractor's staff shall participate in quarterly meetings with the State and representatives from the other third party administrator for medical services, the PBM, the EAP/BHO vendor, and the HM/W vendor to improve coordination of their services to members.
- n. The Contractor's commercial preferred provider organization (PPO) product for Tennessee shall be accredited by the National Committee for Quality Assurance (NCQA). If the Contractor is NCQA accredited for its PPO product as of the start date of this Contract, the Contractor shall maintain such accreditation throughout the term of this Contract. If the Contractor is not NCQA accredited for its PPO product as of the start date of this Contract, the Contractor shall obtain such accreditation by December 31, 2011 (or a later date as specified by the State) and shall maintain it thereafter. If the Contractor is not NCQA accredited for its commercial PPO product as of the start date of this Contract, the Contractor shall develop and implement a work plan, approved by the State, to obtain NCQA accreditation. The Contractor shall annually submit to the State a report with HEDIS results for its PPO product (refer also to Contract Attachment C, Reporting Requirements).

A.6. Pharmacy.

- a. The State contracts with a pharmacy benefits manager (PBM) for the purpose of providing most outpatient pharmacy services. However, the PBM is not the exclusive provider of all pharmacy products. Rather, the Contractor shall have responsibility for paying claims for certain office-administered immunizations (e.g., for seasonal flu, pneumococcal, shingles, etc.), injectibles, infusion therapy, and other specialty pharmacy products as directed by the State.

The Contractor shall pay for allowable, medically-necessary office visits for members who bring pharmacy-supplied specialty pharmacy products to a provider for administration.

The Contractor shall ensure that its network providers comply with the applicable drug utilization review and prior authorization requirements for office-administered, office-supplied specialty pharmacy products. The Contractor shall further ensure that its providers do not bill members for any claims that the Contractor rejects because of the provider's failure to comply such requirements. Additionally, the Contractor shall provide its network providers with sufficient provider training, references and educational materials to ensure provider compliance.

- b. Except as provided in Contract Section A.6.a., above, the Contractor is not responsible for the provision or payment of pharmacy services. However, the Contractor is responsible for coordinating with the PBM and the State as necessary to ensure that members receive appropriate pharmacy services. Coordination by the Contractor shall include the following:
 - (1) Inclusion of pharmacy benefit information in its member handbook (see Contract Section A.13.e.(2)), including the toll-free telephone number for the PBM.
 - (2) Inclusion of the PBM's telephone number, hours of operation, and website address on the back of the member identification card (see Contract Section A.13.).
 - (3) Inclusion of pharmacy benefit information in the Contractor's annual enrollment transfer materials for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other vendors (as directed by the State), and other updates and/or changes that may be helpful to the State's members.

- (4) Accepting and maintaining prescription drug data from the PBM in a manner and format and at a frequency specified by the State.
- (5) Intervening with individual network providers, as identified by the Contractor, the PBM, the HM/W vendor, or the State, (1) whose prescribing practices appear to be operating outside industry or peer norms as defined by the State, (2) are non-compliant as it relates to adherence to the State's formulary and/or generic prescribing patterns, and/or (3) who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices by the identified network provider. Interventions shall be individualized and face-to-face. As appropriate, the intervention may be a team effort that involves representatives from the Contractor, the PBM, the EAP/BHO vendor, and/or the HM/W vendor, but the Contractor shall take the lead in organizing the meetings, including all meeting logistics.

A.7. Behavioral Health.

The Contractor is not responsible for providing benefits or paying claims for mental health and substance abuse (behavioral health) services. The Contractor is responsible for working directly with the State's "carve-out" Employee Assistance Program (EAP)/Behavioral Health Organization (BHO) vendor. Coordination by the Contractor shall include the following:

- a. Inclusion of behavioral health benefit information in its member handbook (see Contract Section A.13.), including the toll-free telephone number to contact the EAP/BHO vendor.
- b. Inclusion of the EAP/BHO vendor's telephone number, hours of operation, and website address on the back of the member identification card (see Contract Section A.13.d.(3)v.).
- c. Inclusion of behavioral health benefit information in the Contractor's annual enrollment transfer materials for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members.
- d. Accepting and maintaining data from the EAP/BHO in a manner and format and at a frequency specified by the State.
- e. Assistance in the co-management of medical/psychiatric disorders to include consultations when necessary between medical staff.
- f. Clinical education of network providers regarding screening and management of depression and anxiety in the primary care setting, including depression and anxiety as a secondary diagnosis.
- g. Providing individualized and face-to-face clinical education to network providers identified by the EAP/BHO vendor, the PBM, the HM/W vendor, or the State as needing additional education regarding prescribing patterns and clinical interventions/treatment for behavioral health conditions.
- h. Participating as applicable in the EAP/BHO vendor's discharge activities for individual members with both medical and behavioral health needs.
- i. Other activities necessary for the appropriate coordination of benefits and claims payment of medical and behavioral health benefits.

A.8. Health Management Services.

The State contracts with a vendor to provide certain health management services, including wellness and disease management. The Contractor is not responsible for the provision of these health management services. However, the Contractor is responsible for coordinating with the Health Management and Wellness (HM/W) vendor as necessary to ensure that members receive appropriate health management services. Coordination by the Contractor shall include the following:

- a. Inclusion of health management information in its member handbook (see Contract Section A.13.), including the toll-free telephone number to contact the HM/W vendor and the Nurse Advice Line and how to access decision aids.
- b. Inclusion of the HM/W vendor's telephone number, hours of operation, and website address on the back of the member identification card (see Contract Section A.13.d.(3)v.).
- c. Inclusion of health management benefit information in the Contractor's annual enrollment transfer materials for distribution to members. Such materials shall include website information, toll-free member service number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members.
- d. Accepting and maintaining data from the HM/W vendor in a manner and format and at a frequency specified by the State.
- e. The Contractor shall notify the HM/W vendor whenever it has authorized admission of a member to an inpatient hospital, rehabilitative facility, or skilled nursing facility or has authorized a member to begin receiving home health services.
- f. The Contractor's facility discharge planning process shall include, as appropriate, coordination with the State's HM/W vendor to provide health management services (e.g., case management and/or disease management services). The discharge plan shall identify the post-discharge care that the Contractor will provide (e.g., rehabilitative facility, skilled nursing facility, physician follow-up, home health services, physical therapy, occupational therapy) and the services that will be provided by the HM/W vendor (e.g., preventive coaching and monitoring).
- g. The Contractor shall provide the HM/W vendor with a copy of the member's written discharge plan, as available, (see Contract Section A.4.e.) within twenty-four (24) hours of discharge.
- h. If the Contractor has negotiated a case rate with a network provider to provide covered benefits to a member or has negotiated payment with an out-of-network provider to provide covered benefits to a member, the Contractor shall ensure that the provider transmits clinical information, including medical records and discharge plan, regarding the member to the HM/W vendor, as specified by the HM/W vendor and/or the State.
- i. As directed by the State, the Contractor shall implement cost-sharing incentives (e.g., lower rates of co-insurance, provision of co-payments in lieu of co-insurance, waiver of or provision of lower deductible amounts) for members engaged in disease management and other programs as reported to the Contractor by the State or the HM/W vendor.

A.9. Claims Processing, Payment and Reconciliation.

- a. The Contractor shall process all medical claims in strict accordance with the Plan Documents. The Contractor shall not modify covered benefits during the term of this Contract without the prior written approval of the State.

- b. Upon request by the State, the Contractor shall modify its systems and processes to reflect approved plan design changes, including but not limited to changes in covered benefits, scope of covered benefits, and cost-sharing, to the Public Sector Plan(s) within sixty (60) days of notification by the State. Should said change(s) not be effective within sixty (60) days, the Contractor shall have until the effective date of the change to modify its systems and processes. For reference, the draft benefit design for the 2011 plan year is included as Appendix 7.2; the Insurance Committees will finalize the benefit design during the summer of 2010.
- c. The Contractor shall ensure that claims submitted by network providers are paperless for the members. The Contractor's agreement with providers shall require network providers to submit claims directly to the Contractor.
- d. The Contractor shall process claims, either filed directly by members and/or provider(s), in an accurate and timely manner and in accordance with the requirements in Contract Attachment B. The Contractor shall submit to the State, at least one (1) month prior to the go-live date, a summary of its methodology for conducting internal claims audits, including audits to determine claims payment and processing accuracy and claims payment turnaround. The State reserves the right to review the methodology and require changes, where appropriate. The Contractor shall notify the State in writing at least thirty (30) days in advance of any significant changes to its methodology. The State reserves the right to review the change and require changes, where appropriate. The Contractor shall submit its audit methodology with each applicable performance measure report (see Contract Attachments B and C).
- e. The Contractor shall confirm eligibility of each member as claims are submitted, on the basis of the enrollment information provided by the State, which applies to the period during which the charges were incurred.
- f. In concert with its claims payment cycle, the Contractor shall provide an electronic remittance advice (RA) to the provider indicating the disposition of every adjudicated claim submitted by providers. The remittance advice shall contain appropriate explanatory remarks related to payment or denial of each claim. If a claim is partially or totally denied due to insufficient information and/or documentation, then the remittance advice shall specify all such information and/or documentation. Providers that do not have the capability of receiving an RA electronically may have one mailed to them.
- g. An incomplete claim may be resubmitted with the information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing and payment.
- h. Explanation of Benefits (EOB)
 - (1) The Contractor shall generate and mail an explanation of benefits (EOB) to the member each time the Contractor processes a claim from a provider. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include but not be limited to the date the Contractor received the claim, the date the Contractor adjudicated the claim, the claim number, Identification number of the head-of-contract, the patient name, the date of service, the provider name, the Contractor's contact information, submitted charges, total amount paid by the Contractor to the provider, the amount paid by a second insurance carrier, the amount the member owes the provider (any applicable co-payment/co-insurance and non-covered services), the deductible amount, the co-payment/co-insurance amount, any non-covered amount, the out-of-pocket amounts paid for the year, how to file an appeal, and a notice that if the member

owes any amount, other than applicable cost-sharing, for emergency or urgent care services received from an out-of-network provider, the member should contact the Contractor.

- (2) The Contractor shall also generate and mail an EOB to the member each time the Contractor processes a claim submitted by the member. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include information similar to the EOB for provider-submitted claims but tailored to member-submitted claims.
- i. If a member receives a covered benefit from a network provider, the provider's contract rate shall be used to determine the member's deductible (if applicable) and any co-insurance amount, and the member shall not be responsible for payment in excess of that amount. In addition, if a member receives a medical service that is a covered benefit from a network provider but the claim for the service is denied as ineligible for payment (e.g., because it was treatment for a pre-existing condition, the service exceeded the applicable service limitation, not medically necessary, or the service was subject to prior authorization and was not approved by the Contractor) the member shall not be responsible for payment to the provider in excess of the provider's contract rate.
- j. The Contractor shall only pay claims that are for covered benefits provided to eligible members and provided in accordance with the Contractor's utilization management and other applicable requirements and with the Plan Documents.
- k. The Contractor shall not pay for services that result from a referral prohibited by Section 1877 of the Social Security Act (Limitation on Certain Physician Referrals).
- l. The Contractor shall not pay for preventable events and conditions, e.g., hospital-acquired conditions and preventable surgical errors, that are identified as non-payable by Medicare. In addition, as directed by the State, the Contractor shall not pay for other preventable events and conditions that are identified as non-payable by other federal or state payers.
- m. The Contractor shall pay claims for services from out-of-network providers submitted by members by directly reimbursing the provider. However, if the member has already paid said claim, then the Contractor shall reimburse the member directly. In either case the Contractor shall send the member an EOB as required by Contract Section A.9.h.(2).
- n. The Contractor shall pass directly to the State the payment terms that the Contractor has negotiated with providers. The Contractor shall not receive any differential between the provider contract rate and the payment funded by the State; the Contractor shall ensure that the State and the member receives the full benefit of any provider payment terms, including but not limited to provider fee schedules, contract rates, other payment arrangements, discounts, rebates, refunds, or credits negotiated by the Contractor. All special pricing considerations and financial incentives shall accrue to the State and plan members.
- o. The Contractor shall ensure that any payments funded by the State are accurate and in compliance with the terms of this Contract, including the Liquidated Damages requirements of this Contract (see Contract Attachment B); agreements between the Contractor and providers; and State and Federal laws and regulations.
- p. The State shall determine all policies and benefits related to the Public Sector Plans. Should the Contractor have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request a determination in writing. The State will then respond in writing

making a determination within thirty (30) days. The Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

- q. The State shall have the sole responsibility for and authority to clarify and/or revise the benefits available under the Public Sector Plans. It is understood between the parties that the Public Sector Plans cannot and do not cover all medical situations. In a case where the benefits are not referenced in the Plan Documents or are not clear, the Contractor shall comply with any applicable policy issued by the Benefits Administration Division to interpret the Plan Documents. If the benefits are not referenced in any policy or are not clear, the Contractor shall utilize its policies in adjudicating claims, and the Contractor shall advise the Benefits Administration Division 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.
- r. The Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB) in accordance with the regulations promulgated by the Tennessee Department of Commerce and Insurance, Chapter 0780-1-53 Tenn. Comp. R. & Regs. The Contractor shall provide a quarterly report of said activities to the State (refer also to Contract Attachment C, Reporting Requirements).
- s. The Contractor shall notify the State on a weekly basis of receipt of any notices from Medicare that Medicare may have made primary payments for services when it should have been the secondary payer (a Medicare Secondary Payer demand letter). The Contractor shall resolve issues as to whether Medicare is the primary or secondary payer within thirty-one (31) days of receiving the demand letter.
- t. The Contractor shall comply with the State's requirements regarding subrogation as provided in Contract Attachment D.
- u. The Contractor shall determine whether eligible expenses are medically necessary.
- v. The Contractor shall have a process in place based on the most appropriate up to date clinical information for determining those procedures and services that are considered experimental/investigative. Unless otherwise directed by the State, the Contractor shall submit to the State, at least one (1) month prior to the go-live date, detailed information on the Contractor's process for determining experimental/investigational procedures and services. The State reserves the right to review the process and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its process. The State reserves the right to review the change and require changes, where appropriate.
- w. The Contractor shall respond to all requests from the State for paid claims incurred within a specified period of time within seventy-two (72) hours of receiving the request using the template prior approved in writing by the State.
- x. The Contractor shall submit monthly claims reports to the State as provided in Contract Attachment C, including but not limited to a monthly paid claims report, reconciliation report, and recoveries report (refer also to Contract Attachment C, Reporting Requirements).
- y. The Contractor's provider agreements shall include the maximum recoupment periods permitted under TCA 56-7-110.
- z. 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. The Contractor shall maintain security and

quality controls over the design, printing and mailing of checks, as well as any fraud prevention feature of checks.

- aa. The State will only pay for approved and correctly paid claims, not for rejected, reversed, or duplicate claims. Additional requirements related to payments are listed in Contract Section C.3.
- bb. The Contractor shall issue all related U.S. Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing the 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.
- cc. 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. In addition, in the event of termination of this Contract, the Contractor shall continue to provide and pay claims for services to any member who is hospitalized on the effective date of termination. Said coverage shall discontinue when the member is discharged from the hospital.
- dd. **Fraud and Abuse**
 - (1) The Contractor shall implement procedures to prevent and detect fraud or abuse by providers or members and shall perform fraud investigations of members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud.
 - (2) The Contractor's procedures for preventing and detecting fraud and abuse shall include, at a minimum, claims edits, post-processing review of claims, utilization management, provider profiling and credentialing, and provisions in the Contractor's provider agreement and/or provider manual. The Contractor's claim edits shall include, at minimum, edits to identify upcoding and duplicate claims.
 - (3) In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the Benefits Administration Division and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:
 - i. Discontinue further investigation if there is insufficient justification; or
 - ii. Continue the investigation and report back to the Benefits Administration Division and the Division of State Audit; or
 - iii. Continue the investigation with the assistance of the Division of State Audit; or
 - iv. Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.
 - (4) The Contractor shall submit to the State, at least two (2) months prior to the go-live date, two (2) written copies describing its fraud and abuse program. The State reserves the right to review the documents and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its programs related to insurance or provider fraud, abuse, and waste. The State reserves the right to review the change and require changes, where appropriate.

- (5) The Contractor shall provide a written narrative or report to the State on a quarterly basis regarding the effectiveness of the Contractor's fraud and abuse program, including its fraud and abuse detection activities, findings from those activities, follow-up on findings, proposed Improvement activities, and any estimated savings to the Public Sector Plans associated with the Contractor's detection of such fraudulent or wasteful activities.

A.10. State Audits. Upon thirty (30) days written notice and the establishment of applicable third party confidentiality agreement(s), if any, reasonably required by the Contractor, the State and/or its authorized representative shall have the right to examine and audit the Contractor services and pricing to ensure compliance with all applicable requirements. For the purpose of this requirement, the term, "Contractor," shall include its parent organization, affiliates, subsidiaries, subcontractors, and providers.

- a. The Contractor shall provide access, at any time during the term of this contract and for three (3) years after final contract payment (longer if required by law), to the State and/or its authorized representative to examine and audit Contractor services, payments, and pricing pursuant to this Contract. The State reserves the right to request that documentation be provided for review at the authorized representative's location, the State's location, or at the Contractor's corporate site.
- b. The Contractor shall, at its own cost, provide the State and/or its authorized representative with prompt and complete access to any data, documents, access to systems, and other information necessary to ensure Contractor compliance with all requirements of this Contract.
- c. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall also provide a response to all "findings" received. Such response shall occur within thirty (30) days, or at a later date if mutually determined with the State to be more reasonable based on the number and type of findings.
- d. The State shall not be responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing data, reports, documentation, systems access, or space.
- e. If the outcome of the audit results in an amount due to the State, then the State will work with the Contractor to negotiate terms of repayment. In the absence of such agreement, the State will deduct one-sixth of the total amount due from the fees due to the Contractor pursuant to Section C.3 for each month for six months. If the Contractor disagrees with a finding resulting in a payment to the State, the State will review the Contractor's comments, but if the State retains the original audit findings the Contractor will be responsible for any payment to the State.

A.11. Member Services.

- a. All members services representatives handling inquiries related to the Public Sector Plans shall be familiar with the terms and provisions of the Plan Documents, including without limitation, eligibility, benefits, excluded services and procedures, deductibles, applicable cost-sharing, including co-payments and co-insurance, out-of-pocket maximums, instructions for completing a claim form, determining the status of claims, how to handle a complaint, and the member appeals process.
- b. During normal business hours, the Contractor's member services representatives shall be dedicated to the Public Sector Plans. A Contractor may be allowed through written

approval by the State to use a "designated" call unit (as opposed to a "dedicated" call center) provided that the unit could meet all other call center standards defined in this Contract.

- c. The Contractor shall have sufficient staff to respond to inquiries, correspondence, complaints, and problems. The Contractor shall not answer technical questions regarding eligibility policy and shall refer these questions to the State.
- d. The Contractor shall provide appointment scheduling assistance to members who are unable to secure an appointment with a geographically-accessible provider within the timeframes specified in Contract Section A.3.c. The State defines "appointment scheduling assistance" to include the following: (1) if the member is unable to secure an appointment with a network provider within a reasonable period of time through the member's own good faith efforts and the member requests the Contractor's assistance, then the Contractor has an affirmative obligation to contact the provider directly to facilitate appointment scheduling. Additionally, (2) if a member is unable to locate a network provider who is accepting new patients through their own good faith efforts and the member requests the Contractor's assistance, then the Contractor has an affirmative obligation to assist the member in locating such a provider and securing an appointment.
- e. The Contractor shall have and implement procedures for monitoring and ensuring the quality of services provided by its member services representatives. Such procedures may include but are not limited to the following activities:
 - (1) auditing calls/correspondence for each member services representative;
 - (2) silent monitoring of calls;
 - (3) recording calls for quality and training purposes;
 - (4) skill refresher courses; and
 - (5) call coaching.
- f. The Contractor shall set standards for customer satisfaction for member services representatives based upon, but not limited to, an evaluation of the following areas: documentation, greeting, courtesy, responsiveness, explanation and guiding techniques, and accuracy. The standards shall be submitted to the State for prior written approval before they are used to measure customer satisfaction. Adherence to the standards shall be measured, monitored and reviewed by the Contractor each month.
- g. The Contractor shall provide a personalized response, in writing, to ninety-five percent (95%) of written (mail or email) inquiries from members concerning requested information, including the status of claims submitted and covered benefits, within five (5) business days and one hundred percent (100%) within ten (10) business days. The Contractor shall acknowledge receipt of email inquiries within one (1) business day.
- h. The Contractor shall designate a client service liaison to respond to member-related issues identified by the State. For matters designated as urgent by the State, the Contractor shall contact the member and resolve the issue and then notify the State of the resolution.
- i. **Member Appeals Process**
 - (1) The Contractor shall maintain an appeals process by which members may appeal decisions regarding administration of benefits, medical necessity determinations, and disputes arising from the Contractor's utilization management program.
 - (2) The Contractor shall maintain formal appeal procedures affording two levels of review. The Level I and Level II reviews shall be conducted by committees

designated by the Contractor. Persons making Level I determinations shall not be involved in Level II decisions. With the prior written approval of the State, additional levels of review may be offered. Also, with the prior written approval of the State, where a favorable resolution is unlikely (e.g., services or supplies are specifically excluded from covered benefits or the Contractor has determined that the service is experimental/investigational), a member may bypass the Contractor's formal appeals process.

- (3) At least one (1) month prior to the go-live date, the Contractor shall provide the State two (2) written copies describing in detail the Contractor's appeals process and procedures along with two (2) written copies of sample determination letters for Level I and Level II appeals. The State reserves the right to review the appeals process and procedures and letters and require changes, where appropriate.
- (4) The Contractor shall submit quarterly appeals reports with information regarding each appeal filed with the Contractor (refer also to Contract Attachment C, Reporting Requirements).
- (5) The Contractor shall provide the State with copies of requested appeal files within ten (10) business days of the State's request.
- (6) Any time a member files an appeal, the Contractor shall ensure that all records and information related to the appeal are preserved for the greater of (a) one (1) year following the conclusion of the appeal process, including any external appeals (e.g., the State's appeal process) and (b) any longer period required by other provisions of this Contract or state or federal law.
- (7) The Contractor shall include notification of the member's right to appeal in any member communication regarding benefit coverage decisions, including but not limited to, letters to members and providers, member handbooks, and Explanation of Benefit (EOB) statements. The text and format of this notice is subject to prior written approval from the State.
- (8) The Contractor shall maintain a procedure for resolving complaints informally by phone. Where a complaint cannot be resolved to the member's satisfaction, the Contractor shall advise the member of his/her right to file an appeal and shall provide instructions for doing so.
- (9) The Contractor shall designate the manner by which a member may file an appeal. The Contractor may require the member to submit a written request or to complete and submit a "member appeal form" or other designated form. If form(s) are required, the Contractor will make such forms available on its website and by mail within five (5) business days upon request of the member.
- (10) The Contractor shall allow a member one hundred and eighty (180) days to initiate a Level I appeal following notice of an adverse determination. Where a Level I determination is unfavorable, the Contractor shall advise the member of their right to initiate a Level II appeal within ninety (90) days of notice of the Level I decision.
- (11) For pre-service appeals (Level I and Level II), the Contractor shall complete review and issue a written decision to all parties involved within thirty (30) days of receipt. For post-service appeals (Level I and Level II), the Contractor shall complete review and issue a written decision to all parties involved within sixty (60) days of receipt. For expedited appeals not involving a third party review the Contractor shall complete review and issue a written decision to all parties

involved within seventy-two (72) hours of receipt. All other expedited appeals shall be completed within seven (7) calendar days. All decision notices shall advise of any further appeal options. Where the Contractor's appeals process has been exhausted, adverse determination notices must advise the member of the option to pursue a State-level appeal within two (2) years and must include the State's appeal form.

- (12) The State sponsors an appeal process available to members after they have exhausted the Contractor's appeals process. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals. The Contractor shall have the appropriate qualified individuals, including the Contractor's Medical Director, and the Account Manager available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State.
- (13) To the extent that any foregoing requirements of this Section A.11.1 conflict with Section 1001(4), as amended by Section 10101(g), of the Patient Protection and Affordable Care Act (Pub. L. 111-148) or the implementing regulations of these provisions, then (consistent with Section D.16), the Contractor shall immediately consult with the State and adjust its process in order to comply with the federal law.
- (14) Pursuant to Section D.16, the Contractor and the State will jointly work to interpret and implement the requirements of the Patient Protection and Affordable Care Act (PPACA, Pub. L. 111-148), as amended, and implementing regulations. The State acknowledges that the Contractor has no financial liability for the comparative effectiveness research fee on self-funded plans pursuant to Section 6301(e)(2) of the PPACA; rather, the public sector plans will incur these costs as plan expenditures.

J. Unless otherwise directed by the State, the Contractor shall conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey. The Contractor shall contract with a vendor that is certified by NCQA to perform CAHPS surveys, and the vendor shall perform the CAHPS adult commercial survey. The Contractor shall report the results of the survey to the State by June 15 of each calendar year (refer also to Contract Attachment C, Reporting Requirements). Based upon the results of the survey, the Contractor shall develop an action plan to correct problems or deficiencies identified through this activity. The Contractor shall submit the action plan to the State by August 1st. The State reserves the right to review the action plan and require changes, where appropriate.

A.12. Call Center. The Contractor shall operate a call center that uses a toll-free telephone number dedicated to the Public Sector Plans as the entry point for members contacting the Contractor. The dedicated toll-free customer service phone number shall become the property of the State of Tennessee upon the termination of this Contract. The Contractor shall transfer said number to the State at no cost to the State such that the State or its designee can maintain this same number for continuous, uninterrupted use by members needing assistance with pharmacy services after the termination of this Contract.

- a. The Contractor's call center shall be open and staffed with trained personnel on the date specified in Contract Section A.21.
- b. The Contractor's call center and dedicated member services representatives shall be located in the continental United States.

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- c. The Contractor's call center shall accept calls Monday through Friday, during the hours specified in the Contractor's Proposal in response to RFP #3176-00104 and approved by the State, except on official State Holidays.
- d. The Contractor's call center shall be equipped with TDD (Telephone Device for the Deaf) in order to serve the hearing impaired population.
- e. During normal business hours the Contractor's call center shall have at least one member services representative on duty who is bilingual in English and Spanish. The Contractor shall provide oral Interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.
- f. During normal business hours as well as after hours, calls to the Contractor's call center regarding clinical concerns shall be transferred or forwarded to the Nurse Advice line, which will be provided by the State or the HM/W vendor.
- g. The Contractor shall provide the State's Agency Benefits Coordinators (ABCs) with a special number or access code that they can use to have immediate access to a member services representative. The Contractor can satisfy this "hotline" requirement by expediting calls to this special number to the front of the general queue – or it may provide dedicated staff to serve callers to this number.
- h. The Contractor's call center shall meet each of the following performance standards:
 - (1) The Contractor's call center shall answer, by a person, one hundred percent (100%) of calls within five (5) minutes (300 seconds).
 - (2) The Contractor's call center shall maintain an Average Seconds to Answer (ASA) of less than one (1) minute (60 seconds) and after answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.
 - (3) The Contractor's call center shall maintain a blocked call rate of less than one percent (1%) per quarter.
 - (4) The Contractor's call center shall maintain an Abandoned Call rate of not more than three percent (3%).
- i. The Contractor shall calculate each performance measure for three continuous periods of equivalent length during the normal business hours of each business day.
- j. The Contractor shall provide call center statistics for members to the State on a daily basis during the thirty (30) days prior to the go-live date through the sixty (60) days after the go-live date. After which time the Contractor shall submit, by the first business day of each week, a report with data for the preceding week, and by the fifth business day of the month, a summary report with data for the preceding month. The monthly report shall include weekly and monthly data. (See Contract Attachments B and C.)
- k. The Contractor's call center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the performance standards described in this Contract.
- l. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to program, benefit, or enrollment changes.

- m. The Contractor's call management systems shall be equipped with caller identification. In addition, the Contractor's call center shall adopt caller identification for itself that is prior approved in writing by the State.
- n. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music and/or messages prior approved by the State for the callers while they are on hold and shall play messages as directed by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless prior approved in writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls are being recorded and may be monitored by the Contractor and the State for quality control purposes.
- o. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the member services representative who handled the call. The Contractor shall be able to provide a full recording of each call upon the State's request, using only the member's name or identifier to locate the call(s).
- p. The Contractor's call management systems shall facilitate the processing of all calls received and assign incoming calls to available member services representatives in an efficient manner. The system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to external call centers.
- q. The Contractor may use an automated interactive voice response (IVR) system for managing inbound calls, provided that the caller always has the ability to leave the IVR system and wait in queue in order to speak directly with a live-voice member services representative during normal business hours rather than continue through additional prompts. The Contractor shall not have more than one level of menu choices (limited to five (5) options) unless prior approved in writing by the State. The Contractor's decision tree and menu are subject to State review and prior written approval.
- r. The Contractor shall inform callers of their likely wait times (based on real-time information, including call volume and member services representative availability) as they enter the queue. The Contractor shall also provide a "dial back" option that allows callers to receive a call back from the next available member services representative. Note that calls receiving a call back pursuant to this provision are not counted as "abandoned."
- s. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the call center.
- t. The Contractor shall have the ability to allow third parties (the State or its authorized representative) to monitor calls from a remote location. Additionally, the Contractor's system shall be able to record calls for monitoring.
- u. The call management system shall enable the logging of all calls, including:
 - (1) the caller's identifying information (e.g., employee ID);
 - (2) the call date and time;
 - (3) the reason for the call (including a reason code using a coding scheme prior approved by the State in writing);
 - (4) the member services representative that handled the call;
 - (5) the length of call; and

- (6) the resolution of the call (including a resolution code using a coding scheme prior approved by the State in writing) (and if unresolved, the action taken and follow up steps required).

Additionally, the call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history shall contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the data management transaction (e.g., the State and/or one of its authorized representatives or the member), and the member services representative that processed the transaction. Related correspondence and calls shall be indexed and properly recorded such that they can be treated in reporting and analysis as part of a distinct transaction.

A.13. Member Communications/Materials.

- a. The Contractor shall, in consultation with and following written approval by the State, print and distribute member materials, including but not limited to member handbooks, identification cards, welcome packets, provider directories (see Contract Section A.13.d., A.13.e., A.13.f. and A.13.g.), letters, mass mailings, and administrative forms and manuals pertaining to or sent to members. Unless otherwise directed by the State, all member materials shall be prior approved in writing by the State.
- b. The Contractor shall work in conjunction with the State and its marketing staff and vendor to ensure continuity of branding across all plan and member materials, website, and any other communications information. This branding shall include, but is not limited to, use of the ParTners for Health logo, color scheme and applicable taglines. All uses of these branding elements shall be subject to prior approval by the State.
- c. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, revision, printing, and distribution of all member materials that are required to be produced under the terms of this Contract. The Contractor shall ensure that up-to-date versions of all printed member materials can be downloaded from its website.
- d. **Member Identification Cards**
- (1) The Contractor shall provide members with identification (I.D.) cards on an annual basis.
- (2) The cost of creating and mailing I.D. cards pursuant to subsection (d)(1) above and (d)(7) below shall be borne by the Contractor.
- (3) Identification cards shall comply with the State's guidelines for I.D. cards, which include but are not limited to the following:
- i. The "ParTners for Health" logo shall appear in either the upper left or upper right corner of the front of the card, as directed by the State, and the Contractor's logo may appear in the other corner.
- ii. The words "Tennessee State Group Insurance Program" shall appear in the top center of the front of the card in a font size of no less than 11 point; the words "Administered by CONTRACTOR NAME" may appear beneath this in a smaller font size (at least two points less).
- iii. The front of the card shall also include the following information: member name, member number (which shall NOT be the member's Social Security Number), group name and/or number, benefit option (e.g., Partnership PPO), network name (if applicable), co-payment amounts, and primary care provider name (if applicable).

- iv. The back of the card shall include the following information: disclaimers regarding prior authorization, card effective date, the Contractor's member services phone number and hours of operation, and the number and hours of operations for the PBM, EAP/BHO, and HM/W vendor, and website addresses.
- v. The Contractor shall use the Edison employee identification number as the primary unique identifier for members and shall include this number on the member's identification number.

- (4) The format for identification cards shall be prior approved in writing by the State.
- (5) The Contractor shall mail identification cards to members no later than twenty-one (21) days prior to the go-live date and thereafter fourteen (14) days prior to the start of each benefit year. During the benefit year the Contractor shall mail I.D. cards to members no later than ten (10) days from receipt of new enrollment or change in enrollment, as indicated in the enrollment information from the State and no later than ten (10) days from receipt of a member's request for a replacement or duplicate card (at no charge to the member).
- (6) The Contractor shall have the capability on its website (see Contract Section A.14.) to allow members to print out temporary cards.
- (7) The Contractor shall allow each member to have one duplicate card upon the member's request.
- (8) As directed by the State, the Contractor shall re-issue identification cards to reflect approved plan design changes, including but not limited to changes in cost-sharing, within the timeframe specified by the State (refer to Contract Section C.3.e. regarding the cost of identification cards re-issued at State direction).

e. Member Handbook

- (1) The Contractor, following review and approval by the State, shall annually update, print and distribute member handbooks and shall maintain on its website an up-to-date version of the member handbook that incorporates changes made between annual printings.
- (2) The member handbook shall be specific to each of the three Public Sector Plans and shall detail benefits and excluded services and procedures; detail cost-sharing requirements and out-of-pocket maximums for the Standard PPO option, the Partnership PPO option, and other benefit options as directed by the State; describe additional features of the Partnership PPO, including requirements for transferring to the Partnership PPO; describe procedures for accessing services, including use of network and out-of-network providers and utilization management; describe appeal procedures; include information specified by the State regarding pharmacy benefits, behavioral health benefits, and health management/wellness benefits; and provide other information helpful to members.
- (3) The Contractor shall distribute the member handbook to every head-of-contract no later than twenty-one (21) days prior to the go-live date and thereafter fourteen (14) days prior to the start of each benefit year.
- (4) Each year the Contractor shall print member handbooks for one hundred and twenty-five percent (125%) of the number of heads-of-contract.

- (5) Upon the State's request, the Contractor shall provide member handbooks to Agency Benefits Coordinators within fifteen (15) days of the State's request to provide copies.
- f. On an annual basis, at least two (2) months prior to the State's annual transfer period, the Contractor shall provide to the State, in both hard copy and electronic format, information requested by the State, which shall include but not be limited to a provider network list, toll-free member services number, website address, website logon information, a confidentiality statement, procedures for accessing services, and other updates and/or changes that may be helpful to potential members.
- g. Unless otherwise directed by the State, the Contractor shall mail a welcome packet to all members no later than twenty-one (21) days prior to the go-live date. Thereafter, all members shall receive a welcome packet within ten (10) days of the Contractor's receipt of their enrollment information. The welcome packet shall include, at a minimum, a welcome letter, a member handbook, an I.D. card, a provider directory, the Contractor's website address, website logon information, and a confidentiality statement. If the Contractor sends the I.D. card separately, the welcome packet must be sent before the I.D. card is sent.
- h. The Contractor shall use first class rate for all mailings, unless otherwise directed or prior approved in writing by the State. The Contractor may use bulk mail and medical mail rates, if prior approved in writing by the State.
- i. The Contractor shall have the exclusive responsibility to write, edit, and arrange for clearance of materials (such as securing full time use of a stock photograph used in brochures for perpetuity) for any and all member materials in time for the materials to be approved by the State and printed for the annual transfer period.
- j. The Contractor shall ensure that its member materials are culturally sensitive and professional in content, appearance, and design.
- k. The Contractor shall, to the extent practicable, use relatively large and legible fonts in its member materials. Additionally, the Contractor shall make maximum use of graphics to communicate key messages to populations with limited literacy or limited English proficiency. The Contractor shall also prominently display the Contractor's call center telephone number and hours of operation in large, bolded typeface on all member materials.
- l. Unless otherwise prior approved in writing by the State, the Contractor shall design all member materials at the sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index or other suitable metric that the State prior approves in writing. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a reading level analysis and certification of the reading level of each piece of material.
- m. The Contractor shall provide electronic templates of all finalized member materials in a format that the State can easily alter, edit, revise, and update. Absent gross negligence or malfeasance by the Contractor, the Contractor has no liability for errors on other deliverables that the State did not find or correct before giving final approval for the individual materials. However, the Contractor shall produce and distribute corrected versions of the individual materials at the State's direction (refer to Contract Section C.3.e. regarding production and distribution costs).
- n. The Contractor covenants that all materials distributed to members and prepared or produced by the Contractor shall be accurate in all material respects.

- o. At the State's request, the Contractor shall notify members, in writing, of any benefit changes no less than thirty (30) days prior to the implementation of the change (refer to Contract Section C.3.e. regarding production and distribution costs).
- p. Unless otherwise directed by the State, the Contractor shall print and distribute any mass mailings developed by the State within seven (7) business days of receiving the text from the State (refer to Contract Section C.3.e. regarding production and distribution costs).

A.14. Website.

- a. The Contractor shall maintain a website dedicated to and customized for this Contract. The design of the website, inclusive of the site map, page layout, color/font scheme and branding, static content and any documents which can be accessed via or downloaded from the website, must be prior approved in writing by the State. The website shall be designed for members and dedicated to the Public Sector Plans. Additionally, the Contractor shall obtain prior, written approval from the State for any links from the site to an external (governmental and non-governmental) website/portal or webpage.
- b. The website shall be fully operational, with the exception of member data/Protected Health Information on or before the date specified in Contract Section A.21.
- c. The Contractor shall update content and/or documents posted to the website within five (5) business days of the State's approval of changes to said content and/or documents.
- d. In association with the State's annual transfer period, the Contractor shall provide on the website by the first day of the period (generally October 15) all information pertinent to each new plan year.
- e. The Contractor shall submit to the State a website design specifications document, inclusive of a comprehensive site map, page design documentation including "screenshots" of all pages, all links to external sites (governmental and non-governmental) and all static content and documents associated with release #1 of the website for review and approval by the date specified in Contract Section A.21.
- f. The Contractor shall host the website on a non-governmental server, which shall be located within the United States.
- g. The Contractor shall ensure that the website/portal meets all of the capacity, availability, performance and security requirements outlined in Contract Sections A.17. and A.19.
- h. The Contractor shall obtain and cover the cost of the domain name for the website/portal. The Contractor shall transfer ownership of the domain name to the State upon termination of this Contract without delay and at no cost to the State.
- i. To ensure accessibility among persons with a disability, the Contractor's website shall comply with Section 508 of the Rehabilitation Act of 1973 (29 USC Section 794d) and implementing regulations at 36 CFR 1194 Parts A-D.
- j. The website/portal shall be "Bobby-approved" (as defined in Contract Section A.22.).
- k. At a minimum the website shall contain a home page with general information and links to additional information, including but not limited to frequently asked questions (FAQs), the member handbook, the up-to-date Internet-based directory of providers (see Contract Section A.3.), temporary identification cards, evidence-based practice guidelines, protocols, or pathways applicable to the Public Sector Plans, provider quality comparative information, appeals forms (if applicable), claim forms, information about the explanation

of benefits (EOB), including a sample form with an explanation of each item, and contract rates to help members understand their EOBs.

A.15. Administrative Services.

- a. The Contractor, upon request by the State, shall review and comment on proposed revisions to the benefits in the Public Sector Plans. When so requested, the Contractor shall comment in regard to:
 - (1) Industry practices;
 - (2) the overall cost impact to the Public Sector Plans;
 - (3) any cost impact to the Contractor's fee;
 - (4) impact upon utilization management performance standards;
 - (5) necessary changes in the Contractor's reporting requirements; and/or
 - (6) system changes.
- b. The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefits, premiums, cost-sharing and cessation of coverage as requested by the State, members, and providers.
- c. The Contractor shall refer calls from Agency Benefits Coordinators (ABC) regarding eligibility or enrollment systems issues to the State. The Contractor shall refer calls from ABCs regarding clinical issues to the Nurse Advice line, which will be provided by the State or the HM/W vendor.
- d. 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. For matters designated as urgent by the State, the Contractor shall provide a response to the State within four (4) hours during normal business hours. During non-business hours the Contractor shall provide a response to urgent matters to the State within twenty-four (24) hours. Staff members, from the applicable business unit, with final decision making authority shall provide responses.
- e. To maintain the privacy of personal health information, the Contractor shall provide to the State a method of securing email for daily communications between the State and the Contractor.
- f. 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 the staff requested by the State, which may include a Program Director and representatives from the Contractor's 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 benefits. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting the Public Sector Plans. The Contractor shall also provide information to the State regarding the administration of the benefit, internal procedures for billing and reconciliation of transactions, the provision of medical treatment, and other administrative matters. These meetings will take place at the State of Tennessee offices in Nashville, TN. However, at its discretion, the State may allow the Contractor to participate in such meetings by teleconference.
- g. The Contractor's Medical Director and/or other appropriate staff, as specified by the State, shall present a seminar to Benefits Administration Division staff at least once per year on a topic prior approved by the State in writing.

- h. The Contractor shall not modify the services or benefits provided to members during the term of this Contract without the prior written consent of the State.
- i. The Contractor shall determine medical eligibility of members who are newly enrolled as incapacitated dependents according to State eligibility guidelines and report the results to the State.
- j. The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the options in the Public Sector Plan(s). This assistance may include but not be limited to:
 - (1) Written information;
 - (2) Audio/video presentations;
 - (3) Attendance at meetings, workshops, and conferences; and
 - (4) Training of State staff and other persons on Contractor's administrative and benefits procedures.

Any onsite visits to member agencies shall require the prior approval of the State.

- k. The Contractor shall refer all media and legislative inquiries to the Benefits Administration Division, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas; in all such instances, the Contractor shall copy the Benefits Administration Division on all correspondence.
- l. The Contractor shall ensure that the U.S. Postal Service returns all undeliverable mail and mail forwarding information to the Contractor, not to the State. Unless otherwise directed by the State, for all mailing materials, the Contractor shall use the "Address Service Requested" endorsement as described in Section 507.1.5 of the U.S. Postal Service's Domestic Mail Manual (DMM).
- m. The Contractor shall review all returned mail from any mailings to members or providers to determine if the member or provider has moved, if the Contractor has the wrong address, and/or if the member or provider is communicating other contact information to the Contractor or to the State. If the U.S. Postal Service indicates that a new address is available, the Contractor shall send the member a "Notice of Address Change Instructions" within three (3) business days and communicate the updated address information to the State within thirty (30) days. The Notice of Address Change Instructions shall be prior approved by the State in writing. Unless otherwise directed by the State, the Notice of Address Change Instructions shall explain to members that they need to contact their employer to update their address and contact information. The Contractor shall track returned mail and shall report monthly to the State the number of pieces of returned mail, the reason the mail was returned and action taken by the Contractor. The Contractor shall include in this report a list of all members whose mail was undeliverable due to an incorrect address provided by the State (see Contract Attachment C, Reporting Requirements).
- n. Unless prior approved in writing by the State and in compliance with State and Federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

A.16. Staffing.

- a. The Contractor shall provide and maintain qualified staff to provide services required under this Contract. The Contractor shall ensure that all staff, including the Contractor's employees, independent contractors, consultants, and subcontractors, performing services under this requirement have the experience and qualifications to perform the applicable services. The Contractor shall maintain staffing at a level that enables the Contractor to meet the requirements of this Contract.
- b. For its work under this Contract, the Contractor shall not use any person or organization that is on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list unless the Contractor receives prior, written approval from the State.
- c. The Contractor shall ensure that all staff receives initial and ongoing training regarding all applicable requirements of this Contract and the Public Sector Plans. The Contractor shall ensure that staff who provide services under this Contract are specifically oriented and trained regarding their functions, knowledgeable about the Contractor's operations relating to the Public Sector Plans, and knowledgeable about their functions and how those functions relate to the requirements of this Contract.
- d. The Contractor shall have on staff sufficient qualified and licensed nurses and physicians whose primary duties are to conduct medical necessity reviews of claims, including review of complex or questionable medical claims.
- e. The Contractor's utilization management (UM) reviewers shall be familiar with the terms of the Plan Documents. The UM reviewers shall consist of qualified nurse reviewers and physician reviewers. The Contractor shall exercise due diligence and care in its selection and retention of staff that perform utilization management services. The Contractor shall provide providers with uninterrupted telephone access to UM reviewers continuously during the Contractor's normal business hours.
- f. The Contractor shall have an ongoing dedicated, full-time Account Team that can provide daily operational support as well as strategic planning and analysis. All members of the Account Team shall have previous experience administering medical benefits for large employers. An available member of the Account Team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract. The Account Manager shall also be available via cell phone and email after hours, including weekends.
- g. The Contractor shall designate a dedicated full time Account Manager as a member of the Account Team. The dedicated Account Manager shall have the responsibility and authority to manage the entire range of services specified in this Contract and shall respond promptly to changes in benefit plan design, changes in claims processing procedures, or general administrative problems identified by the State. At a minimum, the Account Manager shall meet in person with the State once a month and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference.
- h. The Contractor shall survey the State annually in January to determine the State's satisfaction with the Account Team and report the results of the survey to the State (see Attachment C, Reporting Requirements).
- i. The Contractor agrees that the State may approve or disapprove the staff assigned to this Contract prior to the proposed assignment. The State may also direct the Contractor to replace staff members providing core services as it deems necessary and appropriate. The decision of the State on these matters shall not be subject to appeal.

- j. Key personnel commitments made in the Contractor's proposal shall not be changed unless prior approved by the State in writing. The Contractor shall notify the State at least fifteen (15) business days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact upon the Contract. The decision of the State on these matters shall not be subject to appeal.
- k. If any key position becomes vacant, the Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement in writing.

A.17. Information Systems.

a. Claims Management System

- (1) The Contractor shall operate a claims management system that tracks accumulations toward deductibles, tracks co-payments and co-insurance amounts and appropriately links claim history, enrollment information, member services, provider network, and utilization management information. This shall include the daily electronic exchange of member-level deductible and maximum out-of-pocket accumulator data with the EAP/BHO vendor.
- (2) Unless and until a lower threshold is specified by the State, the claims management system shall automatically calculate payment amounts for ninety-five percent (95%) of clean claims, i.e., without recourse to manual or other calculation methods external to the system.
- (3) The Contractor's claims management system shall be able to receive and process (i.e., without subsequent data entry) physician and hospital claim submissions electronically.
- (4) The Contractor's claims management system shall retain claim history on-line for at least two (2) years. (This does not limit the Contractor's obligations to retain all records in accordance with Contract Section D.9, Records.)
- (5) The Contractor shall test the accuracy of automated features of the claims management system (e.g., deductible calculation) at least twice a year as part of its internal audit program.

b. Clinical Edit Software

The Contractor shall use a clinical edit software program that automatically evaluates all claims for medical bills involving the use of current ICD and CPT/HCPCS codes. Clinical claim review software shall be updated no less than once every year, and all changes and new codes shall be incorporated by the Contractor within thirty (30) days of the change becoming effective.

c. Pricing of Provider Network Claims

The Contractor's claims management system shall automatically price network claims using current network provider rate information. The claims management system shall store network provider information to determine provider status and reimbursement for claims from network providers. Network provider rate information shall be updated in the claims management system according to the following standards:

- (1) 90% of network providers shall be updated within fifteen (15) days of the execution of the provider agreement.

- (2) 100% of network providers shall be updated within thirty (30) days of the execution of the provider agreement.
- d. **Member Services Representative Systems Access**
 The Contractor's member services representatives shall have access to claims management and other systems as necessary to respond to inquiries from members.
- e. The Contractor's Systems shall have the capability of adapting to any future changes necessary as a result of modifications to the design of the Public Sector Plans or this Contract and its requirements, including e.g., data collection, records and reporting based upon unique identifiers to track services and expenditures across population types/demographic groups, regions/parts of the state. The Systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, e.g., in response to changes in Contract requirements or increases in enrollment estimates. The Contractor's System architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:
 - (1) Changes in payment methodology;
 - (2) Provider reimbursement terms;
 - (3) Changes in service authorization and utilization management criteria;
 - (4) Changes in program management rules, e.g. eligibility for certain services; and
 - (5) Standardized contact/event/service codes.
- f. The Contractor shall ensure that its electronic data processing (EDP) and electronic data interchange (EDI) environments (both hardware and software), data security, and internal controls meet all applicable Federal and State standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. Said standards shall include but not be limited to the requirements specified under each of the following HIPAA subsections:
 - (1) Electronic Transactions and Code Sets
 - (2) Privacy
 - (3) Security
 - (4) National Provider Identifier
 - (5) National Employer Identifier
 - (6) National Individual Identifier
 - (7) Claims attachments
 - (8) National Health Plan Identifier
 - (9) Enforcement

Unless the State prior approves in writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standards (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.

- g. All Contractor systems shall maintain linkages and "parent-child" relationships between initial and related subsequent interactions/transactions/events/activities. Additionally, when the Contractor houses indexed images of documents used by members, providers and subcontractors to transact with the Contractor, the Contractor shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider/subcontractor identification numbers. The Contractor shall also ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about the same matter/problem/issue.

h. Upon the State's request, the Contractor shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The Contractor shall also be able to generate a sample of said document.

i. **Retention and Accessibility of Information**

- (1) The Contractor shall provide and maintain a comprehensive information retention plan that is in compliance with state and federal requirements.
- (2) The Contractor shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.
- (3) The Contractor shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.
- (4) If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

j. **Information Ownership.** All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. The Contractor is expressly prohibited from sharing or publishing State information and reports or releasing such information to external entities, affiliates, parent company, or subsidiaries without the prior written consent of the State.

k. **System Availability, Business Continuity and Disaster Recovery (BC-DR)**

- (1) The Contractor shall ensure that critical member, provider and other web-accessible and/or telephone-based functionality and information including the website described in Section A.14. (to be agreed to by the State and the Contractor) are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by the State and the Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement. Any scheduled maintenance shall occur between the hours of midnight and 5:00 a.m. Central Time and shall be scheduled in advance with notification on the member website/portal. The Contractor shall make efforts to minimize any down-time between 5:00 a.m. and 10:00 p.m. Central Time.
- (2) The Contractor shall ensure that the Systems within its span of control that support its data exchanges with the State and the State's vendors are available and operational according to the specifications and schedule associated with each exchange.
- (3) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan. The BC-DR plan shall encompass all information systems supporting this Contract. At a minimum the Contractor's BC-DR plan shall address the following scenarios:

- i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
 - ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
 - iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and
 - iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system.
- (4) The Contractor shall provide the State results of its most recent test of its BC-DR plan one (1) month prior to the go-live date.
 - (5) The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions. The Contractor shall submit an annual BC-DR Results Report to the State (refer to Contract Attachment C, Reporting Requirements).
 - (6) In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall submit to the State a corrective action plan that describes how the failure will be resolved. The Contractor shall deliver the corrective action plan within ten (10) business days of the conclusion of the test.
 - (7) In the event of a declared major failure or disaster, as defined in the Contractor's BC-DR plan, the Contractor's critical functionality as discussed in Section A.17.k.(1) shall be restored within seventy-two (72) hours of the failure's or disaster's occurrence.
 - (8) The Contractor shall maintain a duplicate set of all records relating to this Program in electronic medium, usable by the State and the 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 Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation. At the end of the term of this Contract or upon notice of termination of this Contract prior to the term date, the Contractor shall convey the original and the duplicate records medium and the information they contain to the State on or before the date of termination.
- i. Prior to implementing any major modification to or replacement of the Contractor's core information systems functionality and/or associated operating environment, the Contractor shall notify the State in writing of the change or modification within a reasonable amount of time (commensurate with the nature and effect of the change or modification) if the change or modification: (a) would affect the Contractor's ability to perform one or more of its obligations under this Contract; (b) would be visible to State system users, members and providers; (c) might have the effect of putting the Contractor in noncompliance with the provisions or substantive intent of the Plan Documents and/or this Contract; or (d) would materially reduce the benefits payable or services provided to the average member. If so directed by the State, the Contractor shall discuss the

proposed change with the State/its designee prior to implementing the change. Subsequent to this discussion, the State may require the Contractor to demonstrate the readiness of the impacted systems prior to the effective date of the actual modification or replacement.

m. **System and Information Security and Access Management Requirements**

- (1) The Contractor's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:
 - i. Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;
 - ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities and the ability to create, change or delete certain data (global access to all functions shall be restricted to specified staff jointly agreed to by the State and the Contractor);
 - iii. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and
 - iv. Ensure that authentication credentials are not passed in clear text or otherwise displayed or presented.
- (2) The Contractor shall make System information available to duly authorized representatives of the State and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
- (3) The Contractor's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the Contractor and the State.
- (4) Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:
 - i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
 - ii. Have the date and identification "stamp" displayed on any on-line inquiry;
 - iii. Have the ability to trace data from the final place of recording back to its source data file and/or document;
 - iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
 - v. Facilitate batch audits as well as auditing of individual records.
- (5) The Contractor's Systems shall have inherent functionality that prevents the alteration of finalized records.
- (6) The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Contract.

- (7) The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
- (8) The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.
- (9) The Contractor shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Contractor's span of control.
- (10) Unless the State prior-approves in writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standard (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.
- (11) The Contractor shall commission a security risk assessment at least annually and communicate the results to the State as part of an information security plan provided prior to the start date of operations. The risk assessment shall also be made available to appropriate state and federal agencies. At a minimum the assessment shall contain the following: identification of loss risk events/ vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 - 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR §164.308(a)(6)).

A.18. Data Integration and Technical Requirements.

- a. The Contractor shall maintain an electronic data interface with the State's Edison System for the purpose of processing State member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of Protected Health Information (PHI) with the State of Tennessee, the State requires the use of second level authentication. This is accomplished using the State's standard software product, which supports Public Key Infrastructure (PKI). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor shall, with adequate notice, cooperate with the State to maintain the security of protected information according to all applicable State and Federal standards.
- b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not perform changes to enrollment data without the State's approval. This prohibition shall

include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

- c. At least two (2) months prior to the go-live date, the Contractor shall complete testing of the transmission, receipt, and loading of the eligibility file from the State.
- d. At least one (1) month prior to the go-live date, the Contractor shall load, test, verify and make available online for use the State's eligibility/enrollment information. The Contractor shall certify, in writing, to the State that the Contractor understands and can fully accept and utilize the eligibility/enrollment files as provided by the State.
- e. The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Public Sector Plans.
 - (1) **Daily Enrollment Update:** To ensure that the State's enrollment records remain accurate and complete, the Contractor shall, unless otherwise directed by the State, retrieve, via secure medium daily enrollment files from the State, in the State's Edison 834 file format (see RFP 317816-00104 Appendix 7.11. for the current file format, which may be revised), for participants who are maintained in the State's Edison System (files will include full population records for all members and will be in the format of ANSI ASC X12.84, Benefit Enrollment and Maintenance (834), version 004010X095A1, with several fields customized by the State).
 - (2) The Contractor shall complete and submit to the State a Daily File Transmission Statistics Report within twenty-four (24) hours of receipt of the file. The Contractor shall submit this report via email to designated State staff. (See Contract Attachment C.)
 - (3) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) business day of receipt of the daily file and one hundred percent (100%) shall be posted within three (3) business days of receipt of the daily file.
 - (4) The Contractor and/or its subcontractors, as applicable, shall resolve all discrepancies identified by the processing of the enrollment file within five (5) business days of receipt of the file from the State. The State and the Contractor shall work to develop a process for responding to invalid or non-processed records.
 - (5) **State Enrollment Data Match:** Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its database of State members. The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.
- f. **CMS Data Match:** The Contractor shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) providing for a data match, no less frequently than quarterly, of Contractor's full file of members against CMS Medicare files for purpose of determining the primary payer. Furthermore, the data match shall generate a report of all Medicare enrollees identified. Such report shall be submitted to the State as specified in Contract Attachment C.

- g. The Contractor shall reconcile, within ten (10) business days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.
- h. The Contractor shall establish and maintain systems and processes to receive all appropriate and relevant data from entities and vendors providing services to members, including vendors under contract with the State (e.g., the PBM, EAP/BHO vendor, and HM/W vendor) and integrate such data into Contractor's systems and processes as appropriate.
- i. The Contractor shall transmit medical claims data to the State's current health care decision support system (DSS) vendor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 317816-00104 Appendix 7.11. DSS Vendor File Format, or in a mutually agreed upon format. The data feed(s) shall be provided at no additional charge to the State. The Contractor shall transmit the claims data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State, until all claims incurred during the term of this Contract have been paid. The Contractor shall ensure that all claims processed for payment have valid provider identifications, complete ICD-9 and CPT-4/HCPCS codes (and when applicable, updated versions), and other identifying variables as contained in the file layout in RFP 317816-00104 Appendix 7.12. DSS Vendor File Format.
- j. The Contractor shall adhere to the additional requirements related to the State's DSS vendor listed in Section C.3. of this Contract.
- k. Claims data provided to the DSS vendor shall meet the quality standards detailed in the Liquidated Damages section of this Contract (Contract Attachment B) as determined by the State's DSS vendor.
- l. The Contractor shall provide transmittal of claims data via secure medium to any additional third parties including the State's HM/W vendor, EAP/BHO vendor, or others as identified by the State.
- m. To the extent that the Contractor receives electronic lab results for laboratory tests performed by contract providers, the Contractor shall transmit these lab results to the State's DSS vendor in a mutually agreed upon format. The Contractor shall transmit the data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month or more frequently as directed by the State.
- n. The Contractor shall load all current prior authorizations and related data that exist for current members from all existing claims administrators no later than one (1) month prior to the go-live date and update/refresh the data, as specified by the State, until go-live.
- o. Unless otherwise directed by the State, the Contractor shall accept at least one (1) year of historical data from each current claims administrator. This includes, but is not limited to, claims history (with proprietary pricing and discount information redacted), provider data, member data, and prior authorization data.
- p. The Contractor's systems shall conform to future federal and state specific standards for data exchange by the standard's effective date.
- q. The Contractor shall partner with the State and member agencies in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort.

- r. The Contractor's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.
- s. Within sixty (60) days of notice of termination of this Contract, the Contractor shall transfer to the State all required data and records necessary to administer the plan(s)/program(s), subject to State and Federal confidentiality requirements. The transfer shall be made electronically via secure medium, in a file format to be determined based on the mutual agreement between the State and the Contractor.
- t. If a member changes his or her PPO Grand Division, benefit option, or third party administrator outside of the Annual Enrollment Transfer Period (due to a move, HIPAA qualifying event, etc.), then the Contractor shall transfer to the new third party administrator or benefit option the in-network and out-of-network paid amounts that the member would have otherwise applied to his or her current year deductible and/or out-of-pocket maximum had the member not made a change. The Contractor shall transfer said data to the member's new third party administrator or benefit option within a reasonable time frame and update the transferred data with new paid claims data upon the member's request. Likewise, the Contractor shall transfer any existing prior authorization or utilization management information to the new third party administrator as appropriate. The Contractor shall also take all reasonable measures to facilitate the member's transition, maintain the member's continuity of care and service delivery, and minimize the administrative burden or other disruption to the member.

A.19. Privacy & Confidentiality.

- a. The Contractor shall develop, adopt, and implement standards, which are, at a minimum, compliant with the HIPAA statute and the HIPAA privacy and security rules in 45 CFR Part 164, to safeguard the privacy and confidentiality of all Protected Health Information (PHI) about members. For example, the Contractor shall ensure that it does not have completed forms containing PHI sitting in public view, left in unsecured boxes or files, or left unattended in any off-site location (e.g., in an automobile). The Contractor's procedures shall include but not be limited to safeguarding the identity of members as members of a Public Sector Plan and preventing the unauthorized disclosure of PHI. The Contractor shall comply with the HIPAA amendments in the American Recovery and Reinvestment Act, Public Law 111-5, the HITECH Act, and any implementing regulations when they become effective.
- b. The Contractor shall not use or further disclose protected health information (PHI) other than as permitted or required by HIPAA and the Business Associate Agreement; or as required by law. Use of PHI for payment, treatment, or health care operations may include disclosure only as permitted by HIPAA, including when such information is strictly necessary to resolve the issue or concern under discussion and the person has adequate permission or legal authority to review such information. In the absence of exigent circumstances, the Contractor shall not disclose any member's PHI to another business associate for pecuniary gain unless the State specifically prior authorizes such disclosure in writing.
- c. The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. The Contractor shall report to the State any unauthorized use or disclosure of the PHI.
- d. The Contractor shall mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of the Federal privacy rule.
- e. The Contractor shall provide access to PHI in a "designated record set" in order to meet the requirements under 45 CFR §164.524.

- f. The Contractor shall make any amendment(s) to PHI in a "designated record set" pursuant to 45 CFR §164.526.
- g. The Contractor shall document disclosures of PHI and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.
- h. The Contractor shall (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits, (ii) report to the State any security incident (within the meaning of 45 CFR § 164.304) of which the Contractor becomes aware, and (iii) ensure that any agent of the Contractor, including any subcontractor, agrees to the same restrictions and conditions that apply to the Contractor with respect to such information.
- i. The Contractor shall not sell member information unless it is aggregated blinded data, which is not identifiable on a member basis. The Contractor shall not use member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service.
- j. The Contractor shall comply with all privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health (HITECH) Act. Unless the State prior approves in writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standards (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.
- k. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments.
- l. The Contractor shall assure that all Contractor staff is trained in all HIPAA requirements, as applicable.

A.20. Reporting & Systems Access.

- a. The Contractor shall submit reports in a mutually agreeable electronic format (e.g., Microsoft Word or Microsoft Excel), of the type, at the frequency, and containing the detail described in Contract Attachment C. Reporting shall continue for the twelve (12) month period following termination of this Contract.
- b. The Contractor shall provide a mutually agreed upon mechanism for the State to access data, including program and fiscal information regarding members served, services rendered, etc. and the ability for said personnel to develop and retrieve reports. This requirement could be met by the provision of access to a decision support system/data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees and a maximum of five (5) State employees no later than nine (9) days prior to the go-live date. Additional or replacement users may be added at any time at the State's request.
- c. The Contractor shall provide a minimum of three (3) State employees and a maximum of five (5) State employees with access to the Contractor's eligibility system no later than nine (9) days prior to the go-live date. Additional or replacement users may be added at any time at the State's request. Access shall include the ability to do real-time updates to the Contractor's eligibility records.

- d. The Contractor shall train the three (3) to five (5) State staff (and any additional or replacement users) regarding access to the Contractor's system on all Contractor systems and tools no later less than one (1) month prior to the go-live date. Such training may be delivered remotely or in-person.
- e. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of reports that cannot be generated using the Contractor's standard reporting package. The Contractor shall deliver such reports to the State within five (5) business days of the State's request. If requested by the State, the Contractor shall deliver up to five (5) reports annually deemed as "urgent" by the State within two business days. All ad-hoc reports shall be provided at no additional cost to the State.
- f. Within thirty (30) days of the contract start date, the Contractor shall provide the State the most recent copy of the Contractor's SAS 70 report as well as the SAS 70 Type II report for any subcontractor processing claims that represent more than twenty percent (20%) of medical expenses for members. Thereafter, a copy of this report(s) shall be provided to the State upon request.
- g. The Contractor shall ensure that reports submitted by the Contractor to the State shall meet the following standards:
 - (1) The Contractor shall verify the accuracy and completeness of data and other information in reports submitted.
 - (2) The Contractor shall ensure delivery of reports or other required data on or before scheduled due dates.
 - (3) Reports or other required data shall conform to the State's defined written standards.
 - (4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.
 - (5) Each report shall be accompanied by a brief narrative that describes the content of the report and highlights salient findings of the report.
 - (6) As applicable, the Contractor shall analyze the reports for any early patterns of change, identified trend, or outlier (catastrophic case) and shall submit a written summary with the report including such analysis and interpretation of findings. At a minimum, such analysis shall include the identification of change(s), the potential reasons for change(s), and the proposed action(s).
 - (7) The Contractor shall notify the State regarding any significant changes in its ability to collect information relative to required data or reports.
 - (8) The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report within the specified timeframe (see Contract Attachment B).
 - (9) State requirements regarding reports, report content and frequency of submission may change during the term of the Contract. The Contractor shall have at least forty-five (45) days to comply with changes specified in writing by the State.

A.21. Due Dates for Project Deliverables/Milestones.

Unless otherwise specified in writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
Implementation		
1. Call center and other information systems are fully operational	A.2.a	December 1, 2010
2. Go-live	A.2.c	January 1, 2011
3. Kick-off meeting for all key Contractor staff	A.2.d	Within 30 days after Contract start date
4. Implementation plan	A.2.e	no later than 30 days after Contract start date
5. State readiness review	A.2.f	November 1, 2010, or before
6. Implementation Performance Assessment	A.2.j	February 15, 2011, or before
Provider Network		
7. Appointment Standards Report	A.3.d and Attachment C	semi-annually after the 1 st and 3 rd calendar quarters starting with a submission for the 2 nd and 3 rd calendar quarters after go-live
8. Quarterly Network Changes Update Report	A.3.l and Attachment C	within five (5) business days of the end of each quarter
9. Provider directories	A.3.p	December 11, 2010, or before and then, within 10 days of receipt of enrollment information
10. GeoNetworks® Report	A.3.r and Attachment C	semi-annually after the 1 st and 3 rd calendar quarters starting with a submission for the 2 nd and 3 rd calendar quarters after go-live
11. Annual Provider Turnover Report	A.3.s and Attachment C	annually
12. Monthly Unique Care Exception Report	A.3.bb and Attachment C	monthly after go-live
Utilization Management		
13. Description of UM program, evaluation methodology, and audit program	A.4.m	October 1, 2010, or before
14. Quarterly Utilization and Practice Report	A.4.n and Attachment C	quarterly after go-live
Quality Assurance Program		
15. Summary of quality assurance program	A.5.j	December 1, 2010, or before

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
16. Weekly Case Conference Calls	A.5.k	weekly after go-live
17. Monthly Conference Calls	A.5.l	monthly after go-live
18. Quarterly Coordination Meetings	A.5.m	quarterly after go-live
19. HEDIS Report	A.5.n and Attachment C	annually by June 15 for prior year
Claims Processing, Payment and Reconciliation		
20. Quarterly COB Report	A.9.s and Attachment C	quarterly after go-live
21. Description of process for determining experimental/investigational procedures and services	A.9.w	December 1, 2010, or before
22. Monthly Paid Claims Report	A.9.y and Attachment C	monthly after go-live
23. Monthly Reconciliation Report	A.9.y and Attachment C	monthly after go-live
24. Monthly Recoveries Report	A.9.y and Attachment C	monthly after go-live
25. Description of fraud and abuse program	A.9.dd.(4)	October 1, 2010, or before
26. Quarterly Fraud and Abuse Report	A.9.dd.(5) and Attachment C	quarterly after go-live
Member Services		
27. Description of member appeals process and procedures and sample determination letters	A.11.i (3)	December 1, 2010, or before
28. Quarterly Appeals Reports	A.11.i (4) and Attachment C	quarterly after go-live
29. CAHPS Survey Report	A.11.j and Attachment C	annually by June 15
Call Center		
30. Call center open	A.12.b	December 1, 2010
31. Call center statistics	A.12.i -k, Attachment B and C	daily from December 1, 2010 through January 31, 2011; weekly starting December 6, 2010, and monthly starting January 5, 2011
Member Communication/Materials		
32. I.D. cards	A.13.d	December 11, 2010, or before, and then, within 10 days of receipt of enrollment information and 14 days prior to each benefit year

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
33. Member handbook	A.13.e	December 11, 2010, or before, and then, at least 14 days prior to each benefit year
34. Annual transfer materials	A.13.f	annually two (2) months before the annual transfer period
35. Initial welcome packets	A.13.g	December 11, 2010
36. Ongoing welcome packets	A.13.g	within 10 days of receipt of enrollment information
Website		
37. Website go-live	A.14.a	December 1, 2010, or before
38. State review of website	A.14.c	November 1, 2010, or before
Administrative Services		
39. Quarterly meetings with the State	A.15.f	quarterly after go-live
40. Seminars	A.15.g	at least annually
41. Dependent Eligibility Verification Report	A.15.i and Attachment C	annually
42. Monthly Returned Mail Report	A.15.m. and Attachment C	monthly after go-live
Staffing		
43. Account Team satisfaction survey	A.17.h	annually (each January)
44. Account Team Satisfaction Survey Report	A.17.h and Attachment C	annually
Information Systems		
45. Business continuity/Disaster Recovery (BC-DR) Results Report	A.17.f and Attachment C	December 1, 2010 and then annually in January
Data Integration & Technical Requirements		
46. Completion of eligibility file testing	A.18.c	November 1, 2010, or before
47. Edison System Interface/Eligibility file acceptance	A.18.d	December 1, 2010, or before
48. Daily enrollment update	A.18.e.(1)	daily after December 1, 2010
49. Daily File Transmission Statistics Report	A.18.e.(2) and Attachment C	within 24 hours of receipt of file
50. State enrollment data match	A.18.e.(5)	up to four (4) times annually, as requested by the State
51. Quarterly CMS Data Match and Report	A.18.f and Attachment C	quarterly after go-live

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
52. Duplicate data processing records	A.17.k.(8)	Before contract termination
53. Completion of testing files from other vendors	A.18.h.	November 1, 2010, or before
54. Interface with other vendors/file acceptance	A.18.h.	December 1, 2010
55. File acceptance from other vendors	A.18.h.	daily, unless otherwise directed by the State
56. Claims data transmission to DSS vendor	A.18.i.	15 days following the end of each calendar month
57. Claims data transmission to third parties	A.18.l.	daily, unless otherwise directed by the State
58. Electronic lab results transmission to DSS vendor	A.18.m.	15 days following the end of each calendar month
59. Load current prior authorizations and related data	A.18.n.	December 1, 2010, or before
60. Transmission of data and records to State	A.18.s.	within 60 days of notice of termination
Reporting & Systems Access		
61. Reports specified in Contract Attachment C	A.20.a and Contract Attachment C	as specified in Contract Attachment C
62. Reporting system access	A.20.b	December 23, 2010, or before
63. Eligibility system access	A.20.c	December 23, 2010, or before
64. State staff systems training	A.20.d	December 1, 2010, or before
65. SAS 70 report(s)	A.20.f	within thirty (30) days of the contract start date

A.22. Definitions.

- a. **Abandoned Call:** A call in which the caller elects an option and is either not permitted access to that option or disconnects from the system.
- b. **Affiliate:** A business organization or entity that, directly or indirectly, is owned or controlled by the Contractor, or owns or controls the Contractor, or is under common ownership or control with the Contractor.
- c. **Agency Benefits Coordinator (ABC):** An Agency Benefits Coordinator serves as the liaison between the Public Sector Plans and members.
- d. **Average Seconds to of Answer (ASA):** The mean time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a member services representative at the call center answers the call. For this definition, the term "answer" shall mean begin an uninterrupted dialogue with the caller. If a member services representative asks the caller to hold

during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be "answered" for purposes of this definition until the member services representative returns to the caller and begins an uninterrupted dialogue. If a caller requested a returned call using the dial-back feature described in Contract Section A.12 the ASA shall be defined as the time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time of the returned call (regardless of whether the member answered).

- e. **Balance Billing:** Seeking payment from a member for any charged amount(s) over and above the allowable amount or contract rates.
- f. **Benefits Administration:** The division of the Tennessee Department of Finance & Administration that administers the Public Sector Plans and the Cover Tennessee programs.
- g. **Blocked Call:** A call that can not be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up behind a defined threshold.
- h. **Bobby-approved:** Standards for website accessibility in keeping with Americans with Disabilities Act of 1990, Public Law 101-336, (as amended) and implementing regulations and other national standardization criteria. For more information refer to: <http://www.accessible.org/bobby-approved.html>.
- i. **Business Days:** Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Government Holidays are excluded.
- j. **Calendar Days:** All seven days of the week.
- k. **CFR:** Code of Federal Regulations.
- l. **Clean Claim:** A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider in order to be processed and paid by the Contractor. In addition to the provider, this includes information, adjustment, or alteration by the member, the subscriber, third-party payers (i.e. – Medicare), and/or plan sponsor.
- m. **Co-insurance:** That percentage of the charge for a medical service provided to a member that is the responsibility of the member.
- n. **Co-payment:** That portion of the charge (flat dollar amount) for each medical service provided to a member that is the responsibility of the member.
- o. **Day(s):** Calendar day(s) unless otherwise specified in the Contract.
- p. **Deductible:** The amount specified in the Plan Documents that must be paid by each member prior to payment of any covered benefits by the Contractor.
- q. **Denied Claim:** A claim that is not paid for reasons such as eligibility and coverage rules.
- r. **DSS:** A decision support system is a database and query tool.
- s. **eValue8:** A quality assessment of third party administrators and other health care administrative service organizations performed by the National Business Coalition on Health and its local designees. For additional information, please see <http://www.nbch.org/evalue8>.

- t. Head of Contract: Eligible employee, retiree, or individual qualified under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) (not including dependents) who is enrolled in one the medical benefit options of the Public Sector Plans.
- u. HIPAA: Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and implementing regulations.
- v. HITECH: Health Information Technology for Economic and Clinical Health Act Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5 (Feb. 17, 2009) and implementing regulations.
- w. Information System(s) (System(s)): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.*, structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.
- x. Leapfrog Hospital Survey: An annual survey of acute care hospitals in which The LeapFrog Group collects quality and other measures. For additional information, see <http://www.leapfroggroup.org/cp>.
- y. Lock-in: An action by a third party administrator to limit the number or subset of providers from which a member can seek covered services so as to prevent "doctor shopping" and mitigate risks of fraud and abuse.
- z. Member: Any person who is enrolled in one the medical benefit options of the Public Sector Plans administered by the Contractor in accordance with the Plan documents.
- aa. National Provider Identification Number (NPI): A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty.
- bb. Network Provider: A provider that has a provider agreement with the Contractor to provide services according to specific terms and rates.
- cc. Paid Claim: A claim that meets all coverage criteria of the Public Sector Plans and is paid by the Contractor and submitted to the State for reimbursement.
- dd. Out-of-Network: The services received and the reimbursement level available when provided by providers that do not have a provider agreement with the Contractor to provide services according to specific terms and rates.
- ee. Out-of-Pocket Expenses: The sum of any deductibles, co-payments or co-insurance required or incurred for any covered benefit.
- ff. Plan Documents: The State Plan, Local Education Plan, and Local Government Plan Documents, which are located on the State's website at www.tn.gov/finance/ins/publications.html and which govern coverage of services and eligibility under each plan.
- gg. PEPM: Per Employee per month. For purposes of this definition, "employee" shall include any enrollee in the public sector plans and who is also a head of contract as defined in Section A.22.s.

- hh. PPO Grand Division: A defined geographical area that includes specified counties in the State of Tennessee. The Contractor shall serve an entire PPO Grand Division. The following counties constitute the PPO Grand Divisions in Tennessee for this Contract:

East PPO Grand Division – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle PPO Grand Division – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Sequatchie, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West PPO Grand Division – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

- ii. Protected Health Information (PHI): As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.
- jj. Public Sector Plans: Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees, including the Standard Preferred Provider Organization (PPO), the Partnership PPO, and any other benefit options specified by the State.
- kk. RFP: Request for Proposals.
- ll. Specialty Pharmacy Benefits: Medications and biologicals used in the treatment of complex clinical conditions such as cancer, HIV/AIDS, organ transplant, Gaucher's disease and hemophilia. These agents require special handling and/or close supervision or clinical management and tend to be very expensive. They would include injectibles and home infusion therapies.
- mm. Seconds to Answer: The total time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a member services representative at the call center answers the call. For this definition, the term "answer" shall mean begin an uninterrupted dialogue with the caller. If a member services representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be "answered" for purposes of this definition until the member services representative returns to the caller and begins an uninterrupted dialogue.
- nn. Spouse: Legally married spouse, as of date of marriage as defined in Chapter 3 of Title 36, *Tennessee Code Annotated*.
- oo. State: The State of Tennessee.
- pp. State, Local Government, and Local Education Insurance Committees: Policy making bodies for the State, Local Government, and Local Education plans established under *Tennessee Code Annotated* 8-27-101, 8-27-207, and 8-27-301 respectively.
- qq. State Government Holidays: Days on which official holidays and commemorations as defined in *Tennessee Code Annotated* 15-1-101 *et seq.* are observed.

- rr. Subcontract: An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms of this Contract, when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract.
 - ss. Subcontractor: Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms of this Contract.
 - tt. Telecommunication Device for the Deaf (TDD): Special telephone devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones. Also known as TTY.
- A.23. The Contractor acknowledges the State will monitor and age the outstanding check balance and the Contractor agrees, upon request of the State, to conduct a review and/or cancel-reissue of stale dated outstanding items. In a format mutually agreed to, the Contractor on a daily basis, shall provide a detailed listing of the payment activity, including check serial numbers and ACH payment identifiers, payee names, payment amounts, plan group (State, Local Education and Local Government) and associated claim numbers, balancing to the required funding amount for that day. Said listing shall enable the State to reconcile the payment detail to the required funding amount, while providing related payment information needed to record the necessary accounting entries by expense classifications. The Contractor shall further provide monthly check Reconciliation Reports that provide detail (check number, issue date, payee name, claim numbers, check amount, paid or cancel date) of all checks issued or cancelled during the month, and detailed listing of outstanding checks at each month-end.
- A.24. The Contractor is responsible for the fee charged by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor shall pay during the term of this contract all applicable fees as assessed by the State's DSS vendor related to any data format changes, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor shall 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.

B. CONTRACT TERM:

This Contract shall be effective for the period commencing on August 27, 2010, and ending on December 31, 2015. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

C. PAYMENT TERMS AND CONDITIONS:

- C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Twenty One Million Six Hundred Fifty Two Thousand Two Hundred Thirty Six Dollars (\$21,652,236.00). The payment 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 payment 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 payment 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 payment 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 payment methodology 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 based upon the following payment rates:

(1) Administrative Component Fees.

ADMINISTRATIVE COMPONENTS	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD				
	January 1 – December 31, 2011	January 1 – December 31, 2012	January 1 – December 31, 2013	January 1 – December 31, 2014	January 1 – December 31, 2015
Basic Administrative Services *	\$17.00	\$17.83	\$18.67	\$19.55	\$20.45
Utilization Review	\$10.50	\$10.50	\$10.50	\$10.50	\$10.50
Total Administrative Fee	\$27.50	\$28.33	\$29.17	\$30.05	\$30.95

* Basic administrative services include: claims administration, network access, underwriting, standard ad hoc reports, member communication materials, assumption of claims fiduciary liability and member ID cards.

(2) Total Enrollment Level-Based Fee.

TOTAL ENROLLMENT * LEVELS (all members, not just employees)	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD				
	January 1 – December 31, 2011	January 1 – December 31, 2012	January 1 – December 31, 2013	January 1 – December 31, 2014	January 1 – December 31, 2015
Below 10,000	\$65.00	\$66.95	\$68.96	\$71.03	\$73.16
10,000 – 29,999	\$43.00	\$44.29	\$45.62	\$46.99	\$48.40
30,000 – 49,000	\$34.50	\$35.54	\$36.60	\$37.70	\$38.83
50,000 – 74,999	\$31.50	\$32.45	\$33.42	\$34.42	\$35.45
75,000 – 99,999	\$28.50	\$29.36	\$30.24	\$31.14	\$32.08
100,000 and above	\$27.50	\$28.33	\$29.17	\$30.05	\$30.95

* "Total enrollment levels" reflects all members (i.e., all employees, retirees, and dependents) covered in all regions by the Contractor. January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The sum of the PEPM and the number of employees (or heads of contract), not total enrollment levels, will generate the Contractor's total payment.

Carriers will invoice the State based on enrollment as approved by the State.

- c. **Potential Fee Reductions.** The fees payable to the Contractor (detailed in subsections b. (1) & (2), above) shall be reduced by the State in accordance with the schedule below if the Contractor fails to achieve specified discount guarantees (detailed in Section C.3.d.(4)).

DISCOUNT GUARANTEE TYPES	PERCENT OF FEES AT RISK BY CONTRACT PERIOD				
	January 1 – December 31, 2011	January 1 – December 31, 2012	January 1 – December 31, 2013	January 1 – December 31, 2014	January 1 – December 31, 2015
Inpatient Facility Guaranteed Overall Discounts	6.66%	6.66%	5.00%	3.33%	3.33%
Outpatient Facility Guaranteed Overall Discounts	6.66%	6.66%	5.00%	3.33%	3.33%
Professional Services Guaranteed Overall Discounts	6.66%	6.66%	5.00%	3.33%	3.33%

- d. **Claims Payments.** The State will fund the Contractor for the total issue amount of the claims payments, net of cancellations, voids or other payment credit adjustments. Unless otherwise mutually agreed in writing by the parties, the Contractor shall notify the State of the funding amount required and the State will fund the Contractor weekly, provided that the Contractor's payment process includes timely settlement of ACH transactions. As the parties shall mutually agree in writing, the transfer of said funding to the Contractor for claims payments shall be effected weekly by either ACH debit from the Contractor to a designated State bank account; or wire transfer of funds to the Contractor's designated bank account.

- (1) The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.
- (2) The State reserves the right to review documentation either before or after the transfer of funding for claims payments and, as the State may deem appropriate, to adjust the funding amount to be transferred or withhold the amount of any overpaid funding from another funding transfer.
- (3) The Contractor acknowledges that funding for Claims Payments shall be adjusted in full consideration of the Contract Scope of Service requirement that the Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB); see Contract Section A.9.

- (4) The Contractor shall effect and evidence achievement of the guaranteed overall discounts for member services detailed by type and period below.

DISCOUNT TYPES	PERCENT OVERALL DISCOUNTS GUARANTEED BY CONTRACT PERIOD				
	January 1 – December 31, 2011	January 1 – December 31, 2012	January 1 – December 31, 2013	January 1 – December 31, 2014	January 1 – December 31, 2015
Inpatient Facility Guaranteed Overall Discounts	62.60%	62.80%	62.90%	63.00%	63.10%
Outpatient Facility Guaranteed Overall Discounts	63.20%	63.40%	63.50%	63.60%	63.70%
Professional Services Guaranteed Overall Discounts	48.30%	48.90%	49.00%	49.10%	49.20%

- e. The State shall reimburse the Contractor for the actual cost of the following in the performance of this Contract, provided that the Contractor provides documentation of actual costs incurred as required by the State.
- (1) **Postage.** In a situation where unanticipated plan modifications would require notification to plan members that is not detailed in the terms and conditions of this Contract, the State may request the Contractor to produce and mail such notification to plan members. In such extreme situations, the State shall reimburse the Contractor only for the actual cost of postage for mailing materials produced at the specific direction of the State and authorized by the State.
 - (2) **Printing / Production.** The State shall reimburse the Contractor an amount equal to the actual net cost of document printing / production as required and authorized by the State as described in Contract Section C.3.e.(1) above. Additionally, if error(s) in member materials, approved by the State in writing, are detected after the materials have been mailed, the State will reimburse the Contractor for the production and postage cost of mailing the corrected version.
- Notwithstanding the foregoing, the State retains the right to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.
- f. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received, provided that the Contractor shall comply with the State's requirements regarding subrogation, as specified in Contract Section A.9. and Contract Attachment D. However, if the Contractor subcontracts the subrogation function to a subcontractor that is not an organizational unit, affiliate, subsidiary, or parent company, then the Contractor may instead request reimbursement from the State for seventy-five percent (75%) of the subcontracted costs incurred for subrogation activities for the public sector plans. Such reimbursement shall be in lieu of rather than in addition to the five percent (5%) retention allowance described above.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Invoice Requirements. The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in Section C.3, above, and as required below prior to any payment.

- a. The Contractor shall submit invoices no more often than monthly, with all necessary supporting documentation, to:

Marlene Alvarez, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 2600
Nashville, Tennessee 37243

- b. The Contractor agrees that each invoice submitted shall clearly and accurately (all calculations must be extended and totaled correctly) detail the following required information.

- (1) Invoice/Reference Number (assigned by the Contractor);
- (2) Invoice Date;
- (3) Invoice Period (period to which all invoiced charges are applicable);
- (4) Contract Number (assigned by the State to this Contract);
- (5) Account Name: Finance & Administration, Benefits Administration Division;
- (6) Account/Customer Number (uniquely assigned by the Contractor to the above-referenced Account Name);
- (7) Contractor Name;
- (8) Contractor Federal Employer Identification Number or Social Security Number (as referenced in this Contract);
- (9) Contractor Contact (name, phone, and/or fax for the individual to contact with billing questions);
- (10) Contractor Remittance Address;
- (11) Complete Itemization of Charges, which shall detail the following:
 - i. Service or Milestone Description (including name /title as applicable) of each service invoiced;
 - ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced;
 - iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced;
 - iv. Amount Due by Service; and
 - v. Total Amount Due for the invoice period.

- c. The Contractor understands and agrees that an invoice to the State under this Contract shall:

- (1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
- (2) not include any future work but will only be submitted for completed service; and
- (3) not include sales tax or shipping charges.

- d. The Contractor agrees that timeframe for payment (and any discounts) begins when the State is in receipt of each invoice meeting the minimum requirements above.

- e. The Contractor shall complete and sign a "Substitute W-9 Form" provided to the Contractor by the State. The taxpayer identification number contained in the Substitute W-9 submitted to the State shall agree to the Federal Employer Identification Number or

Social Security Number referenced in this Contract for the Contractor. The Contractor shall not invoice the State for services until the State has received this completed form.

- 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. Regulred 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 State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.
- 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 terminate the Contract and withhold payments in excess of fair compensation for completed services.
- a. The State will provide notification of termination for cause in writing. This notice will: (1) specify in reasonable detail the nature of the breach; (2) provide the Contractor with an opportunity to cure, which must be requested in writing no less than 10 days from the date of the Termination Notice; and (3) shall specify the effective date of termination in the event the Contractor fails to correct the breach. The Contractor must present the State with a written request detailing the efforts it will take to resolve the problem and the time period for such resolution. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there

have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations. In circumstances where an opportunity to cure is not available, termination will be effective immediately.

- b. Notwithstanding the foregoing, 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.
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- 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 below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). 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 at Contract Attachment A, 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 under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.
- D.10. **Monitoring.** The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.
- D.11. **Progress Reports.** The Contractor shall submit brief, periodic, progress reports to the State as requested.
- D.12. **Strict Performance.** Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.
- D.13. **Independent Contractor.** The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint ventures, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.
- The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.
- D.14. **State Liability.** The State shall have no liability except as specifically provided in this Contract.
- D.15. **Force Majeure.** The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, 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 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, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, Suite 2600
Nashville, Tennessee 37243
Marlene.alvarez@tn.gov
Telephone: 615.253.8358
Facsimile: 615.253.8556

The Contractor:

Tim Cullen, Account Manager
CIGNA
1000 Corporate Centre Drive, Suite 500
Franklin, Tennessee 37067
Telephone: 615.595.3382

Facsimile: 615.595.3287
Timothy.Cullen@CIGNA.com

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

- 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. **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.5. **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.htm. 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.

E.6. Insurance. The Contractor shall carry adequate liability and other appropriate forms of insurance.

- a. The Contractor shall maintain, at minimum, the following insurance coverage:
- (1) Workers' Compensation/ Employers' Liability (Including all states coverage) with a limit not less than the relevant statutory amount or one million dollars (\$1,000,000) per occurrence for employers' liability whichever is greater.
 - (2) Comprehensive Commercial General Liability (Including personal injury & property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) aggregate.
 - (3) Automobile Coverage (Including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars (\$1,000,000) per occurrence.
 - (4) Professional Malpractice Liability with a limit of not less than one million dollars (\$1,000,000) per claim and two million dollars (\$2,000,000) aggregate.
- b. At any time State may require the Contractor to provide a valid Certificate of Insurance detailing Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured. Failure to provide required evidence of insurance coverage shall be a material breach of this Contract.

E.7. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal 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 applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information 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 applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

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. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

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

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

- a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.
- b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.
- c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.9. State Ownership of Work Products. The State shall have ownership, right, title, and interest, including ownership of copyright, in all work products, including computer source code, created, designed, developed, derived, documented, installed, or delivered under this Contract subject to the next subsection and full and final payment for each "Work Product." The State shall have royalty-free and unlimited rights and license to use, disclose, reproduce, publish, distribute, modify, maintain, or create derivative works from, for any purpose whatsoever, all said Work Products.

- a. To the extent that the Contractor uses any of its pre-existing, proprietary or independently developed tools, materials or information ("Contractor Materials"), the Contractor shall retain all right, title and interest in and to such Contractor Materials, and the State shall acquire no right, title or interest in or to such Contractor Materials EXCEPT the Contractor grants to the State an unlimited, non-transferable license to use, copy and distribute internally, solely for the State's internal purposes, any Contractor Materials reasonably associated with any Work Product provided under the Contract.
- b. The Contractor shall furnish such information and data as the State may request, including but not limited to computer code, that is applicable, essential, fundamental, or intrinsic to any Work Product and Contractor Materials reasonably associated with any Work Product, in accordance with this Contract and applicable state law.
- c. Nothing in this Contract shall prohibit the Contractor's use for its own purposes of the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of providing the services requested under this Contract.
- d. Nothing in the Contract shall prohibit the Contractor from developing for itself, or for others, materials which are similar to and/or competitive with those that are produced under this Contract.

E.10. Competitive Procurements. This Contract provides for reimbursement of the cost of goods, materials, supplies, equipment, or contracted services. Such procurements shall be made on a competitive basis, where practical. The Contractor shall maintain documentation for the basis of each procurement for which reimbursement is paid pursuant to this Contract. In each instance where it is determined that use of a competitive procurement method was not practical, said documentation shall include a written justification, approved by the Commissioner of Finance and Administration, for such decision and non-competitive procurement.

E.11. State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State

for the Contractor's temporary use under this Contract. Upon termination of this Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the residual value of the property at the time of loss.

E.12. 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.13. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;
- b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted 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.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded or disqualified.

E.14. 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 # 31786-00104 (Attachment 6.2) 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.

E.15. Limitation of Liability. The parties agree that the Contractor's liability under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this section limit the liability of the Contractor for intentional torts, criminal acts, or fraudulent conduct.

E.16. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

In the event of any such suit or claim, the Contractor shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Contractor written notice of any such claim or suit, and the Contractor shall have full right and obligation to conduct the Contractor's own defense thereof. Nothing contained herein shall be deemed to accord to the Contractor, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by *Tennessee Code Annotated*, Section 8-6-106.

E.17. 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— In the event of a Breach, the State may assess Liquidated Damages as detailed in Contract Attachment B. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. 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 Liquidated Damages contained in above referenced Contract Attachment B 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 Liquidated Damages 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 liquidated damage amount is 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 withhold the Liquidated Damages 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 Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages 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 Liquidated Damages previously withheld except in the event of a Partial Default.

The State may conduct "secret shopper" and other monitoring activities during the operation of this Contract. The State may also assess liquidated damages for breaches of contract that it discovers during these and other activities as detailed in Contract Attachment B.

- (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. The Notice of Partial Default and termination of services associated with the Breach shall advise the Contractor whether the State will provide an opportunity to cure. 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 Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages 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.

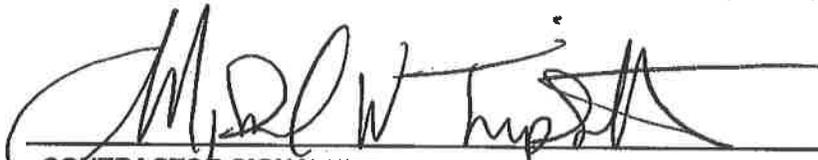
The Termination Notice must (1) specify in reasonable detail the nature of the Breach; (2) provide Contractor with an opportunity to cure, which shall be no less than 30 days from the date of the Termination Notice; (3) shall specify the

effective date of termination in the event Contractor fails to correct the Breach. The Contractor shall present the State with a written request detailing the efforts it will take to resolve the problem. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations.

- 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.18. **Overpayments.** The Contractor shall have responsibility for overpayments to its providers resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees, 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 shall assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud.
- E.19. **Third Party Beneficiary.** This Contract has been entered into solely for the benefit of the State and the Contractor and is not intended to create any legal, equitable, or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.
- E.20. **Confidential and Proprietary Information.** The State agrees to protect, to the fullest extent permitted by state law, the confidentiality of information expressly identified by the Contractor as confidential and proprietary, including information that would allow a person to obtain unauthorized access to confidential information or to electronic information processing systems owned by or licensed to the State.

IN WITNESS WHEREOF,

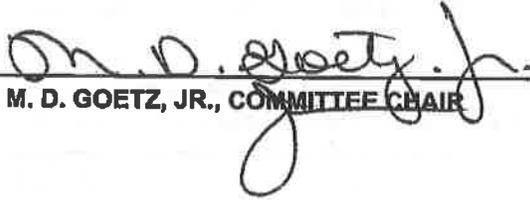
CONNECTICUT GENERAL LIFE INSURANCE COMPANY (CGLIC):


CONTRACTOR SIGNATURE

8/18/10
DATE

Michael W Triplett President Regional Segment
PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

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


M. D. GOETZ, JR., COMMITTEE CHAIR

8-24-2010
DATE

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	Edison # 22047
CONTRACTOR LEGAL ENTITY NAME:	Connecticut General Life Insurance Company (CGLIC)
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	06-0303370

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.



CONTRACTOR SIGNATURE

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.

Michael W Triplett President Regional Segment

PRINTED NAME AND TITLE OF SIGNATORY

8/18/10

DATE OF ATTESTATION

LIQUIDATED DAMAGES

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

As prior approved by the State in writing performance guarantees shall be measured specific to the Public Sector Plans or on the Contractor's book of business.

1. Implementation Plan	
Guarantee	The Contractor shall provide a project implementation plan that meets the requirements of Contract Section A.2.e. to the State no later than thirty (30) days after the contract start date.
Assessment	Ten thousand dollars (\$10,000) for each day beyond the deadline that the plan is not provided to the State. Fifty thousand dollar (\$50,000) maximum.
Measurement	Measured, reported, and reconciled no later than three (3) months after the go-live date.
2. Operational Readiness	
Guarantee	The Contractor shall resolve all findings identified by the State during its operational readiness review, as required in Contract Section A.2., prior to the go-live date.
Assessment	Twenty-five thousand dollars (\$25,000) per finding if the standard is not met. Two hundred and fifty thousand dollar (\$250,000) maximum.
Measurement	Measured and reported no later than three (3) months after the go-live date.
3. Edison System Interface	
Guarantee	Contractor's interface with the Edison System shall be fully operational by the date specified in Contract Section A.21.
Assessment	Ten thousand dollars (\$10,000) per day, for every day beyond the deadline that the interface is not fully operational. One hundred fifty thousand dollar (\$150,000) maximum.
Measurement	Measured and reported beginning the day after the date specified in Contract Section A.21 and continuing – as necessary – until the interface is fully operational. (Reconciled upon final recognition of operational status.)
4. Call Center and Other Systems Operational	
Guarantee	The Contractor's call center and other systems shall be fully operational no later than the date specified in Contract Section A.21.
Assessment	Twenty-five thousand dollars (\$25,000) for every day beyond the deadline that the call center or other system is not operational. Two hundred and fifty thousand dollar (\$250,000) maximum.
Measurement	Measured and reported no later than three (3) months after the go-live date.
5. Program Go-Live Date	
Guarantee	All medical claims administrative services for the Public Sector Plans shall take effect (i.e., "go-live") and be fully operational on the go-live date specified in Contract Section A.21.
Assessment	Fifty thousand dollars (\$50,000) for every day beyond the deadline that medical claims administrative services are not fully operational. Five hundred thousand dollar

	(\$500,000) maximum.
Measurement	Measured and reported no later than three (3) months after the go-live date.
6. Plan Design	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design as required in Contract Sections A.2 and A.9.
Assessment	One thousand dollars (\$1,000) per occurrence (defined as an individual claim) if the standard is not met plus the actual costs incurred of the incorrectly-processed claim. Fifty-thousand dollar (\$50,000) annual maximum (which excludes the actual costs incurred incorrectly-processed claims, which shall not be subject to a cap).
Measurement	Measured, reported, and reconciled after each occurrence.
7. Maximum Seconds of Answer	
Guarantee	The Contractor's call center shall answer, by a person, one hundred percent (100%) of calls within five (5) minutes (300 seconds), as required in Contract Section A.12.
Assessment	Five hundred dollars (\$500) for each second above the threshold during each period on any single day. One Hundred-Fifty-thousand dollar (\$150,000) annual maximum.
Measurement	The Contractor shall calculate the number of instances during each morning, mid-day, and evening periods (see Contract Section A.12) during which a caller's time-to-answer exceeds this threshold. Based on Contractor's internal telephone support system reports. Measured and reported on a daily basis during the thirty (30) days prior to the go-live date through sixty (60) days after the go-live date, weekly, and monthly. Please note that the monthly report shall include rates for each day as well as averages for days of week, time of day, each week, and each month.
8. Website	
Guarantee	The Contractor's website for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information on or before the date specified in Contract Section A.21, as required in Contract Section A.14.
Assessment	Twenty thousand dollars (\$20,000) per day that the standard is not met. One Hundred-Fifty Thousand annual maximum.
Measurement	Measured, reported, and reconciled no later than three (3) months after the go-live date.
9. Written Member Inquiries	
Guarantee	As required in Contract Section A.11, the Contractor shall respond to ninety-five percent (95%) of written inquiries (mail and e-mail) from members within five (5) business days and one hundred percent (100%) within ten (10) business days.
Assessment	One thousand dollars (\$1,000) for each full percentage under each standard.
Measurement	Measured, reported and reconciled quarterly.
10. Member Communications	
Guarantee	All materials produced by the Contractor shall be provided to the State for review and approval at least fourteen (14) days prior to planned printing, assembly, and/or distribution, as required in Contract Section A.13.
Assessment	One thousand dollars (\$1,000) for each instance that the standard is not met.
Measurement	The State will notify the Contractor of any such occurrence. Any amounts due for the

	Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State.
11. Reading Level	
Guarantee	The Contractor shall provide to the State a draft of all member communications with both an accurate Flesch-Kincaid reading level analysis that indicates that the materials are at or lower than the 6.0 reading level and a reading level at or below 6.0.
Assessment	One thousand dollars (\$1,000) for each occurrence in which the standard is not met. An occurrence shall be defined as the initial submission to the State of the draft member communication for approval.
Measurement	Measured and reported after each occurrence.
12. Initial Welcome Packet Distribution	
Guarantee	Ninety-seven percent (97%) of welcome packets, containing ID cards, member handbooks, and provider directories, shall be produced and mailed no later than twenty-one (21) days prior to the go-live date.
Assessment	Ten thousand dollars (\$10,000) if the standard is not met.
Measurement	Measured, reported, and reconciled no later than three months after the go-live date.
13. Distribution of Ongoing Welcome Packet	
Guarantee	Ninety-seven percent (97%) of welcome packets shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.13.
Assessment	Ten thousand dollars (\$10,000) per year in which the standard is not met.
Measurement	Measured, reported, and reconciled annually.
14. Annual Transfer Period Materials	
Guarantee	On an annual basis, at least two (2) months prior to the State's annual transfer period, the Contractor shall provide to the State, in electronic format, the camera-ready materials to be sent during the Annual Enrollment Transfer Period about the medical benefit, as required in Contract Section A.13.
Assessment	If the aforementioned information is not distributed to the State as required, then the total assessment shall be ten thousand dollars (\$10,000) per year in which the standard is not met.
Measurement	Measured, reported, and reconciled annually.
15. Member Satisfaction Survey	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Member Satisfaction survey(s) required by Contract Section A.11., shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term.
Assessment	Fifty thousand dollars (\$50,000) for each year that the standard is not met.
Measurement	Measured, reported, and reconciled annually.
16. Appeal Decisions	
Guarantee	Ninety-five percent (95%) of pre-service appeals shall be decided within thirty (30) days and ninety-five percent (95%) of post-service appeals within sixty (60) days, as required

	in Contract Section A.11.	
Assessment	Ten thousand dollars (\$10,000) for each instance that the standard is not met. One Hundred Thousand dollar (\$100,000) annual maximum.	
Measurement	Measured, reported, and reconciled quarterly.	
17. Expedited Appeal Decisions		
Guarantee	One hundred percent (100%) of expedited appeals, not involving a third party review, shall be decided within seventy-two (72) hours as required in Contract Section A.11. In the event that the Contractor requires an external medical consultation, the timeframe shall be extended from seventy-two (72) hours to seven (7) calendar days.	
Assessment	Two thousand dollars (\$2,000) for each instance that the Contractor exceeds the standard. One Hundred Thousand dollar (\$100,000) annual maximum.	
Measurement	Measured, reported, and reconciled quarterly.	
18. State Inquiries		
Guarantee	The Contractor shall respond to all non-urgent inquiries in writing from the State within one (1) week after receipt of said inquiry, as required in Contract Section A.15.	
Assessment	Five hundred dollars (\$500) for each instance that the standard is not met. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured and reported after each occurrence.	
19. Plan Changes		
Guarantee	The Contractor shall correctly implement any plan design changes within sixty (60) days of written notification from the State as required in Contract Section A.9.	
Assessment	Five thousand dollars (\$5,000) per day if the standard is not met. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured and reported after each occurrence.	
20. Member Notice of Provider Termination		
Guarantee	The Contractor shall provide written notice to members regarding terminated hospitals and physician groups, as specified in Contract Section A.3.	
Assessment	Five thousand dollars (\$5,000) per occurrence (defined as each provider termination) if the standard is not met. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured and reported after each occurrence.	
21. Provider/Facility Network Accessibility		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan members shall have the Access Standard indicated.	
Definition	Provider Group – Urban and Suburban	Access Standard
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Cardiologists	1 physician within 30 miles

	Endocrinologists	1 physician within 30 miles
	Acute Care Hospitals	1 facility within 30 miles
	Provider Group – Rural	Access Standard
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 30 miles
	Obstetricians/Gynecologists	1 physician within 30 miles
	Pediatricians	1 physician within 30 miles
	Cardiologists	
	Endocrinologists	
	Acute Care Hospitals	1 facility within 30 miles
Assessment	One hundred thousand dollars (\$100,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a GeoAccess report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use GeoAccess' default definitions for urban, suburban, and rural areas. At the Contractor's request, the State may also approve other methodologies, including but not limited to (a) the current GeoAccess standards; (b) the most recent version of the rural-urban commuting area (RUCA) codes as defined by the U.S. Bureau of the Census and the U.S. Department of Agriculture Economic Research Service; (c) the ZIP code approximation of the RUCA codes; (d) the current definition of "rural areas" used by the U.S. Department of Health and Human Services Office of Rural Health Policy; or (e) the most recent definitions of Office of Management and Budget (OMB) with respect to county-level metropolitan and micropolitan areas. Further, the State may specify the use of a particular methodology following the completion of the 2010 decennial Census.	
Measurement	Compliance report is the semi-annual GeoNetworks Analysis submitted by the Contractor. Measured, reported and reconciled semi-annually.	
22. Appointment Scheduling		
Guarantee	The Contractor shall assist members to secure a timely appointment within the timeframes specified in Section A.3.	
Assessment	One thousand dollars (\$1,000) for occurrence, including Secret Shopper occurrences identified by the State or its authorized agent, in which the Contractor does not provide the appointment scheduling assistance required in Section A.3. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured and reported after each occurrence.	
23. Missing Authorization Information		
Guarantee	As specified in Contract Section A.4., the Contractor shall immediately contact the provider to obtain any missing information necessary to make a pre-certification, prior authorization, or concurrent review decision	
Assessment	One thousand dollars (\$1,000) for each pre-certification, prior authorization, or concurrent review decision that was not made within the timeframes specified in Contract Section A.4 and was missing information necessary to make the decision. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured, reported, and reconciled quarterly.	
24. Prior Authorizations		
Guarantee	The Contractor shall complete ninety-seven percent (97%) of all prior authorizations	

	within the timeframes specified in Section A.4.
Assessment	Ten thousand dollars (\$10,000) for each quarter in which the standard is not met.
Measurement	Measured, reported, and reconciled quarterly.
25. Data Review	
Guarantee	All plan design implementation data, associated with the program setup, and identified in the Implementation plan, as required in Contract Section A.2. shall be delivered to the State for review and approval prior to the go-live date.
Assessment	Fifty thousand dollars (\$50,000) if the standard is not met.
Measurement	Measured and reported no later than three (3) months after the go-live date.
26. Eligibility Set-Up	
Guarantee	As required in Contract Section A.18., eligibility information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.21.
Assessment	Ten thousand dollars (\$10,000) for each day beyond the date specified in Contract Section A.21. One hundred thousand dollar (\$100,000) maximum.
Measurement	Measured, reported, and reconciled no later than three (3) months after the go-live date.
27. Eligibility Posting	
Guarantee	Ninety-eight percent (98%) of electronically transmitted enrollment updates shall be posted within one (1) business day after receipt in specified format and one hundred percent (100%) posted within three (3) business days, as required in Contract Section A.18.
Assessment	Five thousand dollars (\$5,000) per day for the first (1 st) and second (2 nd) business days out of compliance; ten thousand dollars (\$10,000) per business day thereafter. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured and reported weekly; reconciled annually.
28. Eligibility Discrepancies	
Guarantee	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within five (5) business days of receipt of the file from the State, as required in Contract Section A.18.
Assessment	Five thousand dollars (\$5,000) per day for the first (1 st) and second (2 nd) business days out of compliance; ten thousand dollars (\$10,000) per business day thereafter. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured and reported quarterly; reconciled annually.
29. Initial Data Loading	
Guarantee	All data required for implementation other than member eligibility data, as described in Contract Section A.2., shall be loaded correctly.
Assessment	Fifty thousand dollars (\$50,000) if the standard is not met.
Measurement	Measured at implementation.
30. Ongoing Data Loading	

Guarantee	All data required for operations other than member eligibility data shall be loaded correctly.	
Assessment	Five thousand dollars (\$5,000) per day for the first (1 st) and second (2 nd) business days out of compliance; ten thousand dollars (\$10,000) per business day thereafter. One hundred thousand dollar (\$100,000) annual maximum.	
Measurement	Measured and reported quarterly; reconciled annually.	
31. Enrollment Data Match		
Guarantee	The Contractor shall submit an Enrollment Data Match, not to exceed four (4) times annually, in an agreed upon format, within fourteen (14) calendar days of the request from the State, as required in Contract Section A.18.	
Assessment	Twenty thousand dollars (\$20,000) for each instance that the standard is not met.	
Measurement	Measured, reported, and reconciled annually but reported twenty (20) days following the update.	
32. Enrollment Data Match Discrepancies		
Guarantee	The Contractor shall resolve the discrepancies identified in the Enrollment Data Match, within the specified timeframe(s) as required in Contract Section A.18.	
Assessment	Twenty thousand dollars (\$20,000) for each instance that the standard is not met.	
Measurement	Measured, reported, and reconciled annually.	
33. Claims Data Quality		
Guarantee	As measured by the State's DSS vendor, the Contractor's data submission to said vendor shall meet the following Data Quality measures.	
Definition	Measure	Benchmark
	Gender	Data missing for <= (less than or equal to) 3% of claims
	Date of birth	Data missing for <= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for <= 5% of outpatient claims
	Outpatient provider type missing	Data missing for <= 1.5% of outpatient claims
	Provider ID missing	Data missing for <= 1.5% of claims
Assessment	Fifty thousand dollars \$50,000 if any of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Measurement	Measured and reported by the State's DSS vendor monthly; reconciled annually.	
34. Claims Data Submission		
Guarantee	The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.18).	
Assessment	Five thousand dollars (\$5,000) per day for the first and second business days out of compliance; ten thousand dollars (\$10,000) per business day thereafter. One hundred thousand dollar (\$100,000) quarterly maximum.	
Measurement	Measured, reported, and reconciled monthly.	

35. Claims Payment Accuracy	
Guarantee	Claims payment accuracy shall be ninety-eight percent (98%) or higher.
Assessment	Fifty thousand dollars (\$50,000) for each full percentage point below ninety-eight percent (98%) for each contracted quarter.
Measurement	Quarterly internal audit performed by the Contractor on a statistically valid sample. Measured and reported quarterly; reconciled annually.
36. Claims Processing Accuracy	
Guarantee	Claims processing accuracy shall be ninety-seven percent (97%) or higher.
Assessment	Fifty thousand dollars (\$50,000) for each full percentage point below ninety-seven percent (97%), for each contracted quarter.
Measurement	Quarterly internal audit performed by the Contractor on a statistically valid sample. Measured and reported quarterly; reconciled annually.
37. Claims Payment Turnaround	
Guarantee	The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety percent (90%) of clean claims and within thirty (30) calendar days for ninety-six percent (96%) of all claims.
Assessment	<u>Non-Investigated Claims (clean)</u> : Twenty-five thousand dollars (\$25,000) for each full percentage point below the required minimum standard of ninety percent (90%) within fourteen (14) days. <u>All Claims</u> : Fifty thousand dollars (\$50,000) for each full percentage point below the required minimum standard of ninety-six percent (96%) within thirty (30) days.
Measurement	Quarterly internal audit performed by the Contractor on a statistically valid sample. Measured and reported quarterly; reconciled annually.
38. Medicare Secondary Payer Notice	
Guarantee	The Contractor shall notify the State on a weekly basis of receipt on any notices from Medicare that Medicare may have made primary payments for services when it should have been a secondary payer (a Medicare Secondary Payer (MSP) demand letter), as specified in Contract Section A.9.
Assessment	One thousand dollars (\$1,000) for every day beyond the specified timeframe that the Contractor does not notify the State. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured, reported, and reconciled after each occurrence.
39. Key Staff Vacancies	
Guarantee	As required in Contract Section A.16., if any key positions become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.
Assessment	Ten thousand dollars (\$10,000) for each week beyond sixty (60) days that the vacancy is not filled. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured, reported, and reconciled annually.
40. Staff Availability	
Guarantee	As required in Contract Section A.16, an available member of the Account Team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m.

	Central Time, Monday through Friday.
Assessment	Ten thousand dollars (\$10,000) per occurrence. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured, reported, and reconciled annually.
41. Systems Access – Online Reporting and Eligibility Systems	
Guarantee	Access to the Contractor's online reporting and eligibility systems shall be granted to a minimum of three (3) State employees and a maximum of five (5) State employees no later than one (1) week prior to the go-live date, as required in Contract Section A.20.
Assessment	Five thousand dollars (\$5,000) per day that the standard is not met.
Measurement	Measured, reported, and reconciled no later than three (3) months after the go-live date.
42. Reporting	
Guarantee	The Contractor shall distribute to the State all reports required in Contract Sections A.1 through A.30 and Contract Attachment C within the time frame specified in the Contract.
Assessment	Five thousand dollars (\$5,000) for each report not delivered to the State within the time frame specified in the Contract. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured, reported, and reconciled after each occurrence.
43. Audit Recovery	
Guarantee	As required in Contract Section A.10, any amount due the State which is not paid by the Contractor within (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month.
Assessment	Compounding interest penalty of one percent (1%) per month for each month payment is not received.
Measurement	Measured, reported, and reconciled after each occurrence.
44. NCQA Accreditation	
Guarantee	The Contractor shall be NCQA accredited for its commercial PPO product as specified in Contract Section A.5.
Assessment	Five hundred thousand dollars (\$500,000) if the standard is not met.
Measurement	Copy of completed NCQA survey and final report.
45. Written Discharge Plan	
Guarantee	As specified in Section A.8., the Contractor shall provide a copy of the written discharge plan to the HM/W vendor for each member who is being discharged from a hospital to a skilled nursing facility, a rehabilitative facility, or a psychiatric facility or who will receive home health services.
Assessment	One thousand dollars (\$1,000) for each plan that is not provided to the HM/W vendor within twenty-four (24) hours from the member's discharge. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	Measured, reported, and reconciled after each occurrence.
46. Authorization of Member Communications	
Guarantee	The Contractor shall not distribute any materials to member prior to receiving the

	express, written authorization by the State for the use of such materials.
Assessment	Ten thousand dollars (\$10,000) for each instance that the standard is not met (i.e., in which the Contractor distributes unauthorized materials to members). The assessment will be per occurrence or bulk mailing rather than per each mailed or distributed piece of information. One hundred thousand dollar (\$100,000) annual maximum.
Measurement	The State will notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State.

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format specified by the State, and shall be of the type and at the frequency indicated below. The State reserves the right to modify reporting requirements as deemed necessary to monitor the Public Sector Plans. The State will provide the Contractor with at least ninety (90) days notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

1. Weekly reports shall be submitted by Tuesday of the following week;
2. Monthly reports shall be submitted by the 15th of the following month;
3. Quarterly reports shall be submitted by the 20th of the following month;
4. Semi-Annual Reports shall be submitted by the 20th of the following month;
5. Annual reports shall be submitted within sixty (60) days after the end of the calendar year.

Unless prior approved in writing by the State, each report shall be specific to the Public Sector Plans (not the Contractor's book of business).

Reports shall include:

1. **Performance Tracking**, as detailed at Contract Attachment B (each component to be submitted at the frequency indicated in Contract Attachment B), submitted by secure email using the template prior approved in writing by the State, which shall include:
 - a. Status report narrative
 - b. Detail report on each performance measure
2. **Appointment Standards Report**, submitted semi-annually after the 1st and 3rd quarters by secure email using the template prior approved in writing by the State.
3. **Quarterly Network Changes Update Report**, submitted quarterly by secure email in Excel by the 5th business day of the end of the quarter using the template prior approved in writing by the State.
4. **GeoNetworks[®] Report**, submitted semi-annually after the 1st and 3rd quarters by secure email using the template prior approved in writing by the State
5. **Annual Provider Turnover Report**, submitted annually by the 15th business day of the end of the year using the template prior approved in writing by the State.
6. **Monthly Unique Care Exception Report**, submitted monthly by secure email using the template prior approved in writing by the State.
7. **Quarterly Utilization and Practice Report**, submitted quarterly by secure email using the template prior approved in writing by the State.
8. **HEDIS Report**, submitted annually by June 15th by secure email using the template prior approved in writing by the State.
9. **Quarterly Coordination of Benefits Report**, submitted quarterly by secure email using the template prior approved in writing by the State
10. **Monthly Paid Claims Report**, submitted monthly by secure email in Excel using the template prior approved in writing by the State.
11. **Monthly Reconciliation Report**, submitted monthly by secure email in Excel using the template prior approved in writing by the State.
12. **Monthly Recoveries Report**, submitted monthly by secure email in Excel using the template prior approved in writing by the State.

13. **Quarterly Fraud and Abuse Report**, submitted quarterly by secure email using the template prior approved in writing by the State.
14. **Quarterly Appeals Report**, submitted quarterly by secure email in Excel using the template prior approved in writing by the State.
15. **CAHPS Survey Report**, submitted annually by June 15th by secure email using the template prior approved in writing by the State.
16. **Dependent Eligibility Verification Report**, submitted annually by secure email using the template prior approved in writing by the State.
17. **Monthly Returned Mail Report**, submitted monthly by email using the template prior approved in writing by the State.
18. **Account Team Satisfaction Survey Report**, submitted annually using the template prior approved in writing by the State
19. **BC-DR Results Report**, submitted annually by email using the template prior approved in writing by the State.
20. **Daily File Transmission Statistics Report**, submitted by secure email within twenty-four (24) hours of receipt of the file using the template prior approved in writing by the State.
21. **Quarterly CMS Data Match Report**, submitted quarterly by secure email in Excel using the template prior approved in writing by the State.
22. **Quarterly Subrogation Reports**, submitted quarterly by secure email using the template prior approved in writing by the State.
23. **Other Reports**, as specified in this Contract and using templates prior approved in writing by the State.

SUBROGATION REQUIREMENTS

As required by Contract Section A.9, the Contractor shall comply with the State's requirements regarding subrogation.

Identification of Subrogation Claims

The Contractor shall maintain a process to screen medical claims through a detection procedure that reviews both occurrence codes and diagnostic codes. The Contractor shall identify claims with subrogation potential within twenty (20) days of the initial claim filing. Of particular significance are claims related to workplace accidents and illnesses, injuries attributable to automobile accidents and expenses covered by property and casualty insurance maintained by homeowners and businesses.

The Contractor shall accept subrogation information from the State's Pharmacy Benefits Manager (PBM) and Employee Assistance Program (EAP)/Behavioral Health Organization (BHO) vendor.

The Contractor shall recognize an allowable expense threshold of one thousand five hundred dollars (\$1,500) for the identification of cases to pursue. In instances where claims are below the threshold, the Contractor shall establish and monitor an accumulator related to the member and the medical event. The Contractor shall continue the monitoring activity for specific instances (medical events) for twelve (12) months after the incident (date of the event which resulted in the first claim for medical services).

The Contractor shall resolve cases with a benefits paid value equal to or less than \$5,000 and submit a case summary to the State regarding the disposition of the issue(s)

Procedural Requirements

Upon identification of claims with recovery potential, the Contractor shall provide an incident notice and request for pertinent information to the head-of-contract with an explanation of the State's requirements related to the recovery of benefit payments through a subrogation process. The Contractor's inquiry shall explain the member's responsibilities and procedures for the member to contact the Contractor.

Following intervals of thirty (30) days, if the head-of-contract fails to reply, the Contractor shall generate and mail second and third notices to the head-of-contract concerning the matter. The second notice shall indicate that all members covered by the head-of-contract, who is subject of the subrogation inquiry, will be disenrolled if there is not a complete response within thirty (30) days. The third notice shall state that all the members covered by the head-of-contract have been disenrolled due to the failure of the head-of-contract to respond. Disenrollment of members shall require prior written approval from the Benefits Administration Division. The Benefits Administration Division will provide the second and final notice to the head-of-contract.

The head-of-contract may reinstate coverage, with no break in coverage permitted, if the employee provides a completed response and remits full premium payments within the three (3) months after the date of termination of coverage. Failure to respond within the three month (3) timeframe will require that each individual to be covered demonstrate insurability through the late applicant process.

In addition to the inquiry process, the Contractor shall evaluate questionnaires submitted by members and complete tasks related to collecting additional data, particularly settlement information, from health care providers, attorneys, court records and liability carriers. Data collection by the Contractor can be completed in writing or telephonically.

The Contractor shall prepare a brief summary for each case with a benefits paid value of greater than \$5,000 and provide it to the Benefits Administration Division for review. The case summary shall include: member name, member identification number, a case number (if assigned), amount of benefit paid, date of incident, Public Sector Plan name and benefits option, recitation of facts, and review of the relevant issues. The Contractor shall also provide a specific recommendation concerning the disposition of the case.

In addition to providing case summaries, the Contractor shall provide quarterly Subrogation Reports detailing the claims reviews it has completed with the disposition and a "Non Response Report" detailing cases where responses from members are pending. The formats of both reports will be determined by the Contractor and Benefits Administration