CONTRACT #26
RFS # 350.50-045
FA # 07-20600-00

Department of Finance & Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of Tennessee, Inc.

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

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

RECEIVED
APR 15 2008
FISCAL REVIEW

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Brian Haile, Deputy Director of Benefits Administration BH

Date: April 15, 2008

RE: Amendment for CoverKids to add Responsibilities Associated with Dental Benefits to CoverKids Program

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee signed by Commissioner Goetz. The modification to the CoverKids contract through this amendment provides for the addition of responsibilities to develop, implement and maintain the systems and reports necessary to coordinate and report the accumulation of copayment amounts attributable to dental claims. This accumulation is necessary to report an aggregate out-of-pocket maximum amount for members pursuant to the current CoverKids contract agreement. The dental claims amounts are to be provided by a third party dental vendor and this is a post contract benefit change that will require additional one-time administrative work. The amendment is slated to take effect May 1, 2008 with the dental benefit to be in effect as of June 1, 2008.

The base contract and all prior amendments are included as is a draft of the amendment created to address the inclusion of responsibilities associated with implementation of the dental benefit for eligible individuals for the CoverKids program.

Thank you for your consideration of this request.

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

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

TO: Commissioner M. D. Goetz, Jr.

FROM: Brian Haile BH

DATE: April 15, 2008

RE: Amendment for CoverKids to add Responsibilities Associated with the Dental Benefit to CoverKids contract

This is to request a start date for the amendment to the BlueCross BlueShield of Tennessee contract for the addition of responsibilities to develop, implement and maintain the systems and reports necessary to coordinate and report the accumulation of copayment amounts attributable to dental claims. This accumulation is necessary to report an aggregate out-of-pocket maximum amount for members pursuant to the current CoverKids contract agreement. The dental claims amounts are to be provided by a third party dental vendor and this is a post contract benefit change that will require additional one-time administrative work. The amendment is slated to take effect May 1, 2008 with the dental benefit to be in effect as of June 1, 2008.

This request is in advance of 60 days after the receipt of the non-competitive contract amendment request provided to you for your approval.

Thank you for your consideration of this request.

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	#350.50-045-07
2) State Agency Name :	Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Adds out of pocket accumulator responsibilities for the dental benefit of CoverKids plan
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA-07-20600-00
6) Contract Start Date :	Februay 12, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$500,000,000
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	#~~2~~ 3
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	May 1, 2008
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$500,000,000
13) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service

RECEIVED
APR 15 2008
FISCAL REVIEW

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

This amendment revises the existing contract to add the responsibility to the Contractor for the development, implementation and maintenance of the systems and reports necessary to coordinate and report the accumulation of copayment amounts attributable to dental claims. This accumulation is necessary to report an aggregate out-of-pocket maximum amount for members of CoverKids.

15) Explanation of Need for the Proposed Amendment :

Additional one-time administrative work by the Contractor is necessary to create the inbound and outbound interface with the third party dental vendor, exchanging out-of-pocket accumulator data with the third party dental vendor and updating existing claims systems with the dental out-of-pocket applied data. The $49,500 one-time fee is to perform the administrative work described above.

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

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

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

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

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

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

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

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

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

This vendor currently provides a set of fully insured benefits for participants in CoverKids and this amendment serves to enhance the level of benefit to individuals already eligible under Federal guidelines for SCHIP programs to include dental benefits and track out of pocket expenditures for members of CoverKids.

21) Justification for the Proposed Non-Competitive Amendment :

The Contractor is currently performing this administrative function for the medical and visual benefits under CoverKids and would take on the additional responsibilities for the interface with the third party dental vendor.

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

Agency Head Signature	4/15/08 **Date**

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
350 . 50 — 045 — 07	FA-07-20600-
State Agency	**State Agency Division**
Finance and Administration	Benefits Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
BlueCross BlueShield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the CoverKids program and calculate the out-of-pocket expenses per family for both medical and dental services

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	93.767

Mark Each TRUE Statement

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.50	200	084	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$1,285,877.00	$3,768,670.00			$5,054,547.00
2008	$17,284,164.00	$50,656,731.00			$67,940,895.00
2009	$26,365,791.00	$77,273,323.00			$103,639,114.00
2010	$32,648,028.00	$95,685,415.00			$128,333,443.00
2011	$34,233,881.00	$100,333,263.00			$134,567,144.00
2012	$15,382,260.00	$45,082,597			$60,464,857
TOTAL:	$127,200,001.00	$372,799,999.00			$500,000,000.00

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2007	$5,054,547.00	
2008	$67,940,895.00	
2009	$103,639,114.00	
2010	$128,333,443.00	
2011	$60,464,857.00	
TOTAL:	**$5,000,000,000.00**	
End Date:	**December 31, 2009**	**December 31, 2009**

State Agency Fiscal Contact & Telephone #

State Agency Budget Officer Approval

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

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

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

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

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

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

AMENDMENT NUMBER THREE
TO CONTRACT NUMBER FA-07-20600-00

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

1. The text of Contract Section A.6.4. is deleted in its entirety and replaced with the following:

   A.6.4. The Contractor shall maintain a year to date calculation of all copayments (including medical and vision services, dental services and prescription drugs) required by Participants, accumulate the amounts by family units and advise the family by letter when the covered members of the family have assumed copayments equal to 5 percent of the allowable family income. The letter will be in a form and substance approved by the State. When the family has reached this threshold, none of the Participants will be responsible for copays for the balance of the calendar year and provider payments shall be adjusted accordingly. The out of pocket limit does not apply to individuals from families with incomes in excess of 250% of the FPL.

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

   c. **Administrative Fees**. The administrative fees, set forth herein, shall be used to calculate plan expenses and shall constitute the amount in addition to the Contractor's portion of the excess premium (defined in section C.3.d. below) which the Contractor shall retain from total premiums remitted by the State as the full remuneration for all service under this Contract. The administrative fee amount shall be included in the calculation of the Excess Premium Distribution based on the monthly enrollment for Group One, Group Two and AI/AN Children and the number of Unborn Child premiums earned during the calculation period.

	2007	2008	2009
Administrative Fee (per member per month & per member per benefit period)	$14.99	$14.99	$14.99

3. The following provision is added as Contract Section A.6.5.:

   A.6.5 Once the State or the Administrative Contractor has notified the Contractor in writing that a Participant should be terminated as no longer eligible for coverage, Contractor shall update its systems to reflect that change in the Participant's coverage. Contractor shall use its standard commercial process to retroactively terminate Participants' coverage.

   A.6.5.1. If Administrative Contractor notifies Contractor of a Participant's termination within three (3) months of the Participant's termination, Contractor will (i) credit the State with any premiums that were paid for that Participant for that time period or (ii) reimburse the Participant (provided that such Participant is a buy-in Participant pursuant to C.3.b. below) for any premiums that were paid by that Participant for that time period.

   A.6.5.2. If Administrative Contractor does not notify Contractor of a Participant's termination within three (3) months of the Participant's termination, Contractor will (i) credit the State only for the most recent three (3) month period of premiums that were paid by the State for that Participant's coverage and (ii) reimburse the Participant only for the most recent three (3) month period of premiums that were paid by the Participant for that Participant's coverage.

A.6.5.3 A retroactive termination shall go back to the end of the last full month that the Participant was eligible for coverage, but not more than a total of ninety (90) days from the date of notice from the Administrative Contractor.

A.6.5.4 The Contractor shall use its standard commercial process to attempt to recover claim payments made to providers and/or Participants during the 3 month (or shorter) period for which a Participant was covered but ineligible; however, it is expressly agreed and acknowledged by the parties that any claims paid by Contractor for an ineligible Participant are the sole responsibility of the State.

A.6.5.5 As of September 1 of each year, the Contractor shall calculate the amount of claim payments (i) made during the previous calendar year period to providers or Participants (ii) for which a Participant was covered but ineligible and (iii) which Contractor has been unable to recover. The Contractor shall notify the State of any such unrecovered amount during the subject period on the monthly bill next following such determination, and the State shall pay this amount promptly upon receipt of such notice.

4. The following provision is added as Contract Section C.3.e.:

C.3.e. The parties agree and acknowledge that development, implementation and maintenance of the systems and reports necessary to coordinate and report the accumulation of copayment amounts attributable to dental claims, which accumulation is necessary to report an aggregate out-of-pocket maximum amount for members pursuant to Section A.6.4. of this Contract, and where such dental claim amounts are provided by a third party dental vendor, shall be a post-contract benefit change that requires additional one-time administrative work (the "Dental OOP Additional Administrative Work") for the Contractor. Such Dental OOP Additional Administrative Work includes, without limitation, creating an inbound and outbound interface with the third party dental vendor, exchanging out-of-pocket accumulator data with the third party dental vendor, updating existing claims systems with the dental out-of-pocket applied data, and updates to reporting packages. In exchange for Contractor's provision of the Dental OOP Additional Administrative Work, the State agrees to pay a one-time fee of Forty-nine Thousand Five Hundred and No/100 Dollars ($49,500.00) for this post-contract benefit change, which amount will be added to the State's monthly bill next following the date of this Amendment.

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. GOETZ, JR., COMMISSIONER DATE

APPROVED:

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

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

CONTRACT SUMMARY SHEET

8-

RFS #	Contract #
350.50-045-07	FA-07-20600- 02
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the CoverKids program (including a benefit for vision).

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	93.767

Mark, if Statement is TRUE

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.50	200	084	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$1,285,877	$3,768,670			$5,054,547
2008	17,284,164	50,656,731			67,940,895
2009	26,365,791	77,273,323			103,639,114
2010	32,648,028	95,685,415			128,333,443
2011	34,233,881	100,333,263			134,567,144
2012	15,382,260	45,082,597			60,464,857
TOTAL:	$127,200,001	$372,799,999			$500,000,000

RELEASED TO ACCOUNTS DIVISION NOV 16 2007 BY OFFICE OF CONTRACTS REVIEW

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$5,054,547	
FY: 2008	$67,940,895	
FY: 2009	$103,639,114	
	$128,333,443	
	$134,567,144	
	$60,464,857	
TOTAL:	$500,000,000.00	
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

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

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A. § 9-4-5119, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred).

Contractor Ownership

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

Contractor Selection Method

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

Procurement Process Summary

AMENDMENT TWO
TO CONTRACT NUMBER FA-07-20600-00

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

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

C.3.a. **Premiums.** The State shall remit payment to the Contractor monthly for all services under this Contract, at the premium amounts indicated below, based upon the number of Participants certified by the Administrative Contractor to the Contractor.

	2007	2008	2009
Group One Children (monthly) [1]	$208.13	$224.43	$239.03
Group Two Children (monthly) [2]	$226.43	$244.23	$261.23
Unborn Child (benefit period) (current enrollee) [3]	$5,080.00	$5,320.00	$5,580.00
Unborn Child (benefit period) [4]	$5,490.00	$5,780.00	$6,110.00
AI/AN Children (monthly) [5]	$ 232.09	$ 250.23	$ 267.65
Unborn AI/AN Child (benefit period) [6]	$ 5,385.00	$ 5,640.00	$ 5,915.00

[1] Group One Children are defined as covered children who are in families with incomes at or above 150 percent of FPL.
[2] Group Two Children are defined as covered children who are in families with incomes below 150 percent of FPL and therefore subject to reduced copays.
[3] Unborn Child (current enrollee) is defined as a female Participant who is enrolled currently in the CoverKids program and who becomes pregnant while enrolled.
[4] Unborn Child is defined as any pregnant Participant not included in Unborn Child (current enrollee).
[5] AI/AN Children are defined as covered children who are (a) certified AI/AN and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the Administrative Contractor to the Contractor for the coverage period.
[6] Unborn AI/AN Child is defined as a female Participant who is reported by the Administrative Contractor as being qualified due to (a) having met the CoverKids income standard, (b) having responsibility for an unborn child, and (c) certification as AI/AN.

(1) If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the premium amounts fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2009 and that figure published in the same month, 12-months prior.

(2) If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the premium fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2010 and that figure published in the same month, 12-months prior.

(3) For the purpose of the payment amounts detailed in this Section, the premium for children and for low income children will be payable on a monthly basis for each month of coverage (a month is defined as the first day of a month to the last day of the month) and the benefit period for a pregnant woman will be defined as the 10 days prior to the date of the application through the sixtieth (60th) day following the end of the pregnancy. The payment of the benefit period for the payment of the pregnant woman will be at the end of the pregnancy.

2. The following provision is added as Contract Section A.5.5.3.:

A.5.5.3 Pursuant to Contract Sections A.5.1. and A.5.5., the State hereby approves the addition of vision benefits to the Plan, as more fully set forth in the Member Handbook, which additional vision benefits shall be effective as of January 1, 2008.

The revisions set forth herein shall be effective December 1, 2007. All other terms and conditions not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

10/29/07

CONTRACTOR SIGNATURE **DATE**

Sonya Nelson Vice President of Blue Cross Blue Shield of Tennessee

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M.D. Goetz Jr. 11-6-07

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

APPROVED:

NOV 9 2007

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

John G. Morgan 11/14/07

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

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.50-045-07	FA-07-20600- 01
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the CoverKids program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	93.767

Mark if Statement is TRUE

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.50	200	084	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$1,285,877	$3,768,670			$5,054,547
2008	17,284,164	50,656,731			67,940,895
2009	26,365,791	77,273,323			103,639,114
2010	32,648,028	95,685,415			128,333,443
2011	34,233,881	100.333,263			134,567,144
2012	15,382,260	45,082,597			60,464,857
TOTAL	$127,200,001	$372,799,999			$500,000,000

RELEASED TO ACCOUNTS DIVISION AUG 20 2007 BY OFFICE OF CONTRACTS REVIEW

COMPLETE FOR AMENDMENTS ONLY

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$5,054,547	
FY: 2008	$67,940,895	
FY: 2009	$103,639,114	
	$128,333,443	
	$134,567,144	
	$60,464,857	
TOTAL	$500,000,000.00	
End Date	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

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

State Agency Budget Officer Approval

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

Contractor Ownership

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

Contractor Selection Method

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

Procurement Process Summary

PROCESSED

AMENDMENT ONE
TO CONTRACT NUMBER FA-07-20600-00

This Contract, by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the State, and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section A., first five un-numbered paragraphs of the Scope of Services only, in its entirety and insert the following in its place:

A SCOPE OF SERVICES

The Contractor agrees to provide fully insured coverage, based upon the benefits provided for in the CoverKids Member Handbook, and the Contractor's medical necessity, utilization management and case management criteria to Participants. Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be Participants, who receive descriptions of the coverage in a Member Handbook (MH). When used in this Contract, the term "Member" shall have the same meaning as the term "Participant."

Participants are defined as:

Group One Children: Enrollees who are members of families with incomes between 150 percent and 250 percent of the Federal Poverty Level (FPL) as reported by the Administrative Contractor to the Contractor for the coverage period. Also included in this group are children from families with incomes greater than 250% of FPL and who pay monthly premiums.

Group Two Children: Enrollees who are members of families below 150 percent of FPL as reported by the Administrative Contractor to the Contractor for the coverage period.

Pregnant women for unborn children: Enrollees reported by the Administrative Contractor as being qualified due to having met the CoverKids income standard and having responsibility for an unborn child. Also included in this category are female enrollees, regardless of income, in the State's CoverTN program who become pregnant while enrolled in such coverage. Further included in this category are pregnant women who access coverage for their unborn children through the payment of a one-time premium (from CoverKids' families with incomes in excess of 250% of FPL).

AI/AN[1] Children: Enrollees who are (a) certified AI/AN and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the Administrative Contractor to the Contractor for the coverage period.

Pregnant AI/AN women for unborn children: Enrollees reported by the Administrative Contractor as being qualified due to (a) having met the CoverKids income standard, (b) having responsibility for an unborn child, and (c) certification as AI/AN.

[1] Pursuant to the CoverKids State Plan and as required by Federal law, American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the Administrative Contractor, will be exempt from all cost sharing to the extent that such children are covered by SCHIP.

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

C.3.a. **Premiums.** The State shall remit payment to the Contractor monthly for all services under this Contract, at the premium amounts indicated below, based upon the number of Participants certified by the Administrative Contractor to the Contractor.

	2007	2008	2009
Group One Children (monthly) [1]	$208.13	$220.23	$234.73
Group Two Children (monthly) [2]	$226.43	$240.03	$256.93
Unborn Child (benefit period) (current enrollee) [3]	$5,080.00	$5,320.00	$5,580.00
Unborn Child (benefit period) [4]	$5,490.00	$5,780.00	$6,110.00
AI/AN Children (monthly)[5]	$ 232.09	$ 246.03	$ 263.35
Unborn AI/AN Child (benefit period)[6]	$ 5,385.00	$ 5,640.00	$ 5,915.00

[1] Group One Children are defined as covered children who are in families with incomes at or above 150 percent of FPL.
[2] Group Two Children are defined as covered children who are in families with incomes below 150 percent of FPL and therefore subject to reduced copays.
[3] Unborn Child (current enrollee) is defined as a female Participant who is enrolled currently in the CoverKids program and who becomes pregnant while enrolled.
[4] Unborn Child is defined as any pregnant Participant not included in Unborn Child (current enrollee).
[5] AI/AN Children are defined as covered children who are (a) certified AI/AN and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the Administrative Contractor to the Contractor for the coverage period.
[6] Unborn AI/AN Child is defined as a female Participant who is reported by the Administrative Contractor as being qualified due to (a) having met the CoverKids income standard, (b) having responsibility for an unborn child, and (c) certification as AI/AN.

(1) If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the premium amounts fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2009 and that figure published in the same month, 12-months prior.

(2) If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the premium fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2010 and that figure published in the same month, 12-months prior.

(3) For the purpose of the payment amounts detailed in this Section, the premium for children and for low income children will be payable on a monthly basis for each month of coverage (a month is defined as the first day of a month to the last day of the month) and the benefit period for a pregnant woman will be defined as the 10 days prior to the date of the application through the sixtieth (60th) day following the delivery. The payment of the benefit period for the payment of the pregnant woman will be triggered by the birth of the child.

The parties agree and acknowledge that the addition of the AI/AN benefit plans shall be a post-contract benefit change that requires additional one-time administrative work (the "Additional Administrative Work") for the Contractor. Such Additional Administrative Work includes, without limitation, a new configuration plan, the creation of new benefit plans on the system, the drafting of a new Benefit Schedule for AI/AN to be included in the Member Handbook, development and issuance of new member ID cards, development of a new premium, updates to the billing system and updates to reporting packages. In exchange for Contract's provision of the Additional Administrative Work, the State agrees to pay a one-time fee of Fourteen Thousand Dollars ($14,000.00), which amount will be added to the State's monthly bill next following the date of this Amendment.

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E Harr 8-8-07

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

Ronald E. Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz Jr. 8-10-07

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

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

PER AUTHORIZED SIGNATURE ABOVE AUG 16 2007

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

COMPTROLLER OF THE TREASURY:

John G. Morgan 8-17-07

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

CONTRACT SUMMARY SHEET

8-8-

RFS #	Contract #
~~350.40-044-07~~ 350.50-045-07	FA-07- 20600-00
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913-01

RECEIVED APR 18 2007 F&A BUDGET DIV

Service Description

To provide statewide administrative services for the CoverKids program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	93.767

Mark, if Statement is TRUE

☒ Contractor is on STARS as required

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

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.50	200	084	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007	$1,285,877	$3,768,670			$5,054,547
2008	17,284,164	50,656,731			67,940,895
2009	26,365,791	77,273,323			103,639,114
2010	32,648,028	95,685,415			128,333,443
2011	34,233,881	100.333,263			134,567,144
2012	15,382,260	45,082,597			60,464,857
TOTAL	$127,200,001	$372,799,999			$500,000,000

COMPLETE FOR AMENDMENTS ONLY

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

State Agency Fiscal Contact & Telephone #

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

State Agency Budget Officer Approval

Maureen Abbey

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

M. D. Goetz II

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged

☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method

☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

4-18-07

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., its successors and permitted assigns, hereinafter referred to as the "Contractor," is for the provision of fully insured health insurance coverage, including customer service, administrative services, claims adjudication, utilization management, case management, care management, maintain an appeal process, disease management services, and development and maintenance of a statewide provider network for the Tennessee CoverKids Plan; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a not for profit corporation.

The Contractor's address is:

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

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

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

A SCOPE OF SERVICES

The Contractor agrees to provide fully insured coverage, based upon the benefits provided for in the CoverKids Member Handbook, and the Contractor's medical necessity, utilization management and case management criteria to Participants. Contractor shall adhere to its standard administrative policies and procedures, including without limitation medical policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be Participants, who receive descriptions of the coverage in a Member Handbook (MH). When used in this Contract, the term "Member" shall have the same meaning as the term "Participant."

Participants are defined as:

Group One Children: Enrollees who are members of families with incomes between 150 percent and 250 percent of the Federal Poverty Level (FPL) as reported by the Administrative Contractor to the Contractor for the coverage period. Also included in this group are children from families with incomes greater than 250% of FPL and who pay monthly premiums.

Group Two Children: Enrollees who are members of families below 150 percent of FPL as reported by the Administrative Contractor to the Contractor for the coverage period.

Pregnant women for unborn children: Enrollees reported by the Administrative Contractor as being qualified due to having met the CoverKids income standard and having responsibility for an unborn child. Also included in this category are female enrollees, regardless of income, in the State's CoverTN program who become pregnant while enrolled in such coverage. Further included in this category are pregnant women who access coverage for their unborn children through the payment of a one-time premium (from CoverKids' families with incomes in excess of 250% of FPL).

A.1 PROVIDER NETWORK

A.1.1 The Contractor shall maintain and administer a Plan provider network covering the entire State of Tennessee service area, for Participants, in accordance with this Contract. The Contractor further agrees to maintain under contract, participation by health care providers including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), Centers of Excellence for high risk cost procedures, nursing homes, laboratories, pharmacies and all other health care facilities, services and providers necessary to provide high quality, cost effective services, adequate distribution, and reasonable access from a geographic and service standpoint throughout the service area(s).

A.1.1.1 When requested by the State, the Contractor shall, within 10 business days and in writing, report to the State any actions it intends to take to correct any deficiencies in network access, as further described in Section A.9.5.

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

A.1.3 The Contractor shall report to the State within five working days of the end of each Contract quarter (the "Quarterly Network Changes Update Report") any changes in the designation of network hospitals, physicians, and other health care providers, but no less than thirty (30) calendar days prior to the removal of a hospital, clinic or ambulatory surgery center from the network.

A.1.4 The Contractor cannot take action to disenroll network primary care providers or hospital providers for one (1) year beginning each January 1, except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/re-credentialing process; non-compliance with Contract requirements; provider request for disenrollment; Participant complaints; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act.

A.1.5 The Contractor, following review and approval by the State, shall, upon enrollment, print and distribute to Participants' homes benefits information (Member Handbooks, or "MH") and provider directories. The MH must describe and outline CoverKids benefits and exclusions. The Contractor's provider directories must be state specific and describe and outline the Contractor's network of providers and its Drug Formulary. Distribution shall be made to every Participant. At the discretion of the State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties. Said Member Handbooks, provider directories and drug formularies shall be updated and distributed to Participants' homes following Contractor's standard procedures. A distribution to all Participants may be directed by the State and executed by the Contractor, but no more frequently than annually. The costs associated with printing and distribution of items described in this subsection are the sole responsibility of the Contractor. Upon mutual agreement of the State and the Contractor, electronic means may be utilized to inform Participants of the network of providers.

A.1.6 The Contractor shall maintain the capability to respond to inquiries from Participants concerning participation by providers in the network, by specialty and by county. Such capabilities shall be by toll-free telephone and an up-to-date Internet based directory of providers that includes provider search capability.

A.1.7 The Contractor shall contract only with providers who are duly licensed to provide such medical services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The Contractor shall perform on a continuous basis, appropriate provider credentialing as described in the Contractor's Proposal that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three years.

A.1.8 The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the program requirements. There must be provisions for face-to-face contact in addition to telephone and written contact. Additionally the Contractor must review and assess the practice patterns of network providers, share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.

A.1.9 The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management, care management, and case management procedures, and other services as required for participation in the provider network.

A.1.10 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of Participants.

A.1.11 The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.

A.1.12 The Contractor will provide Participants access to providers outside Tennessee, in certain situations, through the BlueCard PPO Program. This program is described in Contract Attachment G, BlueCard PPO Program.

A.2 MEDICAL AND CARE MANAGEMENT SERVICES

A.2.1 The Contractor shall provide a medical and care management system designed to help individual Participants secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor must provide a system for reviewing the appropriateness of hospital inpatient care, skilled nursing, inpatient rehabilitative care and other levels of care as necessary. The Contractor must have in place an effective process that identifies and manages those Participants in need of inpatient care. The following services must be provided:

- Identification of patients in need of inpatient care for the purpose of reviewing the level of care requested and determining extent of care required, and the identification of appropriate additional or alternative services as needed. Process must include admission review, or the pre-certification/ authorization of inpatient stay.
- Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and patients' physicians. The concurrent review process will review the continued hospitalization of patients and identify medical necessity for stays, as well as available alternatives.
- Discharge planning, providing a process by which medical management staff work with the hospital, patients' physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient. Prevention of readmission is also a goal of the discharge planning process.
- Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

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

A.2.2 The aforementioned services should be included as required and appropriate for hospital admissions. Pre-admission certification should not be employed for admissions for the normal delivery of children. Prospective review procedures may also include criteria for pre-admission testing and for same-day surgery procedures. If inpatient hospital pre-admission certification is utilized, authorization or denial must occur within one business day for urgent requests upon receipt by the Contractor of all necessary information regarding the admission. Any appeals of requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.

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

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

A.2.4 The Contractor shall maintain an internal quality assurance program. The Contractor shall submit to the State, at Contract implementation, a summary of the plan indicating areas addressed and methodology employed.

The Contractor's CoverKids medical and case management services must be accredited by either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or Utilization Review Accreditation Commission (URAC). If such accreditation is through NCQA, the Contractor shall annually submit to the State its HEDIS (Health Plan Employer Data and Information Set) report card.

A.2.5 The Contractor, in consultation with the State, shall have in place on the Contract effective date disease management programs, acceptable to the State, for the following chronic conditions: diabetes and asthma. In addition, the Contractor shall provide a program for high-risk pregnancies. The Contractor shall provide these disease management programs to optimize the health status of Participants therefore reducing the need for high cost medical intervention. The State reserves the right to review and comment on these programs. Failure to provide programs that meet the State's minimum standards will result in an assessment against the Contractor for payment to the State in the amount of $75,000 for each program of each year of the Contract term in which the Contractor fails to provide disease management programs meeting the minimum standards. At a minimum, each disease management program shall contain the following program components:

- A Population identification process;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
- Process and outcomes measurement, evaluation, and management; and

- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

A.2.5.1 The Contractor shall provide for each disease management program an evaluation methodology that is statistically valid and designed to measure program impact on health status, utilization of medical and pharmacy services and impact on the cost of care for the Participants identified with the chronic condition. The evaluation methodology must be reviewed and approved by the State and its' benefits consultant.

A.2.5.2 The Contractor shall provide a written report to the State, no less than semiannually, detailing Participant participation in each disease management program, and in addition, a written report to the State, no less than annually, with the results of the program evaluation referenced in A.2.5.1.

A.2.5.3 The State reserves the right during the term of the Contract to add, based on mutually agreeable terms and conditions, additional disease management or other care management programs that have demonstrated the ability to improve the health status of Participants and effectiveness and quality of care delivered. The State acknowledges that there may be additional costs associated with adding disease or other care management programs.

A.2.5.4 To assure continuity of care, the Contractor shall, upon cancellation or termination of the Contract for any reason, submit to the State a roster of Participants who are, at the date termination is effective, receiving disease management services, together with all the identifying information and conditions that make the Participants' enrollment in the specified disease management program appropriate.

A.3 **PHARMACY**

The Contractor shall provide a retail and mail order pharmacy program which meets all criteria necessary to provide the benefits in the Member Handbook.

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

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

A.3.2 Retail Network – the Contractor shall:

- Provide a network with Participant access to retail pharmacies, which contractually agree through point-of-sale electronic transmission to verify eligibility, submit Participant claims electronically, agree not to waive co-payments or deductibles, and agree to accept the Contractor's reimbursement as payment in full for covered prescription drugs allowing no balance billing.
- Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.
- Have the ability to refill mail order prescriptions online through the website, by telephone, or by mail, subject to compliance with all applicable federal and state laws and regulations
- Require its network retail pharmacies, who have agreed with the Contractor's terms and conditions for mail order pharmacy, to provide three month drug supplies via US Postal Service, upon request by the member, as required by mail order pharmacy policy.

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

- Provide a toll-free telephone number dedicated to the pharmacy mail-order program.
- Provide special telephone services for Participant consultations with a registered pharmacist.
- Provide a pharmacy claims appeal process.

- Provide a web site for Participants providing access to pharmacy plan benefits, retail pharmacy network, Preferred Drug List (PDL), drugs requiring Prior Authorization, drugs dispensed with limitations, link to mail-order, and, if available, a secure site for Participants to access their pharmacy claims.

A.3.4 Formulary/Preferred Drug List (PDL) and Utilization Review – the Contractor shall:

- Implement and maintain a Formulary/ PDL for the retail and mail order program that is designed to maximize the prescribing and dispensing of safe and clinically and cost effective drugs within each therapeutic class. Changes in the PDL shall be approved and communicated to the State and affected Participants no less than 30 days prior to change implementation date, unless, a shorter notification time is mutually agreed to by the Contractor and State. The State shall not unreasonably withhold its consent.
- Provide a Prospective Utilization Review program for the retail and mail order programs allowing pharmacists access to patient prescription drug profile and history in order to identify potentially adverse events, including but not limited to the following:
  - Drug to drug interaction
  - Duplicate therapy
  - Known drug sensitivity
  - Over utilization
  - Maximum daily dosage
  - Early refill indicators
  - Suspected fraud
- Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.
- Provide a Retrospective Utilization Review program to track provider prescribing habits and identify those who practice outside of their peer norms as well as identify patients who may be abusing prescription drugs or visiting multiple providers.
- Provide a specialty pharmacy program to address the introduction of new biological drugs and drugs to treat Participants with conditions such as hepatitis C, multiple sclerosis, arthritis and hemophilia. Such a program should provide for significant discounts off the Average Wholesale Price (AWP), delivery to the Participant, and pharmacist and nursing support.
- Have the ability to lock a Participant suspected of abusing the system into just one network pharmacy.

A.3.5 Therapeutic Substitution and Generic Dispensing Program – the Contractor shall:

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

A.3.6 Remit to the State no less than quarterly a check for all pharmacy rebates on behalf of the State due to the use of pharmaceuticals by members of the CoverKids plan for the rebates accrued during the claim period ending six months prior to the rebate payment date.

A.3.7 Pharmacy Program Audit – the Contractor shall, with provision by the State of 30 days notice and with execution of any applicable third party confidentiality agreements, submit to examination and audit of applicable pharmacy benefit data by the State, by the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) during the term of this Contract and for three years after final Contract payment (longer if required by law). For the purpose of this requirement, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. Such

audits shall include third party confidentiality agreements between the auditor and the party being audited.

A.4 BEHAVIORAL HEALTH

The Contractor shall maintain the ability to provide for the specialized review of treatment proposals for the provision of services for the treatment of behavioral health, mental health and substance abuse patients. This capability shall include the ability to:

- Review proposed treatment plans
- Refer to a specialty provider network
- Provide case and care management services to Participants and treatment providers
- Work actively with Community Mental Health Centers to enlist that resource as a set of network providers.
- Assist in the co-management of medical and behavioral health and substance abuse cases.

A.4.1 Services provided by primary care pediatricians for the treatment and diagnosis of behavioral health issues for Participants as recommended by the American Academy of Pediatrics shall be reimbursed at the applicable rates.

A.5 CLAIMS PROCESSING

A.5.1 The Contractor shall process all medical claims in strict accordance with the CoverKids Member Handbook, and its clarifications and revisions. The Contractor may not modify these benefits during the term of this Contract without the approval of the State, which approval shall not unreasonably be withheld.

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

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

A.5.3 The Contractor shall ensure that the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Said standards shall include the requirements specified under each of the following HIPAA subsections:

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

The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this Contract and meets the privacy and security requirements of HIPAA. The Contractor must maintain its disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.

A.5.3.1 To maintain the privacy of personal health information, the Contractor shall provide to the State a method of secure email for daily communications between the State and the Contractor.

A.5.4 The Contractor shall confirm eligibility of each Participant as claims are submitted, on the basis of the enrollment information provided by the State's Administrative Contractor, which applies to the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, either filed directly by Participants and/or the provider(s).

A.5.5 The State shall establish all Plan benefits, and have the right to approve the Member Handbooks. Said approval shall not unreasonably be withheld. Should the Contractor have a question on benefit design, 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 determinations.

A.5.5.1 The State shall have responsibility for and authority to clarify and/or revise the benefits available through CoverKids, but these must be agreed to by Contractor, since the coverage is insured coverage. It is understood between the parties that the program cannot and does not cover all medical situations. In a case where the benefits are not referenced in the Member Handbook or are not clear, the Contractor shall utilize its internal administrative policies and procedures in adjudicating claims.

A.5.5.2 The Contractor shall, when processing/adjudicating claims, employ its medical necessity guidelines to the extent that those guidelines do not conflict with or limit the provisions as outlined in the CoverKids Member Handbook.

A.5.6 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide Participants with identification cards. Identification cards shall contain unique identifiers for each Participant; such identifier shall NOT be the member's Federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review any claim forms and identification cards prior to issuance for use. Contractor shall update enrollment and shall mail Participant I.D. cards no later than 14 calendar days from receipt of the new enrollment or change in enrollment data.

A.5.7 The Contractor shall institute its standard subrogation recovery program for insured products.

A.5.8 To ensure coordination between the State and Contractor regarding Medicare Secondary Payer (MSP) claims issues, the Contractor shall resolve within 31 calendar days issues communicated by the State to the Contractor.

A.5.9 The Contractor shall determine eligible expenses which are medically necessary. The Contractor must have on staff qualified and licensed medical personnel whose primary duties are to follow Contractor's standard procedures for determining both prospectively and retroactively the medical necessity of treatments and their associated claims.

A.5.10 The Contractor shall have a process in place for determining experimental and investigational procedures and services, and shall provide to the State within fifteen (15) calendar days of Contract implementation detailed information on the Contractor's process for determining experimental/investigational procedures and services.

A.5.11 Upon conclusion of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered or medical supplies purchased during the period of this Contract with no additional administrative cost to the State.

A.5.12 The State shall assist Contractor in identifying fraud and performing fraud investigations of Participants and providers for the purpose of recovery of overpayments due to fraud. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the Division of Insurance Administration

and the Office of the Inspector General. Additionally, the Contractor will assist the State in identifying fraud and performing fraud investigations with Participants and providers.

A.6 CLAIMS PAYMENT AND RECONCILIATION PROCESS

A.6.1 Contractor shall follow its standard administrative procedure in adjudicating and funding claims reimbursements to providers.

A.6.2 The State will not hold the Contractor responsible for premium payments caused by the State's errors, errors committed by the Administrative Contractor or errors caused by any other agency or department of the State of Tennessee; however, the Contractor shall assist the State in recovery of such overpayments. The requirement that the Contractor assist the State in identifying or recovering overpayments as provided in this Section does not require the Contractor to become a party to any legal proceeding as a result thereof.

A.6.3 Overpayments resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees shall be the responsibility of the Contractor, regardless of whether or not such overpayments can be recovered by the Contractor. 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.

A.6.4 The Contractor shall maintain a year to date calculation of all copayments required by Participants, accumulate the amounts by family units and advise the family by letter when the covered members of the family have assumed copayments equal to 5 percent of the allowable family income. The letter will be in a form and substance approved by the State. When the family has reached this threshold, none of the Participants will be responsible for copays for the balance of the calendar year and provider payments shall be adjusted accordingly. The out of pocket limit does not apply to individuals from families with incomes in excess of 250% of the FPL.

A.7 PREMIUM BILLING AND COLLECTION

A.7.1 The Contractor shall be capable of collecting the appropriate premium amounts from Participants. Not all Participants are required to remit premiums; this is described in the MH.

A.7.2 The Contractor shall maintain accurate records of earned and unearned premiums received and premium refunds.

A.7.3 The Contractor shall send billing statements to Participants at their home address and collect all premium payments (whether monthly or benefit period) in a time and manner consistent with its standard administrative procedures.

A.7.4 The Contractor shall implement a notification process concerning premiums due on a monthly basis and a process to suspend and subsequently terminate coverage for individuals who fail to pay premiums in a timely fashion. The process shall assure that:

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

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

A.8 **CUSTOMER AND ADMINISTRATIVE SERVICES**

A.8.1 The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems, and to assist with meetings with Participants. The Contractor shall answer, in writing, within ten (10) business days ninety percent (90%) of all written inquiries from Participants concerning requested information, including the status of claims submitted and benefits available through the CoverKids plan, its clarifications and revisions.

A.8.2 The State shall consult with Contractor on proposed revisions to the CoverKids benefits. When so requested, the Contractor shall provide information regarding:
- Industry practices; and
- The overall cost impact to the program; and
- Any cost impact to the Contractor's fee; and
- Impact upon utilization management performance standards; and
- Necessary changes in the Contractor's reporting requirements; and
- System changes.

A.8.3 The Contractor shall maintain a formal grievance procedure, by which Participants and providers may appeal: decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. At Contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate. The State sponsors an appeal process available to member participants of self-insured plan options. The Contractor's appeal process shall meet the standards set out in Section 56-32-210, Tennessee Code Annotated.

A.8.4 The State appeals process is available to Participants after the Contractor's appeal process has been exhausted. The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The Contractor shall include a pediatrician in the appeals process for CoverKids. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals.

A.8.4.1 Should the State override the Contractor's decision in an appeal, and mandate benefits that are not covered in the MH, the State shall directly fund the costs of those benefits and reimburse the Contractor for the costs.

A.8.5 The Contractor shall respond to all inquiries in writing from the Division of Insurance Administration within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.8.6 The Contractor shall maintain statewide, toll-free phone lines manned by qualified benefit specialists and for the exclusive purpose of handling inquiries from Participants.

A.8.7 The Contractor shall designate an individual with overall responsibility for administration of this Contract. This person shall be at the Contractor's executive level and shall designate the following positions to interface directly with the State: (1) Program Director (external and marketing operations); and (2) Program Director (internal and administrative functions). Said designees shall be responsible for the coordination and operation for all aspects of the Contract.

A.8.8 The parties shall meet periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by either party.

A.8.8.1 The Contractor shall have in attendance, when requested by the State, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities.

A.8.8.2 The State shall have in attendance, when requested by the Contractor, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda.

A.8.9 The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the CoverKids Plan operations. This assistance may include but not be limited to:

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

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

A.8.10 The Contractor shall, in consultation with and following approval by the State, print and distribute all Member Handbooks, identification cards, provider directories, letters, administrative forms and manuals pertaining to or sent to Participants. Additionally, the Contractor must develop and print Member Handbooks detailing the benefits, procedures for accessing services, and other information helpful to Participants. The MH shall be mailed to the Participant's home address.

Failure to have any of the above communications materials approved by the State before release shall result in an assessment of $1000 per occurrence. The State shall notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid annually upon request by the State. The cost of printing and distributing MHs, provider directories, identification cards, and administrative forms and manuals shall be the responsibility of the Contractor. This provision excludes enrollment forms, which are the State's responsibility.

A.8.11 If the Contractor maintains State-dedicated Internet pages, it shall provide up to date information concerning plan benefits, the drug formulary and the provider networks. The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefit levels, premiums and cessation of coverage as requested by the State, Participants, and providers.

A.8.12 The Contractor shall perform, following review and approval by the State, customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor and shall involve a statistically valid random sample of Participants. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.8.13 The Contractor shall meet and confer at least twice each calendar year with representatives of the children's hospitals in the State and, separately, with Pediatric Independent Practice Association representatives and representatives of the Tennessee Pediatricians Association to discuss plan operations and network participation issues. The State shall be provided an opportunity to attend and observe the Contractor's sessions.

A.8.14 The Contractor shall conduct a provider satisfaction survey of physicians and hospitals, following approval by the State of the form, content and proposed administration of the survey, each October or November and report the results to the State by January 30 of the following year.

A.9 **DATA AND SPECIFIC REPORTING REQUIREMENTS**
The Contractor shall:

A.9.1 Maintain an electronic data interface with the CoverKids Administrative Contractor for the purpose of accessing enrollment information. The Contractor is responsible for equipping itself with the hardware and software necessary for achieving and maintaining access.

A.9.1.1 Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

A.9.2 Maintain, in its computer system, in-force enrollment records of all Participants.

A.9.3 Maintain a duplicate set of all records relating to the benefit payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of 60 days from the date of creation. Upon notice of termination or cancellation of this Contract, the original and the duplicate data processing records medium, and the information they contain shall be conveyed to the State on or before the effective date of termination or cancellation.

A.9.4 Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.9.5 Annually provide the State with a GeoNetworks® report showing service and geographic access (see **Contract Attachment A: Performance Guarantee #8).** The State shall review the network structure and shall inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days.

A.9.6 The Contractor is required to transmit plan enrollment data monthly and medical and prescription drug claims quarterly to the State's healthcare decision support system (DSS) vendor (currently Medstat) until all claims incurred during the term of this Contract have been paid. Data shall be submitted in the format detailed in Attachment E. The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ICD-9 and CPT4 codes (and when applicable, updated versions).

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

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

Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter.

A.9.7 The Contractor shall participate and cooperate with the State to implement a secure, web-accessible community health record (CHR) for Participants. Cooperation shall include, but may not be limited to, the provision of encounter/results data directly to an authorized CHR vendor in a time and manner approved by the State and consistent with the requirements of the CHR vendor and an executed Business Associates Agreement between the Contractor and the CHR vendor. The Contractor shall require subcontractors and providers to participate and cooperate with the State and/or a CHR vendor.

A.10 **SUBMIT MANAGEMENT REPORTS**

The Contractor shall submit Management Reports in a mutually agreeable electronic format (MSWord, MSExcel, etc.), of the type, at the frequency, and containing the detail described in Contract Attachment B. Reporting shall continue for the twelve (12) month period following termination of the Contract.

The Contractor shall also generate and submit to the State, within five working days of the end of each Contract quarter, a Quarterly Network Changes Report (see Section A.1.3), also in electronic format.

A.11 **SERVICES PROVIDED BY THE STATE**

A.11.1 The State shall through an Administrative Contractor provide enrollment records. These records shall include changes in the status of Participants. The Contractor's computer system shall be compatible or have the capability to utilize the enrollment information provided by the Administrative Contractor, in the State's proprietary transaction formats.

A.11.2 The State shall provide on-line access, or other access deemed mutually acceptable, to all enrollment information maintained by the State and instructions required to interpret such information. The Contractor, at its expense, will provide and maintain the necessary software, phone lines, modems, CRTs and other equipment required for this purpose.

B CONTRACT TERM

B.1 Contract Term. This Contract shall be effective for the period commencing on February 13, 2007 and ending on December 31, 2009. The State shall have no obligation for services rendered by the Contractor, which are not performed within the specified term.

B.2 Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total Contract term of no more than five (5) years, provided that the State notifies the Contractor in writing of its intention to do so at least Two Hundred Seventy (270) days prior to the Contract expiration date. An extension of the term of this Contract will be effected through an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract, and shall be based upon rates provided for in the original Contract.

C PAYMENT TERMS AND CONDITIONS

C.1 Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Five Hundred Million Dollars ($500,000,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates

include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

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

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

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

a. **Premiums.** The State shall remit payment to the Contractor monthly for all services under this Contract, at the premium amounts indicated below, based upon the number of Participants certified by the Administrative Contractor to the Contractor.

	2007	2008	2009
Group One Children (monthly) [1]	$208.13	$220.23	$234.73
Group Two Children (monthly) [2]	$226.43	$240.03	$256.93
Unborn Child (benefit period) (current enrollee) [3]	$5,080.00	$5,320.00	$5,580.00
Unborn Child (benefit period) [4]	$5,490.00	$5,780.00	$6,110.00

[1] Group One Children are defined as covered children who are in families with incomes at or above 150 percent of FPL.
[2] Group Two Children are defined as covered children who are in families with incomes below 150 percent of FPL and therefore subject to reduced copays.
[3] Unborn Child (current enrollee) is defined as a female Participant who is enrolled currently in the CoverKids program and who becomes pregnant while enrolled.
[4] Unborn Child is defined as any pregnant Participant not included in Unborn Child (current enrollee).

(1) If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the premium amounts fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2009 and that figure published in the same month, 12-months prior.

(2) If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the premium fixed in Section C.3, above but adjusted by the percentage increase, if any, between the Medical Care Cost Component of the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2010 and that figure published in the same month, 12-months prior.

(3) For the purpose of the payment amounts detailed in this Section, the premium for children and for low income children will be payable on a monthly basis for each month of coverage (a month is defined as the first day of a month to the last day of the month) and the benefit period for a pregnant woman will be defined as the 10 days prior to the date of the application through the sixtieth (60th) day following the delivery. The payment of the benefit period for the payment of the pregnant woman will be triggered by the birth of the child.

b. **Participant Premiums.** For pregnant women from families with incomes above 250% of the FPL who "buy-in" to CoverKids coverage, the Participant shall remit a one-time premium payment to the Contractor for all services under this Contract, at the applicable premium amount indicated above in Section C.3 (a). The benefit period for a pregnant woman will be defined as the 10 days prior to the date of the application through the sixtieth (60th) day following the delivery. The Contractor shall bill the Participant pursuant to Section A.7.3 of this Contract. The billing by Contractor and payment by the Participant of the one-time benefit period premium for such a Participant will be triggered by certification to the Contractor by the Administrative Contractor of such Participant's eligibility for the program. The Participant's failure to remit the premium will preclude coverage from beginning.

c. **Administrative Fees.** The administrative fees, set forth herein, shall be used to calculate plan expenses and shall constitute the amount in addition to the Contractor's portion of the excess premium (defined in section C.3.~~c~~ C.3.d below) which the Contractor shall retain from total premiums remitted by the State as the full remuneration for all service under this Contract. The administrative fee amount shall be included in the calculation of the Excess Premium Distribution based on the monthly enrollment for Group One and Group Two Children and the number of Unborn Child premiums earned during the calculation period.

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	2007	2008	2009
Administrative Fee (per member per month & per member per benefit period)	$14.99	$14.99	$14.99

d. **Excess Premium Distribution.** At the end of the 13 month period following the first day of each calendar year, the Contractor shall calculate the plan expenses for the prior calendar year. Plan expenses shall be comprised of the sum of paid benefits and the total administrative fee amount earned (the basis for which is detailed in C.3.~~b~~ C.3.c) during the subject period. The plan expenses will be compared to the total aggregate premium amount payable during the same period to determine the difference. If the plan expenses are less than the total aggregate premium amount during the subject period, the amount of the difference shall be deemed the "excess premium." Within 15 days of the State's acceptance of the above-referenced calculations, the Contractor shall remit to the State the appropriate portion of the "excess premium" pursuant to the following schedule:

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Excess Premium As Portion Of	Contractor Share of	State Share of

Claims Payments and Administrative Fees	Excess Amount	Excess Amount
For the first 2% of plan expenses	50%	50%
Between 2% and 5% of plan expenses	40%	60%
Between 5% and 7% of plan expenses	25%	75%
Between 7% and 10% of plan expenses	10%	90%
Above 10% of plan expenses	0%	100%

NOTE: Refer to Attachment C of this Contract for an example of excess premium analysis pursuant to this section.

C.4 Performance Guarantees. The Contractor agrees to be bound by the provisions contained in Contract Attachment A, Performance Guarantees, and to pay amounts due upon notification of Contractor non-compliance by the State.

C.4.1 Performance Guarantees under Contract Extension. If this Contract is extended, per Section B.2, the Performance Guarantees shall remain unchanged for the years extended.

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

C.6 Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.7 Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.

C.8 Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9 Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

D STANDARD TERMS AND CONDITIONS

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

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

D.3 Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, provided that the State shall give said notice to the Contractor at least Ninety

(90) days before the effective date of termination, and the Contractor shall give said notice to the State at least Two Hundred and Seventy (270) days before the effective date of termination. Should the State exercise this provision, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Should the Contractor exercise this provision, the State shall have no liability to the Contractor except for those units of service which can be effectively used by the State. The final decision as to what these units of service are, shall be determined by the State. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.

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

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

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

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

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

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

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not

knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

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

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

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

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

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

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

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

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

The Contractor, being an independent contractor, and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public

liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

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

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

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

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

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

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

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

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

E SPECIAL TERMS AND CONDITIONS

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

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

The State:
Marlene Alvarez, Manager of Procurement and Contracting
Tennessee Department of Finance & Administration
Division of Insurance Administration
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Nashville, TN 37243-0295
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The Contractor:
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BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
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Phone: 423-535-5983
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amy_bercher@bcbst.com

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

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

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

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

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

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

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

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

(2) Liquidated Damages (hereafter referenced as "Performance Guarantee Assessments", as contained in Contract Attachment A, Performance Guarantees) — In the event of a Breach, the State may assess Performance Guarantee Assessments. The State shall notify the Contractor of amounts to be assessed.

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

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

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

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

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

(4) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that

the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

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

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

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

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal

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

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

State law and ethical standards.

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

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

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

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

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.
b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.
c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document. See Attachment 6.1.1.

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

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

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

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

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

E.11 Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP-317.50-045 (Attachment 6.3, Section B, Item B.13.) and resulting in this Contract.

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

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — March 27, 2007

RON HARR, SENIOR VICE PRESIDENT — **DATE**

Ronald E. Harr, Sr. Vice President, Gov't. Programs & Public Affairs

PRINTED NAME AND TITLE OF AUTHORIZED CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

3-28-07

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

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

Per authorized signature above

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

COMPTROLLER OF THE TREASURY:

4-19-07

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

Contract Attachment A
Performance Guarantees

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

1. Claims Payment Dollar Accuracy	
Guarantee	The average quarterly financial accuracy for claims payments will be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors divided by the total paid value of Contractor audited dollars paid.
Assessment	**$1000** for each full percentage point below 99% for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 99% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of claims with no in processing or procedural errors, divided by the total number of claims within the audit sample. This excludes financial errors.
Assessment	**$1000** for each full percentage point below 99%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: • 14 calendar days for 90% of **non-investigated (clean)** claims; and • 30 calendar days for 96% of **all** claims
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays. Any claims that include COB and subrogation will be excluded when calculating compliance with the "investigated claims" performance standard.
Assessment	**Non-Investigated Claims (clean)**: **$1000** for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. **All Claims**: **$1000** for each full percentage point below the required minimum standard of 96% within 30 days. Quarterly Guarantee.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
4. Telephone Response Time	
Guarantee	Ninety-five percent (95%) of incoming Participant services calls will be answered by a member services representative in 30 seconds or less.
Definition	Telephone Response Time is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Assessment	**$500** for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
5. Participant Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Participant Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
Definition	Participant Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.
Assessment	**$3,000**. Annual guarantee.
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Participant Satisfaction Survey. Performance will be measured, reported, and reconciled annually.
6. Provider Satisfaction	
Guarantee	The Contractor shall conduct a provider satisfaction survey of physicians and hospitals, following approval by the State of the form, content, and proposed administration of the survey, each October or November. The survey shall include each of the Children's Hospitals in Tennessee, the top 15 percent of facilities based upon inpatient days for the first six months of the calendar year (excluding the

	Children's Hospitals) and the pediatrician IPA who request participation in the annual survey.
Definition	Completion of the survey.
Assessment	$2,500 annually if not complete and all elements provided by the end of January of each year.
Compliance Report	A written report summarizing the survey methods and results.

7. Member Handbooks and Provider Network Directories Distributed

Guarantee	Member Handbooks and Provider Network Directories will be distributed to Participants within 14 calendar days of the effective date of enrollment or to individuals requesting information within 5 business days of the request. (The handbook and provider directory may be a single document).
Definition	Member Handbook and Provider Network Directories will be measured based on date of distribution.
Assessment	Should either of the above listed documents not be distributed as required, the total assessment shall be **$2,500** per year in which the standard is not met.
Compliance report	The Compliance Report reported by Division of Insurance Administration Plan operations. Annual guarantee is measured, reported, and reconciled annually.

8. Provider/Facility Network Accessibility

Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network will assure that 95% of all Participants will have the Access Standard indicated.	
Definition	**Provider Group**	**Access Standard**
	Acute Care Hospitals	1 facility within 30 miles
	Pediatricians, general practice, internists, family practice physicians	2 physicians within 20 miles
	Pediatric Specialists	5 physicians within 100 miles
Assessment	**$1,000 annually** if ANY of the above listed standards are not met, either individually or in combination **measured annually** at the State's discretion.	
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.	

9. Claims Data Quality

Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor (Medstat). The Contractor's quarterly data submission to Medstat must meet the following Data Quality measures.	
Definition	*Measure*	*Benchmark*
	Gender	Data missing for </= (less than or equal to) 3% of claims
	Date of birth	Data missing for </= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for </= 5% of outpatient claims
	Outpatient provider type missing	Data missing for </= 1.5% of outpatient claims
Assessment	**$2500** if ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the MedStat Quarterly Data Quality report provided by MedStat. Performance measured and reported (by MedStat) quarterly; reconciled annually.	

10. Submission of Quarterly Data to Data Management Vendor

Guarantee	Quarterly claims data will be submitted by the contractor to the state's data management vendor (MedStat) no later than the last day of the month following the end of each calendar quarter.
Definition	Quarterly claims data are received by MedStat no later than the last day of the month following the end of each calendar quarter.
Assessment	Failure to submit quarterly claims data no later than the last day of the month following the end of each quarter will result in an assessment of $100 per day for the first and second working days past the compliance date, and $500 for each working day thereafter, to a maximum of $10,000 per quarter.
Compliance report	Compliance reporting submitted by MedStat upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.

11. Member ID Card Distribution

Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 98% of Participants within 14 calendar days of the receipt of enrollment information.
Definition	The actual distribution of a member ID card to 98% of all Participants by the specified dates.
Assessment	Should the above standard not be met, the total amount shall be **$15,000** per year in which the standard is not met.
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.

Contract Attachment B
Management Reporting Requirements

As required by Contract Section A.9, the Contractor shall submit Management Reports by which the State can assess the CoverKids program's general activity and usage, as well as treatment and success tendencies. Reports shall be submitted electronically, and shall be of the type and at the frequency indicated below. Management Reports shall include:

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

2) **Paid Claims Data by Quarter**, including 30 day run-out, and demonstrating Year-to-Date totals.
   - Number of Member Months for Kids and Low Income Kids and number of Pregnant Women (unborn children).
   - Total earned premium
   - Total Paid Medical Expenses
   - Inpatient data:
     - Admissions per 1,000 Participants, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Days per 1,000 Participants, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Average Length of Stay
   - Outpatient data:
     - Distribution of Dollars paid for Outpatient Services (expressed as percentages), for:
       - Medical
       - Surgery/ Diagnostic/Therapeutic
       - Anesthesia
       - Other
       - Total
   - Enrollment analysis, indicating:
     - Month 1, Month 2, Month 3 of the current quarter, and YTD, for:
       - Number of Participants by coverage type
       - Number of Patients
   - Prescription drug utilization- Retail and Mail Order:
     - Number of Prescriptions (total and per Participant)
     - Total Cost
     - Average Cost per Prescription
     - Average Cost per Participant per month
   - Top 10 Drugs by Number of Claims, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit
   - Top 10 Drugs by Cost, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit

A.□ Quarterly Network Changes Update Report, submitted electronically.

Contract Attachment C
Example of Excess Premium Analysis
FOR ILLUSTRATIVE PURPOSES ONLY

Below are hypothetical amounts provided for this illustration only.

Illustration of CoverKids Financial Model

Plan Income

	Premium payable by	amount	Number	Total
Group 1 Children	month	$160	80,000	$12,800,000
Group 2 Children	month	$170	20,000	$3,400,000
Unborn Children	benefit period	$10,000	1,500	$15,000,000
		Total Plan Income		$31,200,000

Plan Expenses

Benefits				$25,000,000
Administrative fees	credited by month or benefit period	$15.75	101,500	$1,598,625
		Total Plan Expenses		$26,598,625
	Income minus Expenses = Excess Premium			$4,601,375

Excess Premium Distribution	**Upper Threshold**	**Insurer**	**State**
For the first 2% of plan expenses	$531,973 (2% x $26,598,625)	$265,986 (50% x $531,973)	$265,986 (50% x $531,973)
Between 2% and 5% of plan expenses	$1,329,931 (5% x $26,598,625)	$319,184 (($1,329,931 - $531,973) x 40%)	$478,775 (($1,329,931 - $531,973) x 60%)
Between 5% and 7% of plan expenses	$1,861,904 (7% x $26,598,625)	$132,993 (($1,861,904 - $1,329,931) x 25%)	$398,979 (($1,861,904 - $1,329,931) x 75%)
Between 7% and 10% of plan expenses	$2,659,863 (10% x $26,598,625)	$79,796 (($2,659,863 - $1,861,904) x 10%)	$718,163 (($2,659,863 - $1,861,904) x 90%)
Above 10% of plan expenses	Applies to the balance	$0	$1,941,513
Total Distribution		$797,959	$3,803,416

This is an illustration of the manner in which the Excess Premium will be distributed, as provided for in Section C.3.c of the pro forma contract. The premium amounts and the administrative fee will be set out in the Contractor's proposal and in the Contract. The premium will paid over the course of the Contract based upon plan enrollments. The administrative fee is to be utilized in the calculation of total expenses and shall constitute the amount in addition to the Contractor's portion of the excess premium

which the Contractor shall retain from total premiums as the full remuneration for service under this Contract.

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	**FA-07-**
CONTRACTOR LEGAL ENTITY NAME:	**BlueCross BlueShield of Tennessee**
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	**62-0427913**

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

SIGNATURE & DATE: Ronald E. Harr March 27, 2007

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

DESCRIPTION/GENERAL INFORMATION

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

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

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

METHOD OF SUBMISSION

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

FREQUENCY OF SUBMISSION

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

TIMING OF SUBMISSION

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

SELECTION CRITERIA

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

Data should include:

- Covered active members and their covered dependents including retirees, surviving spouses/beneficiaries, LOA, LTD, STD, Permanent Disability, Military Leave, and FMLA.
- Employees who have opted-out of coverage
- Employees who have terminated but retain medical coverage through a severance plan paid by the company.
- COBRA enrollee information (if this information is being provided from this data supplier for the client).

Data need not include:

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

DATA FORMATTING

Character Fields

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

Numeric Fields

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

Financial Fields

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

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Family ID and Employee Status, we would like to have information copied down from the employee to the dependent record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person. For financial or quantity fields, (e.g. Employee Medical Contribution), to avoid over-counting, we would only want to see this information on the employee record.

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

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

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

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

ELIGIBILITY LAYOUT – Detail Records

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

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

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

ELIGIBILITY LAYOUT – Trailer Record

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

DESCRIPTION/GENERAL INFORMATION

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

METHOD OF SUBMISSION

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

FREQUENCY OF SUBMISSION

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

TIMING OF SUBMISSION

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

Data Type: Medical Claims / Encounter Records

Definitions:

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

Items for discussion

General

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

Financial Fields

Medstat defines the relationship among financial fields as follows:

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

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

Corrections to paid claims

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

Void/Replacement

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

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

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

Adjustments

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

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

Facility Record Content

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

Example: One facility claim with three service lines:

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

Professional Record Content

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

Example: One professional claim with two service lines:

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

Denied Claims

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

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

Data Type: Capitation Data

Definition

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

Items for Discussion

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

DATA FORMATTING

Character Fields

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

Numeric Fields

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

Financial Fields

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

Medical Record

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

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

29	Diagnosis Code 13 UB	189	193	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
30	Discharge Status Code UB	194	195	2	Numeric	The UB-92 standard patient status code, indicating disposition at the time of billing.	
31	Discount	196	205	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
32	Family ID	206	214	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
33	Gender Code	215	215	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
34	Line Number	216	217	2	Numeric	The detail line number for the service on the claim	
35	Net Payment	218	227	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
36	Network Paid Indicator	228	228	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level	"Y" or "N"
37	Network Provider Indicator	229	229	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs	"Y" or "N"
38	Ordering Provider ID	230	242	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.	The ID should be the physician's Federal Tax ID (TIN).
39	PCP Responsibility Indicator	243	243	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
40	Place of Service Code	244	245	2	Character	Client-specific code for the place of service.	Place of Service values will be identified in the Data **Dictionary.**
41	Procedure Code	246	250	5	Character	The procedure code for the service record.	CPT/HCPCS codes.
42	Procedure Code UB Surg 1	251	255	5	Character	The primary surgical procedure code (1) on the facility claim.	ICD-9 Surgical procedure codes.

43	Procedure Modifier Code 1	256	257	2	Character	The 2-character code of the first procedure code modifier on the professional claim	
44	Provider ID	258	270	13	Character	The identifier for the provider of service.	This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOSP)
45	Provider Type Code Claim	271	273	3	Numeric	Client-specific code for the provider type on the claim record	Provider Type codes are further defined in the **Data Dictionary**
46	Provider Zip Code	274	278	5	Numeric	The 5-digit zip code corresponding to the Provider ID	Provider Location zip code
47	Revenue Code UB	279	282	4	Numeric	The CMS standard revenue code from the facility claim	This field must be at the service/detail level.
48	Third Party Amount	283	292	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Units of Service	293	296	4	Numeric	Client-specific quantity of services or units	
50	Provider Name	297	326	30	Character	The description or name corresponding to the Provider ID.	
51	Financial Cost Amount	327	336	10	Numeric	The amount of payments contributing to total cost of coverage, but received as a standard claim.	Format 9(7)v99 (2 – digit, implied decimal) Usually used for capitation payments.
52	Capitation Type Code	337	338	2	Numeric	Client-specific code for the type of capitation payment	
53	Funding Type Code	339	340	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
54	Account Structure	341	348	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
55	Provider NPI Number	349	358	10	Character	The National Provider ID number for the provider.	
56	Provider Address 1	359	408	50	Character	The current street address1 of the provider of service.	
57	Provider Address 2	409	458	50	Character	The current street address2 of the provider of service.	
58	HRA Amount	459	458	10	Numeric	The amount paid from the HRA as a result of this claim.	
58	Filler1	469	599	131	Character	Reserved for future use	Fill with blanks
59	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'D'

Medical Detail – Trailer Record

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

DESCRIPTION/GENERAL INFORMATION

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

METHOD OF SUBMISSION

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

FREQUENCY OF SUBMISSION

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

TIMING OF SUBMISSION

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

Data Type: Drug Claims

Definitions:

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

Items for discussion

6	General

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

Financial Fields

Medstat defines the relationship among financial fields as follows:

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

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

Corrections to paid claims

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

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

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

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

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

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

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

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

DATA FORMATTING

Character Fields

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

Numeric Fields

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

Financial Fields

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

Drug Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.	
6	Claim Type Code	38	39	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
7	Co-Insurance	40	49	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
8	Copayment	50	59	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
9	Date of Birth	60	69	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
10	Date of Service	70	79	10	Date	The date of service for the drug claim.	MM/DD/CCYY format
11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.

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

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

Drug Detail – Trailer Record

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

ATTACHMENT F

HIPAA BUSINESS ASSOCIATE AGREEMENT TO COMPLY WITH PRIVACY AND SECURITY RULES

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

BACKGROUND

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

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

- [contract number(s) TBD

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

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

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

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

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

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

2.6 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to provide access, at the request of Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least seven (7) days business days from Covered Entity notice to provide access to, or deliver such information.

2.7 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least thirty (30) days days from Covered Entity notice to make an amendment.

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

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

2.10 Business Associate agrees to provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least seven (7) days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the Protected Health Information

was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure.

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

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

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

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

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

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

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

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

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

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

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

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

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

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

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

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

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

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

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

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

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

5. OBLIGATIONS OF COVERED ENTITY

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

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

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

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

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

7. TERM AND TERMINATION

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

7.2 Termination for Cause.

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

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

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

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

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

7.3 Effect of Termination.

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

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

8. MISCELLANEOUS

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

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

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

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

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

COVERED ENTITY:
Name: M.D. Goetz, Jr.
Title: Commissioner of the Department of Finance and Administration, State of

BUSINESS ASSOCIATE:
Name: Tena Roberson
Title: Director, Legal Services & Assoc. General Counsel

Tennessee
Address: 312 8th Avenue, North
Nashville, Tennessee 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email: dave.goetz@state.tn.us

Address: BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
Phone: (423) 535-5158
Fax: 423-535-4576
Email: tena_roberson@bsbst.com

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

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

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

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

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

IN WITNESS WHEREOF,

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Tena Roberson 3/27/07

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

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M.D. Goetz Jr. 3-28-07

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

Contract Attachment G

BLUECARD PPO PROGRAM

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

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

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

1. the actual price paid by the Host Plan on such a claim; or

2. an estimated price determined by the Host Plan in accordance with BlueCard policies, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or

3. an average price, determined by the Host Plan in accordance with BlueCard policies, based on a billed charges discount representing the Host Plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers. An average price may result in greater variation to the Participant and the State from the actual price than would an estimated price.

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

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

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