

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

July 10, 2008

CHANGE NOTICE NO. 7
 TO
 CONTRACT AGREEMENT NO. 071B8000121
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE
Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226		(248) 448-7341
		VENDOR NUMBER
		BUYER/CA (517) 241-1916 Jim Wilson <i>JW</i>
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPSERS		
CONTRACT PERIOD 5 year		From: January 1, 1998 To: September 30, 2008
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective June 30, 2008, this Contract is hereby EXTENDED to September 30, 2008. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request, Ad Board approval on 7/1/2008, and DMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: \$4,848,000.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

February 8, 2008

CHANGE NOTICE NO. 6
TO
CONTRACT AGREEMENT NO. 071B8000121
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 448-7341
Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226		VENDOR NUMBER
		BUYER/CA (517) 241-1916 Jim Wilson
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPERS		
CONTRACT PERIOD 5 year		From: January 1, 1998 To: June 30, 2008
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately, this Contract is hereby **EXTENDED** to June 30, 2008.
NOTE: The Buyer for this Contract is CHANGED to Jim Wilson (517) 241-1916.
 All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request (PRF dated 12/12/07) and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$4,848,000.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 PURCHASING OPERATIONS
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

July 2, 2007

CHANGE NOTICE NO. 5
TO
CONTRACT AGREEMENT NO. 071B8000121
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 448-7341
Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226		VENDOR NUMBER
		BUYER/CA (517) 373-1080 Melissa Castro
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPSERS		
CONTRACT PERIOD 5 year		From: January 1, 1998 To: December 31, 2007
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective June 30, 2007, this Contract is hereby **EXTENDED** to December 31, 2007.
 All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request (PRF dated 6/27/07) and DMB/Purchasing Operations
 Approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$4,848,000.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

July 28, 2006

CHANGE NOTICE NO. 4
 TO
 CONTRACT AGREEMENT NO. 071B8000121
 between
 THE STATE OF MICHIGAN
 and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 448-7341
Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226		VENDOR NUMBER
		BUYER/CA (517) 373-1080 Melissa Castro
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPERS		
CONTRACT PERIOD 5 year		From: January 1, 1998 To: June 30, 2007
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE (S):

Effective immediately this Contract is hereby EXTENDED to June 30, 2007. All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency and vendor agreement and DMB/Purchasing Operations Approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$4,848,000.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

October 24, 2005

CHANGE NOTICE NO. 3
TO
CONTRACT AGREEMENT NO. 071B8000121
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226	TELEPHONE (248) 448-7341
	VENDOR NUMBER
	BUYER/CA (517) 373-1080 Melissa Castro
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPSERS	
CONTRACT PERIOD 5 year From: January 1, 1998 To: December 31, 2006	
TERMS N/A	SHIPMENT N/A
F.O.B. N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A	

NATURE OF CHANGE (S):

Effective October 18, 2005, this contract is hereby **EXTENDED** through December 31, 2006. Also, this contract is **INCREASED** by \$950,400.00.

Effective January 1, 2006, the administrative fee per member per month is \$0.66.

PLEASE NOTE: The buyer has been **CHANGED** to Melissa Castro.

AUTHORITY/REASON:

Per DMB/Acquisition Services Approval.

INCREASE: \$950,400.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: \$4,848,000.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 ACQUISITION SERVICES
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

September 11, 2002

CHANGE NOTICE NO. 2
TO
CONTRACT AGREEMENT NO. 071B8000121
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226	TELEPHONE (248) 448-7341
	VENDOR NUMBER
	BUYER (517) 241-1647 Irene Pena
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPSERS	
CONTRACT PERIOD 5 year From: January 1, 1998 To: December 31, 2005	
TERMS <p style="text-align: center;">N/A</p>	SHIPMENT <p style="text-align: center;">N/A</p>
F.O.B. <p style="text-align: center;">N/A</p>	SHIPPED FROM <p style="text-align: center;">N/A</p>
MINIMUM DELIVERY REQUIREMENTS <p style="text-align: center;">N/A</p>	

NATURE OF CHANGE (S):

Effective immediately, this contract is hereby EXTENDED through December 31, 2005.
Please note new administrative fee rates:
2003 \$0.68 per member per month
2004 \$0.69 per member per month
2005 \$0.69 per member per month

AUTHORITY/REASON:

Per agency's request from Ben Louagio 7/29/02 and vendor's approval by Barbara Murphy on 7/29/02 and in accordance with the modification clause.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$3,897,600.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 OFFICE OF PURCHASING
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

February 20, 2001

CHANGE NOTICE NO. 1
TO
CONTRACT AGREEMENT NO. 071B8000121
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR		TELEPHONE (248) 448-7341
Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226		VENDOR NUMBER
		BUYER (517) 241-1647 Irene Pena
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPERS		
CONTRACT PERIOD 5 year		From: January 1, 1998 To: December 31, 2002
TERMS	N/A	SHIPMENT N/A
F.O.B.	N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A		

NATURE OF CHANGE:

Please note that the buyer of this contract is now Irene Pena.

AUTHORITY/REASON:

DMB/OOP

TOTAL ESTIMATED CONTRACT VALUE REMAINS: \$3,897,600.00

STATE OF MICHIGAN
 DEPARTMENT OF MANAGEMENT AND BUDGET
 OFFICE OF PURCHASING
 P.O. BOX 30026, LANSING, MI 48909
 OR
 530 W. ALLEGAN, LANSING, MI 48933

October 28, 1997

**NOTICE
 TO
 CONTRACT AGREEMENT NO. 071B8000121
 between
 THE STATE OF MICHIGAN
 and**

NAME & ADDRESS OF VENDOR Blue Cross/Blue Shield of Michigan Corporate Accounts 600 Lafayette East Detroit, MI 48226	TELEPHONE (248) 448-7341
	VENDOR NUMBER
	BUYER (517) 241-1218 Chris Fuller
NIGP #918-78 Vision Plan Administration - Department of Management & Budget/MPSERS	
CONTRACT PERIOD 5 year From: January 1, 1998 To: December 31, 2002	
TERMS N/A	SHIPMENT N/A
F.O.B. N/A	SHIPPED FROM N/A
MINIMUM DELIVERY REQUIREMENTS N/A	

The terms and conditions of this Contract are those of ITB #07117001057 this Contract Agreement, and the Vendor's quote dated 9-3-97. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the Vendor, those of the State take precedence.

Total Estimated Value of 5 year Contract = \$3,897,600.00

OFFICE OF PURCHASING
STATE OF MICHIGAN

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DEFINITION OF TERMS

TERMS	DEFINITIONS
Blanket Purchase Order (BPO)	Any binding contractual agreement entered into by the State of Michigan resulting from a bidder's proposal; also "Contract".
Contractor	The successful bidder who is awarded a Contract.
DMB	Michigan Department of Management and Budget
RFP	Request For Proposal - A term used by the State to solicit proposals for services such as consulting. Typically used when the requesting agency requires vendor assistance in identifying an acceptable manner of solving a problem.
ITB	Invitation to Bid - A generic form used by the Office of Purchasing to solicit quotations for services or commodities. The ITB serves as the document for transmitting the RFP to interested potential bidders.
Successful Bidder	The bidder(s) awarded a Contract as a result of the RFP.
State	The State of Michigan

SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A TERM OF CONTRACT

The State of Michigan is not liable for any cost incurred by any bidder prior to signing of a Contract by all parties. The activities in the Contract cover the period January 1, 1998 through December 31, 2002. The State fiscal year is October 1st through September 30th. The Contractor should realize that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

I-B COST LIABILITY

The State of Michigan assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this Contract. Total liability of the State is limited to the terms and conditions of this Contract.

I-C PRIME CONTRACTOR RESPONSIBILITIES

The Prime Contractor will be required to assume responsibility for all contractual activities offered in this proposal whether or not that Contractor performs them. Further, the State will consider the Prime Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the anticipated Contract. If any part of the work is to be subcontracted, responses to this RFP should include a list of subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Primary Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

I-D NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior approval of the State and then only to persons designated.

I-E CONFIDENTIALITY

The Contractor will be bound by the same standards of confidentiality as the state employees. Contractor may not release any products or portions of products resulting from the Contract without approval of the Contract Administrator.

I-F DISCLOSURE

All information in this Contract is subject to the provisions of the Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, et seq..

I-G ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the State of Michigan, its designees, or the Michigan Department of Auditor General at any time during the Contract period and any extension thereof, and for three (3) years from expiration date and final payment on the Contract or extension thereof.

I-H INDEMNIFICATION**1. General Indemnification**

The Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

- (a) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the product provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract.
- (b) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;
- (c) any claim, demand, action citation, or legal proceeding against the State, its employees and agents arising out of related to occurrences that the Contractor is required to insure against as provided for in this Contract;
- (d) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable; provided, however, that this

indemnification obligation shall not apply to the extent, if any, that such death, bodily injury or property damage is caused solely by the negligence or reckless or intentional wrongful conduct of the State;

- (e) any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

2. Patent/Copyright Infringement Indemnification

The Contractor shall indemnify, defend and hold harmless the State, its departments, division, agencies, sections, commissions, officers, employees and agents from and against all loses, liabilities, penalties, fines, damages (including taxes), and all related costs and expenses (including reasonable attorney's fees and disbursements, costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software, commodity or service infringes any United States or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

3. Indemnification Obligation Not Limited

In any and all claims against the State Of Michigan, or any of its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its benefits acts. This indemnification clause is intended to be comprehensive, Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

4. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and effect notwithstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions which occurred prior to termination.

I-I CONTRACTOR'S LIABILITY INSURANCE

The Contractor shall purchase and maintain such insurance as will protect him/her from claims set forth below which may arise out of or result from the Contractor's operations under the Contract (Purchase Order), whether such operations be by himself/herself or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:

- (1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other state the Contractor shall have insurance or participate in a mandatory state fund to cover the benefits payable to any such employee.
- (2) Claims for damages because of bodily injury, occupational sickness or disease, or death of his/her employees.
- (3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than his/her employees, subject to limits of liability of not less than \$300,000 each occurrence and, when applicable \$300,000 annual aggregate, for non-automobile hazards and as required by law for automobile hazards.
- (4) Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than \$50,000 each occurrence for non-automobile hazards and as required by law for automobile hazards.
- (5) Insurance for Subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than \$300,000 each occurrence and when applicable, \$300,000 annual aggregate.

The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract (Purchase Order).

BEFORE STARTING WORK THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF PURCHASING, ORIGINAL CERTIFICATE(S) OF INSURANCE VERIFYING LIABILITY COVERAGE. THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING. These Certificates shall contain a provision that coverages afforded under the policies will not be canceled until at least fifteen days prior written notice bearing the Contract Number or Purchase Order Number has been given to the Director of Purchasing.

I-J LITIGATION

The State, its departments, and its agents shall not be responsible for representing or defending the Contractor, Contractor's personnel, or any other employee, agent, or subcontractor of the Contractor, named as a defendant in any lawsuit or in connection with any tort claim.

The State and the Contractor agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or persons not a party to the Contract.

The Contractor shall submit quarterly litigation reports providing the following detail for all civil litigation in which the Contractor or the Contractor's insurers or insurance agent are parties:

Case number and docket number
name of plaintiff(s) and defendant(s)
names and addresses of all counsel appearing
nature of claim
status of case

The provisions of this section shall survive the expiration or termination of the Contract.

I-K CANCELLATION

- (a) The State may cancel the Contract for default of the Contractor. Default is defined as the failure of the Contractor to fulfill the obligations of the quotation or Contract. In case of default by the Contractor, the State may immediately and/or upon 30 days prior written notice to the Contractor cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees, and procure the services from other sources, and hold the Contractor responsible for any excess costs occasioned thereby.
- (b) The State may cancel the Contract in the event the State no longer needs the services or products specified in the Contract, or in the event program changes, changes in laws, rules or regulations, relocation of offices occur, or the State determines that statewide implementation of the Contract is not feasible, or if prices for additional services requested by the State are not acceptable to the State. The State may cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees by giving the Contractor written notice of such cancellation 30 days prior to the date of cancellation.
- (c) The State may cancel the Contract for lack of funding. The Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation of funds for this project. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State shall have the right to terminate this Contract without penalty at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to the

Contractor. The State shall give the Contractor written notice of such non-appropriation within 30 days after it receives notice of such non-appropriation.

- (d) The State may immediately cancel the Contract without further liability to the State its departments, divisions, agencies, sections, commissions, officers, agents and employees if the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under state or federal antitrust statutes; or convicted of any other criminal offense which in the sole discretion of the State, reflects on the Contractor's business integrity.
- (e) The State may immediately cancel the Contract in whole or in part by giving notice of termination to the Contractor if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, Section 5, and Civil Service Rule 4-6.
- (f) The State may, with 30 days written notice to the Contractor, cancel the Contract in the event prices proposed for Contract modification/extension are unacceptable to the State.

I-L ASSIGNMENT

The Contractor shall not have the right to assign this Contract or to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State. Any purported assignment in violation of this Section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without the prior written consent of the State Purchasing Director.

I-M DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.

I-N NON-DISCRIMINATION CLAUSE

In the performance of this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or

disability. The Contractor further agrees that every subcontract entered into for the performance of this Contract will contain a provision requiring non-discrimination in employment, as herein specified, binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 Public Act 453, as amended, MCL 37.2201, *et seq*, and the Michigan Handicapper's Civil Rights Act, 1976 Public Act 220, as amended, MCL 37.1101, *et seq*, and any breach thereof may be regarded as a material breach of the Contract.

I-O MODIFICATIONS, CONSENTS, AND APPROVALS

The Director of Purchasing reserves the right to modify this service during the course of this Contract. Such modification may include adding or deleting tasks which this service shall encompass and/or any other modifications deemed necessary. Any changes in pricing proposed by the Contractor resulting from the requested changes are subject to acceptance by the state. Changes may be increases or decreases.

IN THE EVENT PRICES ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT SHALL BE SUBJECT TO COMPETITIVE BIDDING BASED UPON THE NEW SPECIFICATIONS.

Any Contract resulting from this RFP may not be modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

I-P ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

The following documents constitute the complete and exclusive agreement between the parties as it relates to this transaction: In the event of any conflict among the documents making up the Contract, the following order of precedence shall apply (in descending order of precedence):

- A. This Contract
- B. State's RFP and any Addenda thereto
- C. Contractor's response(s) to the State's RFP and Addenda

In the event of any conflicts between the specifications, terms, and conditions indicated by the State and those indicated by the Contractor, those of the State take precedence.

This Contract supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties relating to this subject.

I-Q NO WAIVER OF DEFAULT

The failure of a party to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the party of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-R SEVERABILITY

Each provision of this Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions

of the Contract shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-S HEADINGS

Captions and headings used in this Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-T RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

The relationship between the State and the Contractor is that of client and independent Contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this Contract.

I-U NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party as addressed below upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by telefacsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Either party may change its address where notices are to be sent giving written notice in accordance with this Section.

I-V UNFAIR LABOR PRACTICES

Pursuant to 1980 Public Act 278, as amended, MCL 423.231, et seq, the State shall not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled pursuant to Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. Information concerning employees who are listed on the register may be obtained from the Michigan Bureau of Employment Relations at (313) 226-3200.

A Contractor of the State, in relation to the Contract, shall not enter into a Contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Pursuant to Section 4 of 1980 Public Act 278, MCL 423.324, the State may void any Contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer or supplier of the Contractor appears in the register.

I-W SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to the Contractor's indemnity and

other obligations shall survive the expiration or cancellation of this Contract for any reason.

I-X GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan.

I-Y YEAR 2000 SOFTWARE COMPLIANCE

The vendor warrants that all software which the vendor either sells or licenses to the State of Michigan and used by the State prior to, during or after the calendar year 2000, includes or shall include, at no added cost to the State, design and performance so the State shall not experience software abnormality and/or the generation of incorrect results from the software, due to date oriented processing, in the operation of the business of the State of Michigan.

The software design, to insure year 2000 compatibility, shall include, but is not limited to: data structures (databases, data files, etc.) that provide 4-digit date century; stored data that contain date century recognition, including, but not limited to, data stores in databases and hardware device internal system dates; calculations and program logic (e.g., sort algorithms, calendar generation, event recognition, and all processing actions that use or produce date values) that accommodates same century and multi-century formulas and date values; interfaces that supply data to and receive data from other systems or organizations that prevent non-compliant dates and data from entering any State system; user interfaces (i.e., screens, reports, etc.) that accurately show 4 digit years; and assurance that the year 2000 shall be correctly treated as a leap year within all calculation and calendar logic.

**SECTION II
WORK STATEMENT**

II-A PURPOSE

The purpose of this Contract is to obtain services of a contractor who will be responsible for claim processing and administration with respect to the Retiree Vision Care Plan (Plan) of the Michigan Public School Employees Retirement System (MPSERS).

Contract will be the following type:

Unit price Contract

II-B ISSUING OFFICE

This Contract is issued by the State of Michigan, Department of Management and Budget (DMB), Office of Purchasing, hereafter known as the Office of Purchasing, for the State of Michigan, Department of Management and Budget, Michigan Public School Employees Retirement System, hereinafter known as MPSERS. Where actions are a combination of those of the Office of Purchasing and MPSERS, the authority will be known as the State.

The Office of Purchasing is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services described herein. The Office of Purchasing is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract.

II-C CONTRACT ADMINISTRATOR

Upon receipt at the Office of Purchasing of the properly executed Contract Agreement, it is anticipated that the Director of Purchasing will direct that the person named below be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by the Office of Purchasing. The Contract Administrator for this project is:

**Phillip Stoddard
Department of Management and Budget
Michigan Public School Employees Retirement System
P. O. Box 30673
Lansing, MI 48909-8103**

II-D CONTRACT PAYMENT SCHEDULE

The specific payment schedule for this Contract (will be mutually agreed upon by the State and the Contractor(s)). The schedule should show payment amount and should reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy, statements shall be forwarded to the designated representative by the 15th day of the following month.

II-E PRICE PROPOSAL

All rates quoted by Contractor will be firm for the duration of the Contract. No price changes will be permitted, however the rates quoted for each contract year may be higher or lower than the rates quoted for the preceding year. That is, bidders may quote different firm rates for each of the five years of the contract.

II-F BACKGROUND/PROBLEM STATEMENT

The Plan became effective on January 1, 1990. Since July 1, 1991, it has been administered by Vision Service Plan on a self-insured basis. The current contract has been extended to December 31, 1997. As of January 1, 1997, there were 91,862 contracts (families) covering approximately 143,052 individuals, including dependents.

MPSERS is seeking a qualified organization to provide claim processing and administrative services for the Plan effective January 1, 1998. The contract will be for a five-year period commencing on January 1, 1998 and ending on December 31, 2002. Firm prices are to be quoted for each of the five years. The price quoted for each year must be firm for the period from January 1 of that year through December 31 of that year. Prices are to be quoted as a flat monthly fee per enrolled retiree or surviving beneficiary (i.e., per family) for all services specified.

II-G OBJECTIVES

The following are the primary objectives of MPSERS in letting this contract:

1. To have benefits administered in accordance with the Plan.
2. To have valid claims paid on an accurate and timely basis.
3. To obtain on a timely basis, accurate financial and utilization data with respect to the Plan's operations.
4. To have prompt, courteous service rendered to inquiring participants.
5. To have the MPSERS account managed professionally and efficiently by the vendor.
6. To achieve the lowest costs consistent with objectives 1 through 5.

II-H TASKS

1. Capability and Qualifications

MPSERS requires that the contractor shall have a reputation in the industry for good character and judgment. The contractor must be financially stable and have demonstrated a commitment to the vision care administration business. The contractor must have substantial experience with accounts similar in size and characteristics to MPSERS. The contractor must maintain an experienced staff capable of providing efficient, high-quality service to participants and MPSERS at all times and under all circumstances.

a. Experience

The contractor must have as current clients at least one vision care administration account having at least 40,000 covered participants and at least three additional vision care accounts having at least 20,000 covered participants.

b. Capacity

The contractor must, as of the date of its proposal, be actively administering group vision care coverage for at least 500,000 primary covered individuals.

c. Commitment

The contractor or its antecedents must have, as of the date of its proposal, have been actively engaged in the business of administering vision care plans for at least seven years.

2. Eligibility and Enrollment

MPSERS will provide a magnetic tape containing all necessary information with respect to current enrollees as of December 1, 1997. Thereafter, MPSERS will provide a tape or other electronic medium containing additions, changes and deletions to the contractor, at least once a month, according to mutually agreeable procedure.

a. Information and Solicitation Materials

The contractor must:

- (i) prepare and print at its own expense 95,000 plan description brochures and claim kits for transitioning enrollees, 6500 brochures and claim kits for enrollments during the year and 20,000 brochures for prospective retirees. The materials must display MPSERS' logo and must be printed in large type for readability. These materials must be available by 12/15/97.
- (ii) prepare and print at its own expense 6600 brochures and claim kits for enrollments during the second year. Requirements for subsequent years will increase by about 5 percent per year. Materials are due April 1 of each year.
- (iii) mail brochures, claim kits and identification cards at its own expense to all enrollees as of the effective date of the

commencement of its administration and to new participants as part of the enrollment process.

- (iv) prepare and bear the cost of all announcements, letters, notices, forms, postage and other supplies and services for the administration of the plan.

All announcements, form letters, notices and brochures must be prior approved by MPSERS. MPSERS will supply enrollment materials to all eligible retirees and process applications.

b. Customer Service

The Contractor will be required to provide speakers at retiree meetings coordinated or planned by MPSERS, or approved by MPSERS. Meeting requests may vary from year to year but will average 12 to 15 annually with the possibility of up to five of such meetings being out-of-state. The Contractor will share all expenses of the meetings equally with the Dental Plan and Master Health Care Plan contractors. In addition, the Contractor may be required to prepare articles on subjects relevant to vision issues for publication in a newsletter for retirees up to 6 times each contract year.

c. Exception Reports

The Contractor must produce a monthly exception report to identify discrepancies between monthly data submitted by MPSERS and data contained in its complete eligibility file. The Contractor must provide the name and telephone number of a qualified individual who will resolve discrepancies.

d. Identification Cards

The Contractor must provide a MPSERS-specific identification card for each enrollee and adult dependent.

e. Eligibility System

The Contractor must maintain an on-line eligibility system which is interfaced with its claim processing system. The system must be updated at least monthly and must include covered dependents by name. The Contractor will provide and maintain on MPSERS' premises a functional computer terminal for access by MPSERS to MPSERS' eligibility and claim data.

3. Financial Arrangements and Reporting

It is anticipated that the Contractor will establish an account with the State's bank, currently the *National Bank of Detroit (NBD)*. Details will be worked out later, but it is anticipated that the Contractor can either use NBD as a conduit or actually write checks from the account. MPSERS anticipates that if a funds transfer request is received at MPSERS by 1:00 p.m., the transfer can be completed by 8:00 a.m. the following morning. This can be done on a daily basis or less often if appropriate. The Contractor must establish an electronic mail link with

MPSERS for purposes of communicating transfer requests. Other financial arrangements may be agreed upon by the Contractor and MPSERS.

a. Security

The Contractor shall have and maintain in place a system of financial controls and electronic data processing security to ensure the integrity of the MPSERS account and the data used to establish MPSERS' financial obligations.

b. Requests for Funds

Upon requesting a wire transfer for cleared drafts, the Contractor must transmit electronically to an official designated by the State a statement, signed by an officer of the Contractor, certifying that the request accurately states the financial obligations of MPSERS for cleared drafts for the period in question.

c. Documentation

Not later than twenty-five (25) days following the end of each month, the Contractor must provide in hard copy and on magnetic tape, in a format to be agreed upon between the parties, a claim detail report listing each claim processed during the preceding month. The claim detail report must be reconciled with the wire transfer requests for the identical period. The reconciliation must be evidenced by a detailed reconciliation report.

d. Annual Report

Not more than ninety (90) days after the end of each contract year, the Contractor must provide, in a format to be agreed upon between the parties, a complete financial summary of the prior contract year. The report must be available in both hard copy and on magnetic tape. In addition, the Contractor must provide such of its standard financial and statistical reports as may be requested by MPSERS.

e. Payment

MPSERS will make payments monthly for administrative service fees based on the number of enrolled retirees and surviving beneficiaries shown on MPSERS' monthly payroll who have coverage.

f. Government Forms

The Contractor must prepare Internal Revenue Service Form 1099 with respect to providers, and such other federal and state forms as may be required to be filed on behalf of MPSERS.

g. Special Reports

The Contractor must provide to MPSERS at least semi-annually a report documenting its activities and results in administering the COB provisions of the Plan. The report shall include at least the

number of claims during the period for which other coverage was reported, the number of claims for which other coverage was not reported but was identified upon investigation and the dollar amount and percentage of total claim dollars saved as a result of COB administration.

h. Legal Activity

In the event the Plan or the State is sued or threatened with legal action as a result of the administration of the Plan, the Contractor must cooperate with counsel for the Plan or the State and must agree to act as an expert witness if so requested.

i. Timing of Fee Payments

It is anticipated that MPSERS will make payment of the Contractor's administrative fees two business days after the end of the month to which the fees apply. The Contractor must agree to accept such fees in full payment of MPSERS' obligation without imposition of penalties or "late charges."

4. Claim Administration

a. Claim Adjudication and Payment

The Contractor must administer claims in conformity with the Retiree Vision Care Plan. Provisions of the Plan are set forth in Appendix A. The Contractor must issue payment to both participants and providers on a timely and accurate basis.

b. Claims System

Claim processing by the Contractor must be highly system-aided. The system must provide for automated eligibility determination, duplicate claim identification, benefit calculation, data collection and explanation of benefit forms. It must limit the opportunity for processor error, provide security against unauthorized entry, track provider licensing status and maintaining appropriate history on-line.

c. Claim Processing Personnel

The Contractor must maintain an adequate staff of qualified employees to administer the Plan. The Contractor must also have a qualified customer service staff to answer questions from enrollees and providers with an adequate number of toll-free telephone lines available at reasonable hours.

d. Payment In Accordance With Plan

The Contractor must not charge against MPSERS' account for claim payments not authorized under the Plan, except that the Contractor may charge such payments for an individual who was formerly covered by the plan if such payments were made prior to notification of the individual's ineligibility.

e. Claim History

If any transition to a new Contractor is to be made on other than a Plan anniversary, currently calendar year, the Contractor must present a procedure acceptable to MPSERS for adjudicating claims so as to reflect the status of claimant's annual and lifetime maximums under the Plan as of the commencement of its administration. If the Contractor is not VSP, the Contractor must be prepared to accept a claim history tape from VSP and work closely with VSP to resolve any difficulties that may arise in integrating claim history into its system.

The Contractor must also maintain its data in such a manner that it can provide to MPSERS or any subsequent administrator a current claim history tape within 30 days of the date of request. Moreover, the Contractor must provide, on magnetic medium or hard copy, a monthly claim history update until all runout claims are closed.

5. Utilization Data Reporting

MPSERS has established a database of utilization statistics to better manage the Plan using an outside vendor. This database will no longer be maintained after June 30, 1997, however the Contractor will be responsible for maintenance of a claims database and reporting as follows:

a. Data Maintenance

The Contractor must capture and store with respect to each claim all of the data elements specified in Appendix C. The data for each plan year (January 1 through December 31) must be retained for a period of not less than seven years and must be maintained in such form that it can be downloaded to magnetic media and transferred to MPSERS at termination of the contract or at such other time or times as MPSERS shall specify.

b. Reporting

The contractor shall, if requested by MPSERS, prepare a utilization report not more often than annually in a format mutually agreeable to MPSERS and the Contractor. In addition, the Contractor shall prepare such *ad hoc* reports as MPSERS shall request to assist it in monitoring utilization of the plan.

6. Performance Standards

MPSERS intends that services rendered by the Contractor shall be accurate and timely. Therefore, it will require the establishment of performance measurements and standards. It will also require that the Contractor be at financial risk for its performance in the areas of administrative accuracy, financial accuracy and claim processing time.

Not less often than annually, the Contractor must permit a claim audit and performance evaluation by an independent vendor to be selected by the State.

The Contractor must agree to the following performance provisions. **If the Contractor is unwilling to agree, its bid will be disqualified.** Application of these provisions will be determined by a performance appraisal conducted by an outside vendor retained by the State. The appraisal will consist in part of an audit of a statistically valid random sample of claims processed during each contract year.

a. Financial Error Rate

This is defined as the number of claims containing errors of a financial nature (i.e., incorrect benefit amount) divided by the number of claims in the sample. If the financial error rate exceeds two (2) percent then the Contractor's administrative fee for the year audited will be ninety-eight percent (98.0%) of its quoted fee, less an additional one (1) percent for each full percentage point by which the error rate exceeds two (2) percent.

b. Non-Financial Error Rate

This is defined as the number of claims containing errors of a non-financial nature divided by the number of claims in the sample. If the non-financial error rate exceeds four (4) percent then the Contractor's administrative fee for the year audited will be ninety-eight and one-half percent (98.5%) of the fee quoted, less an additional one and one-half percent (1.5%) for each full percentage point by which the error rate exceeds four (4) percent.

c. Turnaround Time

Turnaround time is defined as the number of days between the date a claim for which payment is made directly to a participant is received in the Contractor's claim office and the date the Explanation of Benefits form is mailed. If the average turnaround time for all claims is not less than ten (10) days, then the Contractor's administrative fee for the year audited will be ninety-eight and one-half percent (98.5%) of the fee quoted, less an additional one and one-half percent (1.5%) for each additional three (3) days by which the average turnaround time exceeds ten (1) days. The Contractor must maintain its records in a manner that will allow turnaround time to be calculated by a fully automated computer audit.

In the event that the Contractor's administrative fee for the plan year is to be adjusted under more than one of the preceding subparagraphs, then the adjustment will be computed separately under each subparagraph and the total adjustment for all subparagraphs will be applied to the quoted fee.

Failure to audit any year's claims shall not prejudice MPSERS' right to audit claims of any other year.

In addition to any adjustment of the Contractor's fees as described above, the Contractor shall agree to reimburse to the plan the full amount of any claim overpayment actually discovered by an audit.

Moreover, if the audit or other source shows that there has been a

pattern of overpayments on a particular type or class of claim, and if the Contractor cannot refute such showing, the Contractor shall either recover such overpayments at its own expense or reimburse to the plan the full amount of such overpayments.

7. Senior Account Manager

The Contractor shall provide an experienced senior account manager (SAM). The SAM shall have substantial experience with accounts of MPSERS' size, complexity and composition. The SAM shall have the ability within the Contractor organization to obtain the use of such resources as are necessary to meet MPSERS' needs. The SAM shall be available to meet with MPSERS staff on at least a monthly basis in Lansing.

The SAM shall have at least one qualified back-up or assistant who shall be capable of performing the responsibilities of the SAM in the event that the SAM is unavailable.

The SAM shall not be changed by the Contractor without the approval of MPSERS.

8. Provider Contracting

MPSERS intends that the Contractor shall provide for the care of plan participants on a basis which offers favorable pricing for the State and the participants. To this end, the Contractor shall maintain a network of providers whose maximum fees and other charges shall be determined by contract, either blanket or on a case-by-case basis, between the provider and the Contractor. Periodically, the Contractor shall provide a report to MPSERS that contains a comparison of the contractual fees and charges allowed to network providers for representative services and supplies to those generally charged in the fee-for-service/supply market. The timing and format of the report shall be mutually agreed upon between MPSERS and the Contractor. Contractors should note that compliance with this reporting requirement may necessitate periodic purchase of access to a health care claims database maintained by an outside source such as the Health Insurance Association of America (HIAA).

II-I PROJECT CONTROL AND REPORTS

1. Project Control

- a. The Contractor will carry out this project under the direction and control of MPSERS.
- b. Although there will be continuous liaison with the Contractor team, the client agency's project director will meet monthly at a minimum, with the Contractor's project manager for the purpose of reviewing progress and providing necessary guidance to the Contractor in solving problems which arise.
- c. The Contractor will submit brief written monthly (or more frequently, if necessary) summaries of progress which outline the work accomplished

during the reporting period; work to be accomplished during the subsequent reporting period; problems, real or anticipated, which should be brought to the attention of the client agency's project director; and notification of any significant deviation from previously agreed-upon work plans.

- d. Within five (5) working days of the award of the BPO, the Contractor will submit to MPSERS' project director for final approval a work plan. This final implementation plan must be in agreement with Section IV-C subsection 2 as proposed by the bidder and accepted by the State for BPO, and must include the following:
- (1) The Contractor's project organizational structure.
 - (2) The Contractor's staffing table with names and title of personnel assigned to the project. This must be in agreement with staffing of accepted proposal. Necessary substitutions due to change of employment status and other unforeseen circumstances may only be made with prior approval of the State.
 - (3) The project breakdown showing sub-projects, activities and tasks, and resources required and allocated to each.
 - (4) The time-phased plan in the form of a graphic display, showing each event, task, and decision point in your work plan.

2. Reports

The Contractor shall prepare a reconciliation report on a quarterly basis to assist in an on-going reconciliation of claim payments, fees and other financial transactions. The format and timing of the report shall be determined by mutual agreement between MPSERS and the Contractor.

**SECTION III
CONTRACTOR INFORMATION**

III-A BUSINESS ORGANIZATION

PRIMARY CONTRACTOR:

**Blue Cross/Blue Shield of Michigan
600 E. Lafayette
Detroit, MI 48226**

SUB-CONTRACTOR:

**Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670**

III-B AUTHORIZED CONTRACTOR EXPEDITER:

**J. Paul Austin
Senior Vice President, Michigan Sales and Services
Blue Cross/Blue Shield of Michigan
(248)448-7341**

APPENDIX A

CONTRACTOR'S TECHNICAL PROPOSAL
(EXCERPTS)



Information Required from Bidders

A. Business organization

Name of organization: Blue Cross Blue Shield of Michigan

Address: 600 E. Lafayette, Detroit, Michigan, 48226

Claims Processing and Vision Administration: Vision Service Plan—Eastern Operations Center, 4300 Morse Crossing, Columbus, OH 43219. (614) 471-7511 or (800) 462-7009

Organization: BCBSM is a Michigan non-profit corporation organized under Public Act 350 of the Public Acts of Michigan of 1980

Subcontractor: BCBSM has subcontracted network management, customer service, claims processing and daily administration of the MPSERS account to Vision Service Plan, a not-for-profit, non-stock corporation with no owners or shareholders. VSP is incorporated in California, and is licensed to conduct business in Michigan.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(916) 851-5000 or (800) 852-7600

Roger J. Valine
President, Vision Service Plan



Information Required from Bidders

C. Management Summary

NARRATIVE

Blue Cross Blue Shield of Michigan welcomes the opportunity to submit this proposal to administer the Retiree Vision Plan for the Michigan Public School Employees Retirement System.

As the Plan Administrator for MPSERS, BCBSM will provide a high quality benefit delivery system we believe is unmatched by other plan administrators. BCBSM's commitment to the vision care administration business is rooted in our more than 50 years experience in administering health, dental and vision programs and in providing efficient, high quality service to groups such as MPSERS.

As a non-profit health care prepayment organization established by Michigan Public Acts, our service has not been limited to just our members. Through our sponsorship of community service programs such as Senior Services Health and Consumer Education programs and Medicare Seminars, we have demonstrated our commitment to providing access to health information to all. As a corporate citizen of Michigan, BCBSM has worked with state government to set the direction for Michigan's health care industry. Administration of the Retiree Vision Plan for MPSERS is one more opportunity to again participate in serving Michigan.

BCBSM is uniquely qualified and experienced to manage the plan professionally and efficiently because our subcontractor, VSP, is the current administrator of the MPSERS' vision care plan.

Some examples of our unparalleled qualifications are identified below:

- Paperless Benefits Administration

With VSP's New Benefits System (NBS), patients no longer need to request a benefit form before seeing their doctor. Instead, the covered member simply makes an appointment with a VSP participating doctor and identifies himself or herself as a VSP patient. This paperless benefit administration system allows the participating doctor direct access to eligibility information and plan coverage.

While this new system has not been formally announced to MPSERS members, 56% of the claims paid between January and July 1997 were initiated through the NBS system. This most likely occurred as a result of the participating doctors offering to obtain authorization for their patients, rather than requiring them to present a benefit form at the time of their appointment. The ease with which this system has been incorporated is a clear indication that our *vision* of the future is on target. MPSERS members obviously appreciate the paperless quality and convenience of NBS.

- Additional Value through Plan Enhancements

Effective January 1996, VSP introduced plan enhancements that add significant value. These enhancements give patients added buying power for non-covered items and contact lens services when purchased from a VSP participating doctor. What's more, this buying power is available beyond the initial date of service. Specifically, patients are offered an additional complete pair or prescription glasses and spectacle lens options at a 20% discount. When contact lenses are obtained, patients are offered a 15% discount off the doctor's usual and customary professional services. These discounts are valid for a full twelve months after the covered examination, and must be obtained from the participating doctor who performed the covered eye examination.

- Unparalleled Provider Access

Provider access is an important consideration when selecting a vision program because most plans, including ours, are structured so that patients must see participating doctors to receive maximum coverage. When it comes to access, no one covers Michigan—or the entire nation—like VSP. In Michigan alone, nearly 1,300 doctors practice in both rural and metropolitan areas, giving MPSERS members ready access to a VSP provider. And, MPSERS out-of-state members have access to more than 22,000 participating doctor locations from Los Angeles, California to Portland, Maine.

Current statistics for the MPSERS account attest to our network accessibility: Approximately 87% of the paid claims for MPSERS' members were incurred in-network. After further analysis, VSP has determined that access was not the driving force behind the resulting 13% of out-of-network claims. Using the zip codes of those individuals who chose to receive services from a non-participating provider, VSP prepared a GeoAccess report to determine access to the network. The report showed that more than 90% of these patients live within 9 miles of a VSP participating doctor location. In fact, the average driving distance to five VSP doctor locations is only 6.5 miles.

VSP also prepared a GeoAccess report using zip code data provided by MPSERS.

The results show that nearly 91% of MPSERS' members have access to at least one VSP participating doctor within 9 miles. The remaining 9% are within 15 miles of at least one VSP participating doctor. Clearly, VSP's national network is providing superior accessibility to MPSERS' members, regardless of location. For further detail on the results of this GeoAccess study, please refer to Exhibit A.

- 21st Century Readiness

There is growing worldwide concern about the inability of many computer systems to recognize dates into the year 2000 and beyond. Like BCBSM, VSP is addressing this problem and looks forward to maintaining service commitments and improving levels of performance well into the next century.

We are confident that this "Y2K" problem will not affect our ability to conduct business because:

- VSP started working on this issue in 1989 and determined that all new computer systems that were developed from then on must be Y2K compatible. Since then, more than 60 percent of VSP's core computer systems have been replaced and they expect to replace another 30 percent before the year 2000.
- In 1996, a VSP team completed an assessment of the remaining 10 percent of their core systems.
- In January 1997, a VSP technical team began a detailed analysis and modification of all computer software to address Y2K and leap year compatibility. This effort should last until the end of 1997.
- Throughout 1998, VSP will test their entire computer system (hardware and software) for Y2K issues and make necessary corrections. This testing and software certification will be an ongoing process through the year 2000.
- We recognize that simply examining systems will not ensure success. Our business also depends on customers, suppliers, doctors, optical labs and other business partners, and our facilities' infrastructure to be Y2K compliant. Last April, VSP formed a new team to identify and rectify issues in those areas.

Our approach at BCBSM on Year 2000, which we have determined to be the most cost-effective and one that is generally accepted among companies with large, multiple data bases, is to use "interpretations" of the data field. For companies such as BCBSM, field expansion poses significant risks because of the amount of programming changes that would be called for.

The following is a summary of information contained in this proposal. After your thorough review of the proposal, we are certain you will agree that BCBSM is the right choice as Plan Administrator for the Retiree Vision Plan.

TECHNICAL WORK PLANS

As current administrator for MPSERS' health care plan and the former administrator for the vision plan, BCBSM is experienced and fully aware of the direction we will take in implementing our administrative activities.

Because MPSERS is currently in VSP's system, very little work is necessary. In fact, with the exception of producing and executing a revised contract reflecting the arrangement between MPSERS and BCBSM with VSP as the subcontractor, the implementation process will be transparent to MPSERS and its members. Internally, BCBSM will work with VSP to maintain all levels of service and coordinate eligibility transfer.

Accordingly, our technical work plan follows:

Activity	Responsible	Estimated Start Date	Estimated End Date
Add BCBSM information and print benefit books	VSP—B. Aikman	November 1, 1997	December 15, 1997
Modify Eligibility Process	BC—A. Overton VSP—B. Aikman	November, 1, 1997	December 15, 1997
Implement financial arrangements btw BCBSM & VSP	BC—B. Murphy VSP—J. Kackloudis	November 1, 1997	December 15, 1997

PRIOR EXPERIENCE

Beyond its background in administering health and vision plans for MPSERS, BCBSM has extensive experience servicing retirees enrolled in vision plans. BCBSM currently covers more than 714,000 members through approximately 319,000 group contracts. This experience encompasses non-standard benefit designs and servicing capabilities for retirees living in and outside Michigan. Additionally, BCBSM has experience working with major employer groups that require unique financing arrangements and we are the current administrator for the MPSERS health plan.

The following are two of the major accounts for which BCBSM is administering vision plans:

State of Michigan
 Contact: Duane Marlan,
 Director of Employee Benefits Division,
 Office of the State Employer, DMB
 KNAPPS Centre, Suite 305, 300 South Washington
 Lansing, MI 48909
 (517) 373-1846

Oakland County
 Dean Shackelford, Supervisor
 1200 North Telegraph
 Pontiac, MI 48341
 (248) 858-5212

Beverly Horne	Customer Service Manager	4300 Morse Crossing Columbus, OH 43219 (614) 224-7709 (800) 462-7009	5 to 10%
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In addition, each of VSP's executives will contribute to the overall management and administration of MPSERS' vision plan. These individuals, all located at VSP's headquarters at 3333 Quality Drive, Rancho Cordova, CA 95670, are outlined below:

Name	Title and Department
Roger J. Valine	President and Chief Executive Officer
Richard Steere	Vice President of Marketing
Patricia Cochran	Chief Financial Officer and Vice President of Finance/Group Services
Beverly Westerfeld	Vice President and General Legal Counsel
Mary Ann Cavanagh	Vice President of Customer Relations
Don Price	Vice President of Provider Relations
Cheryl Johnson	Vice President of Health Care Services
Gary Brooks	Vice President of Information Systems
Steve Snyder	Vice President, Eastern Sales Division
Laura Costa	Director of Customer Service
Tatia Davenport	Director of Customer Delight

SUBCONTRACTORS

Vision Service Plan

Roger J. Valine, President
3333 Quality Drive
Rancho Cordova, CA 95670
(916) 851-5000 or (800) 852-7600

Nationwide, VSP has more than 1,600 employees dedicated solely to administering quality vision care benefits.

For MPSERS, VSP would process claims and provide customer service from their Eastern Operations Center in Columbus, Ohio. This VSP office processes all claims and provides customer service support for VSP groups in the eastern region of the country. VSP's Eastern Operations Center currently has approximately 135 full-time employees, including 45 customer service representatives and 20 claims processors.

VSP maintains the largest provider panel in the vision industry, contracting directly with more than 22,000 participating doctor locations and nearly 1,300 locations in Michigan.

Here are a few key facts about the network.

- Because of the important eye and general health related aspects of eyecare, VSP contracts solely with private practice optometrists and ophthalmologists. We believe these professionals focus primarily on providing high-quality care, not generating eyewear sales.
- VSP offers unparalleled doctor access because research shows provider selection to be a key “driver” for MPSERS members. The research, conducted by VSP in late 1996 to uncover the attributes that “drive” satisfaction among patients and groups, found that patients consider doctor selection the second most important factor in judging their vision plan behind the actual care given by the provider.
- All participating doctors must agree to rigid quality and cost controls, including credentialing according to National Committee for Quality Assurance standards.
- Because we want eyecare to be convenient for members, VSP doctors must agree to provide full services, including not only the eye exam but also materials.
- In order to control the quality and cost of materials, VSP doctors are required to use the 350 nationwide VSP contract laboratories for their prescriptions. With less than 25 percent of the nation’s total number of independent optical labs participating, only the best and brightest ever join VSP’s premier system. Even then, gaining membership does not ensure a flow of business. Because VSP doctors can choose any one of the 350 labs, each facility must deliver the finest quality and service to gain and retain a share of business. We believe VSP’s system is far superior to other plans that limit providers to a handful of company-owned labs because they have little competitive incentive to produce a quality product.

A complete list of VSP’s national network is included on diskette as Exhibit B. In addition, Exhibit C contains a complete list of VSP’s contract laboratories.



Information Required from Bidders

D. Bidder's authorized expeditor

J. Paul Austin, senior vice president, Michigan Sales and Services, is authorized to expedite any proposed contract with the state. He can be reached at (248) 448-7341.

Mr. Austin has signed form 285 certifying that he offers to furnish materials and/or service in strict accordance with the requirements of the bid (071I7001057) including instructions and conditions; that prices quoted are correct; and this bid may not be withdrawn for a period of 90 days from the 9-3-97 due date of the bid.

The following responses apply to Vision Service Plan (VSP). VSP will perform as a subcontractor to Blue Cross/Blue Shield of Michigan (BCBSM) for the MPSERS account and will be primarily responsible for the administration of the plan.

- 1. Name one current client for which you are providing vision care administration services (insured or ASO) which has at least 40,000 active and/or retired participants. Provide the name, title, address and telephone number of a person at the client who may be contacted by MPSERS.**

Client	Contact Information	Number of Employees
Michigan Public School Employees Retirement System	Phillip Stoddard, Department of Management and Budget P O Box 30673 Lansing, MI 48909-8103 (517) 322-6033	93,500
Michigan Education Special Services Association (MESSA)	Jim Hobson, Director Field Services P.O. Box 2860 1480 Kendale Boulevard East Lansing, MI 48823 (517) 332-2581	89,750

As VSP will be the claims processor, we have included their clients as reference.

- 2. Name three current clients for which you are providing vision care administration services (insured or ASO) which each have at least 20,000 active and/or retired participants. Provide the name, title, address and telephone number of a person at each client who may be contacted by MPSERS.**

Client	Contact Information	Number of Employees
Chrysler Corporation	Don Longnecker Manager, Health Care Planning 1000 Chrysler Drive Auburn Hills, MI 48326 (810) 512-2498	33,900

Disney Worldwide Services	Dennis Loney, Corporate Manager P O Box 10130 Lake Buena Vista, FL 32830 (407) 824-4488	65,000
United Parcel Service	John Ball, Director of Benefits 55 Glenlake Parkway, NE Atlanta, GA 30328 (404) 828-6689	111,500

As VSP will be the claims processor, we have included their clients as reference.

3. Name three current public-sector clients for which you are providing vision care administration services (insured or ASO). Provide the name, title, address and telephone number of a person at each client who may be contacted by MPSERS.

Client	Contact Information	Number of Employees
State of Ohio	Scott Solsman, Benefits Administrator 106 N High Street Columbus, OH 43215 (614) 466-9081	40,700
University of California	Michele French Director, Health/Welfare Benefits 300 Lakeside Drive Oakland, CA 94612 (510) 987-0164	91,000
State of Indiana	Peggy Montgomery, Compensation/Benefits Officer 402 West Washington, Room W161 Indianapolis, IN 46204 (317) 232-3094	37,500

As VSP will be the claims processor, we have included their clients as reference.

4. How long have you been in the group vision care administration business? In Michigan?

BCBSM has been in the group vision administration business since 1974, both nationally and in Michigan

Vision Service Plan (VSP) has been in the group vision care administration business for a total of 42 years. Our organization was established in California in 1955, and our operations in Michigan began in 1967 (30 years ago). VSP has become the industry's largest vision care plan by focusing solely on providing high-quality, high-value benefits. As you'll see throughout this response, we believe strongly in the overall health benefits of eyecare and our plans are designed to protect the visual welfare of our members.

5. How many group vision care contracts (insured and ASO) do you administer? For the current year and each of the last four years, how many active and retired participants have you administered group vision care plans for?

BCBSM currently covers more than 714,000 members through approximately 319,000 group contracts.

Currently, VSP covers more than 21 million members (employees plus dependents) through nearly 12,000 group contracts nationwide. Of these, approximately 12 million members are covered through fully-insured (risk) contracts, while 9 million are through self-funded contracts.

VSP

YEAR	NUMBER COVERED
1996	20 million
1995	16.8 million
1994	14.5 million
1993	11.3 million
1992	9.5 million

6. If you have a rating from A. M. Best, specify it.

BCBSM does not have an A.M. Best rating

VSP's assigned rating from A.M. Best is "B+" (very good). VSP has been assigned a Financial Size Category of Class V, based on our 1996 financial results. According to A.M. Best, this rating reflects VSP's continued profitability, strong capital support and high quality balance sheet. Although VSP's annual revenues of more than \$870 million support our current established financial strength and stability, A.M. Best considers our substantial growth as cause for caution. On the contrary, VSP has remained financially healthy and successful throughout our history, despite periods of impressive growth.

7. If you have an "ability to pay" rating from Standard & Poor's, Moody's or other "major" financial rating organizations, specify it. If not, is one pending? Have you applied for a rating and withdrawn your application? If you have no rating, do you expect to apply for one? When? If not, why?

Because BCBSM is a non-profit company, it does not have an "ability to pay" rating.

VSP does not have a rating from Standard & Poor's, Moody's, etc. We have never requested one as our financial position does not require use to obtain a credit rating. VSP has no long-term debt other than the mortgages on our buildings, which are secured by the real estate itself.

8. Provide your annual financial report for each of the last three fiscal years.

Copies of BCBSM '94, '95, and '96 annual reports are located in the Exhibits

Please see Exhibit F for VSP's audited financial statements for 1992-93, 1993-94, 1994-95, and 1995-96. As you will see, VSP's financial statements indicate that VSP is a vibrant, healthy organization with the resources to support a strong partnership between VSP and MPSERS.

9. Provide a copy of your most recent Form 10-k if you are required to file one.

Neither BCBSM nor VSP are required to file a Form 10-k.

1. Describe in detail your eligibility system. How does it interface with your claim processing system?

VSP's Benefit Delivery System (BDS) checks patient eligibility on-line, automatically calculating the next eligible service date, and viewing the history of a service request. The system automatically interfaces with our organization's claims system to verify group eligibility, member eligibility, dependent eligibility, service eligibility and service period eligibility. BDS is available on an on-line basis to VSP's Customer Service Representatives, enabling them to assist members and participating doctors with questions ranging from plan benefits, service history, status of out-of-network claims to employee/dependent eligibility.

2. What "problem areas" have you identified in your eligibility system? What enhancements to the system are contemplated or scheduled?

VSP has not identified any "problem areas" within our eligibility system. However, VSP's Information Systems Division (ISD) is working on several new technological directions designed to make our company easier to do business with. They include:

- Internet Doctor Communications (IDC) application. One of our more visible projects, IDC holds great promise because it allows doctors to check member eligibility, place prescription orders and file claims electronically. Over 1,000 VSP doctors are currently using IDC and the numbers are rising daily.
- Member/group communications: VSP's Web site at www.vsp.com allows members to check their eligibility and request benefits via the Internet, as well as locate a nearby VSP doctor. Prospective groups

can learn about VSP and the different plan and service offerings. Visit us at www.vsp.com.

- Client server environment: Given that rapid growth taxes any organization's computer infrastructure, VSP has created a "client server" environment. Client server uses smaller computers than normal mainframe environments and distributes the work over multiple platforms. For example, ISD created a large-scale, client-server-based system in late 1996 to support medical eyecare claims processing. Several enhancements are planned for Medical Eyecare Delivery System (MEDS) in 1997, which will support the processing of Medicaid and Medicare claims, as well as position this system to become VSP's claim system of the future.

3. Provide copies of the plan description brochure and claim kit you would adapt for MPSERS. Provide specimen copies of the identification card you would use for MPSERS.

VSP uses a benefit delivery system that is virtually paperless, so a "claim kit" is not applicable. VSP members enjoy easy access to their vision plan without having to carry an identification card. However, VSP will continue to provide ID cards for MPSERS retirees as we have in the past. A proof of an updated MPSERS' personalized VSP brochure (including ID card) is included as Exhibit G. When patients are ready to access benefits, they simply contact a VSP participating doctor and identify themselves as VSP members. VSP and the doctor's office handle all of the details, from coverage verification to claims submission, etc. All in-network claims are paperless and do not require any submission of forms or receipts by the patient. Currently, 87% of MPSEER members obtain services from VSP participating doctors. Out-of-network claims are reimbursed according to a published schedule. Claim receipts for non-participating provider services

need only be sent to VSP for reimbursement. A special form is not necessary.

1. Explain the banking arrangements you normally use for funding benefits through an ASP arrangement. Note: A bank selected by the State must be used as the bank on which claim drafts are drawn.

BCBSM will notify MPSERS via telephone and electronic mail transmittal of the amount due for the prior month's claims. MPSERS may use their bank, National Bank of Detroit, as a conduit to transfer the monthly payment to our account.

Notification of the wire amount will be made by 11:30 AM on a Tuesday of each month. Payment is due the next day on Wednesday. In the event of a holiday, notification and/or payment will be made the following day.

2. Is an initial claim payment account deposit normally required to establish banking arrangements for an ASP plan? If so, explain the terms and amounts in detail, and how this deposit requirement might change from year to year.

VSP does not currently hold a deposit on behalf of MPSERS. The current arrangement is that MSPERS submits payment within the first week of the month. BCBSM/VSP has waived the requirement for an initial claim payment account.

3. In addition to the requirements described in the RFP, what other services do you provide on a standard basis under your ASP contract?

The following describes all the services provided under an ASC contract arrangement. The scope and level of service for MPSERS goes well beyond this list and is documented in a number of places throughout this RFP response. BCBSM/VSP prides itself on superior delivery of services

to *all* of its customer groups and covered members. MPSERS' high-profile status within VSP ensures constant monitoring of performance at every level of the arrangement. Our working relationship combines the best of both to ensure outstanding delivery of services. We anticipate the accrual of additional benefits to MPSERS, as system enhancements and improved coordination develop.

Administrative services provided by VSP include the following:

- Compile and maintain usual and customary fee data for all participating providers.
- Set participating doctor fees to achieve savings below usual and customary charges by approximately 20%.
- Use computer profiles of participating doctors to monitor practice utilization characteristics (i.e., prescribing rate, type of examination provided, etc.)
- Monitor compliance of VSP rules and procedures through various audits of participating doctors.
- Credential prospective participating doctors according to NCQA standards.
- Print and maintain updated participating doctor directories (hardcopy and diskette) nationwide.
- Monitor wholesale pricing levels and negotiate contract laboratory fees to maximize VSP cost-effectiveness.
- Contract with wholesale ophthalmic laboratories throughout the U.S. for cost and quality control.
- Assure patient satisfaction through formal complaint resolution procedure.
- Conduct surveys to determine patient satisfaction level - both on an overall and specific client basis.

- Nationwide toll-free phone number and customer service from 9:00 a.m. to 9:00 p.m. (Eastern Standard Time), with automated IVR system available to provide support during and after regular business hours, as well as on weekends.
- On-line computer capability for Customer Service to answer questions concerning eligibility, coverage and claim payments with one phone call.
- Provide comprehensive reports and utilization data
- Process participating doctor claims and make payments to participating doctors for covered services.
- Process out-of-network claims and make payment to patients.
- Maintain and expand VSP's data processing capabilities for efficient service.
- Compile and utilize underwriting data to include illustrative rates
- Participating doctors obtain authorization to provide the patient with services and/or materials while verifying the patient's plan coverage and eligibility.
- Provide current list of participating doctors for the patient's area upon request.
- Maintain Disaster Recovery Program in the event of fire or natural disasters.
- Print brochures and maintain a supply for future use.
- Maintain interactive web site for groups, members and participating doctors.

4. Describe your standard reporting package on ASP accounts and your ability to generate ad-hoc reports. Provide a specimen copy of all financial reports you would present during the year and at year end.

BCBSM/VSP offer a variety of reports to help effectively administer your vision plan. Comprehensive reports typically include utilization, claim

detail, service profile, claim summary and/or value reports, provided at no additional charge. The following descriptions briefly summarize each of these reports:

Quarterly Settlements

Approximately 60 days after the close of each quarter, BCBSM will reconcile the amounts we actually paid for MPSERS' benefits as reported in the monthly claims listings.

Rate Renewals

Each year, normally 30 days prior to rate renewal, MPSERS will receive a renewal package providing the adjusted administrative fee, projected claims and illustrative rates for the new contract year. Your renewal package can be provided earlier than the 30-day notification upon your request.

Utilization Report

This detailed analysis provides simple, yet comprehensive data regarding the total cost of claims. The report, available on a quarterly or monthly basis, shows the number of individuals covered, gross dollars received to pay claims and administer the plan, number of paid claims, average claim cost and patient age. Cost information is broken down by month, on a cumulative basis for the last 12 months and year-to-date.

Claim Detail

BCBSM/VSP provide the claim detail report monthly for self-funded programs. This report serves as an invoice for claim payment and lists each person who used the plan, as well as the type/cost of services received. The claim detail report shows information for both in- and out-of-network claims. This report is currently being provided to MPSERS in hard

copy. However, if desired, VSP can also provide MPSERS' data via diskette and/or electronic data interface (EDI).

Service Profile

BCBSM/VSP can generate a service profile report which provides a high level overview of utilization data, such as the percent of patients obtaining each type of service, average rate and claim cost history, as well as other pertinent data. We typically provide this report on an annual basis, upon request.

Claim Summary

This report includes detailed information on the type and frequency of services obtained, separated by in- and out-of-network claims. The claim summary report includes the amount billed by service type, and an outline of the number, type and cost of cosmetic options selected by patients. Upon request, BCBSM/VSP can provide the claim summary report monthly, quarterly or annually.

Value Report

This report allows our customers to analyze savings achieved under the VSP program by providing detailed assessment of the number and type of services obtained. BCBSM/VSP's value report reflects the average dollar and percent savings under the VSP program as compared to average usual and customary (retail) charges. Upon request, we can provide the value report quarterly or annually.

Please see Exhibits H through L for samples of these reports.

All of the reports described above either are or will be customized to reflect MPSERS-specific information. In addition, BCBSM/VSP can

provide ad-hoc reports that list any complaint activity from MPSERS members, as well as various claim information.

5. To what extent, and how, will you assist a retiree if a provider insists on collecting charges in excess of reasonable and customary?

As a condition of membership, participating doctors must accept VSP's discounted fees as payment-in-full for covered services. The doctor is not allowed to collect additional monies from the covered member, other than the copayment, if applicable, and controlled fees for cosmetic options selected by the patient. If such a situation were to occur, VSP would contact the doctor on the patient's behalf and resolve the situation.

6. Provide samples of all documents requiring signature by the State for implementation of the ASO arrangement.

A sample ASC contract is included as Exhibit M.

7. Provide a general discussion of your method of determining renewal ASP fees.

Administrative expenses are developed by analyzing MPSERS' claim level and the cost associated with processing these claims. This amount, when added to the cost of other servicing functions performed for your group (i.e., customer service, actuarial, etc.), as determined through our cost allocation methodologies, results in an administrative expense for MPSERS.

8. How do you determine "reasonable and customary," or "usual customary and reasonable?" Be specific. At what percentile of charges is your R&C set? How often do you update R&C? Do you attempt to control R&C "creep?" If so how?

VSP requires all participating providers to prefile their fees. VSP compensates participating doctors for their professional services on a discounted fee-for-service basis. This variable fee system pays a percentage of each doctor's prefiled usual and customary fees, not to exceed regional caps set by VSP. The collection of all fees in our data base allows us to determine U & C for all participating providers.

All providers are paid at rates less than their prevailing U & C filed fees. VSP pairs all providers according to a formula which discounts exam and dispensing fees up to statewide fee caps, set at the 80th percentile. In Michigan, exams are discounted a minimum 15% and dispensing fees substantially more.

On average, VSP pays approximately 20 percent less than usual and customary for professional services and pays wholesale costs for lenses and frames. As a condition of membership, participating doctors must accept VSP's discounted fees as payment-in-full for covered services. For non-covered options, participating doctors must charge patients according to VSP's patient options price list, which VSP sets and controls.

Fee maximums and discounts are reviewed by the VSP Board of Directors on an annual basis. Any adjustments to these must be approved by an independent public policy committee that includes representatives from groups with VSP coverage. All adjustments consider CPI as a factor.

9. If R&C or UCR are not applicable in your system, explain why.

Please see answer to question number 8 above.

Since more than 16,000 providers participate with VSP and must file their

fees, we consider our data base reflective of U & C for independent practitioners. VSP delivers services and materials to all covered members at costs well below prevailing U & C costs.

1. Describe your computerized vision care claim payment system in detail.

Claims Processing Overview

The following details VSP's automated claims system:

- A VSP claim processor reviews each claim and identifies the services provided.
- The processor enters claim information into VSP's computer system.
- The claims system automatically interfaces with our organization's automated eligibility system to verify group eligibility, member eligibility, dependent eligibility, service eligibility and service period eligibility.
- The claim system automatically calculates payment.

Claims Computer System Profile

Our IBM 9672-RC4 mainframe computer supports VSP's claims processing system. With 33 parallel channels and eight ESCON channels, the system boasts some 1,024 megabytes of memory and represents IBM's latest technology. Using the same CMOS technology as employed in PC manufacturing, this state-of-the-art system can be upgraded overnight with a simple software change. It also has the following characteristics:

- Twenty-four hours a day, seven days per week computer service
- Disc storage capacity: 265 Gigabytes.
- Uninterruptable power supply by battery.
- Disaster recovery support provided by Comdisco.
- On-site generator supported power source.

VSP's current on-line claim system represents a major portion of our mainframe and our organization continually enhances it to insure its

integrity and expand its capabilities. The following descriptions outline the systems playing a role in the overall claims process:

- VSP's Benefit Delivery System (BDS) checks patient eligibility on-line, automatically calculating the next eligible service date, and viewing the history of a service request.
- Group Facts is a software application written by ERISCO and customized for VSP. This application tracks group and eligibility data for billing, posts revenue, and generates 5500 reports and renewals, as well as performing other administrative activities.
- The Professional Relations Operating System (PROS) manages VSP's doctor network fee reimbursement. This system accommodates all of VSP's available benefit plans.
- The Medical Eyecare Delivery System (MEDS), VSP's newest system, was developed primarily for VSP's Managed Eyecare (medical/surgical) Program. This new system can generate encounter data based on state requirements, validate HCFA-1500 claim form data (used for processing and paying medical eyecare claims), and verify the data against group-provided membership information.
- Vision Service Plan maintains on-line claim information for two years after which the information is retained on microfiche for three years.

2. From what location(s) would claims be paid for MPSERS' retirees?

In order to facilitate fast and efficient claims processing, we operate

claims processing sites in the west and east. Each site uses the same claims processing system and claim database, as well as procedures and pricing rules. Claims generated in the east are processed in Ohio at:

Vision Service Plan

3400 Morse Crossing

Columbus, OH 43219

1-800-462-7009

Claims in the west go to California at:

Vision Service Plan

3333 Quality Drive

Rancho Cordova, CA 95670

1-800-852-7600

3. How many employees do you estimate it will take to administer all aspects of the MPSERS account? If you are awarded the contract, how many new employees will you need to hire?

As the current administrator of the MPSERS account, VSP has proven its ability to effectively manage all aspects of the program. Therefore, it will not be necessary to hire additional employees should the contract be awarded to BCBSM with VSP as the subcontractor. Efficient claim adjudication is currently being handled by 20 claim processors in VSP's Eastern Operations Center, who are trained to handle all claims from VSP's customers in the Eastern part of the United States. In total, VSP employs over 1,600 people dedicated exclusively to the administration of vision care programs.

4. How do you hire claim processors? What are the educational and/or experience requirements? Do you train them in-house? If so,

is training done on the job or in a classroom? Do claim processors pay all coverages or do they specialize? What career path opportunities are available to claim processors?

Qualifications for Claim Processors

Claim processors' experience and qualification requirements vary from entry level to senior positions. Entry level requirements include skills such as general office experience, proficient reading and writing ability, good eye/hand coordination, computer keyboard familiarity and the ability to operate standard office equipment. More advanced or senior level requirements include the previously listed skills, as well as basic mathematical skills, ability to meet deadlines in a production environment, basic knowledge of word processing and spreadsheet applications, and the ability to reconcile statements.

Training

Training for claims processors is conducted in a modular process. Each module contains the procedures that apply to a claim type (i.e., examination, lenses, frame, and/or contact lenses). The modules are combined to create a training program which meets specific processor's job requirements. On average, twenty (20) to sixty (60) hours of training is provided. Also, if additional time is required for specialized functions or procedures, supplemental/specific training is provided. Typically, claim processors specialize in processing either in-network or out-of-network claims, but are not designated to individual customers.

Career Path Opportunities

Within the Benefit Services Department, there are essentially six levels of claim processing positions, which vary in level of responsibility, authority, and corresponding salary. These opportunities range from entry level claim processing, through high-level processing of medical/surgical

eyecare claims. In addition, as individuals acquire and refine their skills and knowledge, they may become qualified for higher level positions outside the department. VSP posts available positions throughout the company on a weekly basis and maintains a process for inter-departmental applicants to be considered for open positions before they are advertised outside the organization

5. How do you assure that claim payment turnaround will be maintained during periods of heavy utilization or turnover in staff?

Turnaround time is never a worry for our customers. The vast majority (87 percent) of MPSERS' members see a participating doctor for their care and do not submit claims. Instead, the patient simply pays the \$5.00 examination copayment, the \$7.50 material copayment and for any cosmetic extras selected at the time of their visit. VSP then pays participating doctors directly once per month for claims received during that month.

In the event that a patient chooses a non-participating provider for care, he or she must pay the bill in full and submit a claim to VSP. In accordance with MPSERS' RFP requirements, our performance standard is to process out-of-network claims within 10 working days.

With over 40 years of experience, VSP has refined its ability to ensure timely claims processing regardless of high volume or staff turnover. In addition to the 20 claim processors available in our Eastern Operations Center, VSP also has approximately 60 processors at our Sacramento headquarters that can assist in times of need.

6. Describe your customer service unit. Will callers speak with the processors who pay the claims or will you use a separate

“customer service unit?” During what hours does the inquiry system operate? What about weekends and holidays? After hours? Describe your telephone system. How do you assure that calls are answered promptly? Do “customer service” representatives have on-line access to claims? How do you track pending inquiries? How do you monitor quality?

When MPSERS members have questions about claims, they can call VSP's Customer Service Call Center. The toll-free telephone number, (800) 877-7195, gives patients the option of using our automated Interactive Voice Response (IVR) system, or speaking with a customer service representative. VSP's customer service representatives are available Monday through Friday from 8:00 a.m. until 5:00 p.m., Eastern Standard Time (EST). Also, to accommodate Saturday appointments, customer service representatives are available for doctors on Saturdays from 9:00 a.m. to 2:30 p.m., EST. Additionally, VSP's Interactive Voice Response (IVR) system is available to provide automated support both during and after regular business hours, as well as on weekends.

VSP's system maintains complete plan benefit information on-line. Our customer service representatives and claim processors have on-line access to pertinent patient data such as eligibility, past service and plan coverage information. VSP maintains on-line systems that enable our employees to provide immediate, quality assistance to our customers.

VSP maintains several performance standards for our Customer Service Call Center as outlined below:

Performance Area	Standard	Actual (Q2 1997)
Average Speed of Answer	30 seconds	14 seconds
Abandonment Rate	5% or below	1%
% Inquiries Resolved on 1st Call	97%	98%

% of Calls Answered within 60 seconds	90%	95%
---------------------------------------	-----	-----

Written inquiries are typically routed to VSP’s Research and Adjustment Department, and 99 percent are normally resolved within 48 hours. Pending inquiries are tracked electronically through our Research Inquiry (RI) system. The RI system captures all pertinent data relating to inquiries and/or claims and is used to monitor activity and follow-up on all pending inquiries.

VSP maintains quality through our Customer Service Audit Program. This program is outlined in detail in the response to question 29 below

7. What is the average turnaround time in processing vision care claims? How do you define “turnaround time?”

In-network claims are submitted directly to VSP by the participating doctors, and VSP pays participating doctors and contract laboratories directly for services and materials. Therefore, the turnaround time for in-network claims is irrelevant from the patient’s and group’s perspective. VSP measures timeliness for only out-of-network claims by calculating the number of working days between the received date and the date we mail the check to the patient. In accordance with MPSERS’ RFP requirements, our performance standard is to process out-of-network claims within 10 working days.

8. What are your claim processing standards? How do your actual results for the last 12 months (specify period) compare with the standard in the office or offices that will be used to pay MPSERS’ claims?

VSP maintains some of the highest claim processing standards in the

industry. Quarterly claim audits confirm our efficiency in this area. VSP's current performance standards are as follows:

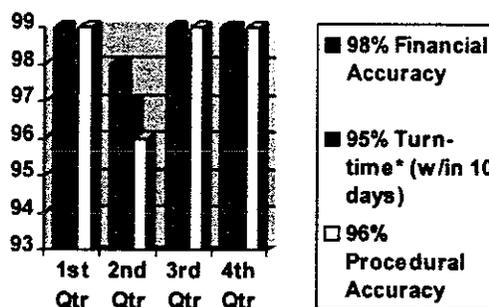
Financial Accuracy: 98 percent
 Turn-Time* (w/in 10 days): 95 percent
 Procedural Accuracy: 96 percent

** Because VSP pays participating doctors directly for in-network claims, turnaround time is measured for out-of-network claims only.*

Effective January 1, 1998, VSP's standard for turn-time will be 95% within 5 days. However, in accordance with this RFP's requirements, our performance standard will be to process all MPSERS' out-of-network claims within 10 working days.

Listed in the chart below are VSP's actual results for each of these performance standards by quarter for 1996. These results apply to both VSP's corporate office and our Eastern Operations Center.

1996 Results by Quarter



** Because VSP pays participating doctors directly for in-network claims, turnaround time is measured for out-of-network claims only. The standard listed here is VSP's usual benchmark. However, in accordance with MPSERS' RFP*

requirements, our performance standard will be to process all out-of-network claims within 10 working days.

9. What is your total error rate per 100 vision care claims? Include financial and non-financial errors. What is your financial error rate per 100 vision care claims? Define “non-financial error” and “financial error.” Describe in detail your system for counting errors. Provide MPSERS with copies of your most recent management reports detailing your error ratios.

VSP calculates claim error rate as a percentage. Our most recent company-wide results (July 1997) are as follows:

	Standard	Actual
Financial Accuracy	98%	99.76%
Processing Accuracy	98%	99.23%

VSP defines “financial error” as that which results in a payment error to the group, provider or lab. We calculate financial accuracy on a monthly basis based upon a randomly selected daily sample of both participating and non-participating doctor claims. The sample size used by VSP’s Audit Unit to pull random samples is calculated through a large-sample, statistical equation that provides a high level of confidence in results. These selected claims are audited for financial accuracy, and any apparent discrepancies are recorded. At the end of the month, these variances are totaled and taken as a percentage of the total dollar amount paid for all claims audited over the month. To be within our standard, this percentage must be no more than 2%.

A “non-financial” error is referred to by VSP as a processing error. Processing errors are those that are caused by a processor whether it caused a payment error or not. Processing accuracy is reckoned in a manner similar to financial accuracy. The same claims audited on a daily

basis for financial accuracy are also audited daily for processor errors. At month's end, all processor errors for the month are totaled and taken as a percentage of the total number of claims audited for the month. Our standard is 98% or more of claims processed without errors.

As requested, copies of the most recent quality control audit reports are included as Exhibit S.

10. How do you define a claim transaction? What is the maximum number of services per claim?

VSP refers to claim transactions as paid claims. A paid claim consists of a reimbursement check issued to either a VSP participating doctor for professional services and/or a VSP contract laboratory for material fabrication. Also, a paid claim can be a reimbursement check sent to a covered member or non-participating provider for services received out of the network. Whether patients receive an eye examination only, examination and lenses, or examination, lenses and a frame, all are considered one paid claim when submitted on the same claim form. Due to the nature of vision care, the maximum number of services per claim is three (exam, lens, and frame).

11. How many transactions on an average day does a claim processor process? How would you expect this to vary for this plan?

Claim processors handle anywhere from 12 to 300 claim transactions per day, depending on the complexity of the claim and the skill level of the processor. For those processors handling routine claims for full-service plans (exam, lens and frame), the average is 100 per day. This average is consistent with the number of MPSERS claims VSP has been processing, and we do not expect it to change significantly.

12. Describe in detail your claim paying process from receipt of claim to payment or denial. Explain what steps are automated. Explain what information the processor must put into the computer system. Are any operations done on a manual basis? If so, describe how the quality of these procedures is maintained and audited.

The following details VSP's automated claims system:

- A VSP claim processor reviews each claim and identifies the services provided.
- The processor enters claim information into VSP's computer system.
- The claims system automatically interfaces with our organization's automated eligibility system to verify group eligibility, member eligibility, dependent eligibility, service eligibility and service period eligibility.
- The claim system automatically calculates payment.

Vision Service Plan's claim, eligibility and processing procedures include varying degrees of automation, mixed and manual intervention. The following table outlines several categories and their corresponding level of automation.

Item	Automated (the data is accessed automatically by the computer in processing the claim)	Mixed (data is accessed by the processor and manually entered into the computer, which then completes processing)	Manual (data is accessed and the benefit calculation is completed by the processor)
UCR limitations		✓	
Provider verification	✓		
Eligibility verification		✓	
Plan specifications	✓		
EOB messages		✓	
Update claim history	✓		
Copayments	✓		

Annual maximums		✓	
COB data			✓
Duplicate bills		✓	
Dependent child age limits		✓	
Claim payment calculations	✓		

VSP's current on-line claim system has been continually enhanced to ensure its integrity and expand its on-line capabilities. Our systems document and track various information, including patient eligibility, claims and plan information.

Vision Service Plan maintains an extensive claims audit program to ensure that claims are quickly and accurately verified for eligibility and processed for payment. This program is explained in detail in the response to question 29 below.

13. Does your system have a facility for bulk payment to providers? If so, describe. Does it reduce costs and if so, how much?

Yes, VSP reimburses participating doctors on a monthly basis with one check. The check will include payment for all relevant claims processed within that month. This system does reduce costs, as it eliminates the need for producing and mailing a separate check for each patient seen by the doctor. The number of reimbursements included in a doctor's check varies widely, depending upon the doctor's volume of VSP patients. Therefore, it is difficult to estimate the total dollar savings. The components involved would be the check printing costs, the cost of mailing materials, and additional postage expense.

14. What percentage of your claims require additional information? How are pending claims handled? Is the filing and call-up automatic or manual?

Approximately 20% of the claims we receive require additional information. In-network claims are simply returned to the doctor if additional information is required. This process does not affect the patient, since the patient simply pays their copay and any cosmetic extras. All claim submission and payment is handled directly between VSP and the doctor. If additional information is needed for an out-of-network claim, the claim is pended electronically, and the patient is contacted by VSP with a request for the missing information.

15. What minimum data do you require to process a claim? What does the processor do if information is missing? How do you assure that the rules for obtaining missing information are followed? Note: See *Utilization Data Requirements in Section V.*

For in-network claims, the following information is needed and captured by our system to process the claim:

- Patient eligibility verification
- Benefit calculation
- Application of deductible
- Error interpretation
- Benefit checks printed
- Duplicate bill check
- Reduction of benefit due to lack of medical necessity
- Coordination of benefits check
- Any contract limitations
- Contract applicable to submitted claim

If any of this information is missing from an in-network claim, the processor returns the claim to the participating doctor with a request to

supply the missing information. To ensure that the rules for missing information are followed, VSP's procedures include electronic edits, as well as audits conducted on our claim processing staff and systems.

16. What controls do you use to guard against duplicate payments? How does your system control payments to payees other than the retiree or provider? How does the system deal with over and under payments? How does your system prevent unauthorized access to computer facilities?

Utilizing the eligibility information supplied by MPSERS, VSP verifies the patient's eligibility prior to authorizing services and/or materials. The eligibility tape BCBSM receives from MPSERS will be VSP's guideline for identifying those employees who are eligible for benefits. VSP's computer system prevents duplicate payments by tracking all services rendered to employees and their designated eligible dependents. When the system is accessed by Social Security number, all past service for the employees and dependents is displayed showing date(s) of service(s) and description(s) of service(s).

VSP's formula for computing claims payment accuracy and error rate includes both underpayments and overpayments. Selected claims are audited for financial accuracy, and any apparent discrepancies are recorded. At the end of the month, these variances are totaled and taken as a percentage of the total dollar amount paid for all claims audited during that month.

VSP uses Computer Associates' TOPSECRET product to password-protect all automated information. This product has a C2 security level as defined by the U.S. Government. It provides audit trails by user ID and allows us to monitor dataset access by user ID. The password security for

our mainframe and PC environments requires unrepeatable password changes every 90 days.

17. Describe your procedures for preventing fraudulent claims. Describe any other security features of your system which you consider particularly significant.

In the vision care industry, insurance fraud is extremely rare. However, VSP prevents fraudulent claim submission in various ways, most notably by verifying the patient's eligibility prior to authorizing services and/or materials. As noted above, the eligibility tape BCBSM receives from MPSERS will be VSP's guideline for identifying those employees who are eligible for benefits. The use of the Social Security number or assigned identification number is how VSP's system identifies an eligible group member. Individual dependent eligibility may also be tracked if supplied by MPSERS.

VSP's computer system tracks all services rendered to employees and their designated eligible dependents. When the system is accessed by Social Security number, all past service for the employees and dependents is displayed showing date(s) of service(s) and description(s) of service(s).

Procedures to Identify Fraudulent Claims

VSP maintains several procedures through our Health Care Services Division to identify participating doctors involved in fraudulent claims. Outlined below are several means by which VSP monitors potential fraudulent claims:

- Through the Doctor Audit Program, VSP verifies that the participating doctor's filed fees are, in fact, less than his or her

usual and customary charges. If VSP finds that the doctor's filed fees are equal to (or more than) usual and customary, the doctor's fees are reduced accordingly.

- If a participating doctor is charging more than allowed on cosmetic extras, restitution will be made to the patient. Additionally, the participating doctor will go through a quality review process to further educate the participating doctor and his or her staff on VSP policies.

Also, when participating doctors receive authorization from VSP, the exact benefits a patient may obtain are provided. When the participating doctor and/or contract laboratory submits the claim to VSP for payment, VSP's system verifies that the services billed were actually benefits available to the patient under their plan coverage.

Fraud Actions

If we suspect fraud, a thorough review is conducted. If the review determines there is a problem with the participating doctor's understanding of VSP requirements, the following actions can take place:

- The participating doctor or staff may be required to go through an education process about VSP policies and procedures
- If VSP receives a complaint regarding a participating doctor's behavior, his or her VSP membership may be suspended
- If warranted, the case may be reported to the appropriate licensing agencies and/or over to the appropriate legal authorities.

18. How frequently are checks issued and EOBs prepared for participants? Providers? Do you batch claim payments to providers?

Since VSP pays participating doctors directly, we do not send a separate EOB to patients for in-network services. Instead, the doctor typically provides the patient with a copy of VSP's BASIC claim form, which the doctor also submits to VSP for payment. This serves as the patient's EOB. This form identifies the services, the \$5.00/\$7.50 copayment(s) and any cosmetic options the patient may have selected. Also, the participating doctor includes his or her usual and customary fees, which communicates the exceptional value of the VSP plan to patients. Please see Exhibit N for a copy of VSP's BASIC claim form.

VSP issues checks to participating doctors once a month, which includes payment for all claims processed within that time period. Included with the check is an itemization of each payment and the corresponding patient information.

With VSP's outstanding network accessibility, most patients receive services from participating doctors. However, to ensure freedom of choice, VSP provides a reimbursement schedule for patients obtaining out-of-network services. Please see Exhibit O for a sample EOB, which VSP includes with members' out-of-network reimbursement checks. VSP processes out-of-network claims and issues checks and EOBs on a daily basis.

19. Provide samples of your checks and EOBs. Provide a list of your standard messages. Explain in detail, your capability to customize messages.

As mentioned above, Exhibits N and O include a copy of VSP's BASIC form and sample EOB. At this time, VSP's system does not offer

customized messages on out-of-network EOBs

20. Does your computer system generate inquiry or follow-up letters? If yes, provide a complete list and at least five sample letters.

Yes, VSP's system generates a variety of inquiry letters. A complete list of these letters is included as Exhibit P, and Exhibit Q contains five samples.

21. Describe in detail how your provider EOBs will identify for the provider which bill is being paid.

VSP reimburses participating doctors on a monthly basis. The VSP check statement contains a detailed record of the reimbursements made for services provided to VSP patients. Patient name and social security number is clearly itemized, along with date of service, the group number under which benefits are provided, and applicable copay amount. A sample of VSP's participating doctor check statement is included as Exhibit R.

22. How long do you maintain claim history in the computer? In readable hard copy? How long do you maintain the history of a terminated participant?

VSP retains submitted and paid claim information for a total of five years. We maintain this data on-line for two years and on microfiche for an additional three years. These procedures for history maintenance apply to both current and terminated participants.

23. How are benefit changes input into the system? How long will it take you to change the claim system for a benefit plan change? How do you handle retroactive benefit changes?

Generally, benefit changes are planned and known well in advance. The Senior Account Management Team will have worked with MPSERS staff to determine what is appropriate. After this review and decision process, should MPSERS wish to make a change to their plan design, the MPSERS' designated VSP Account Manager will communicate this information to VSP's Group Services Department. The Group Services Administrator will then make the necessary changes to VSP's computer systems, including eligibility and claims. VSP's performance standard for turnaround on changes to be made is five days.

In the event that a retroactive change is necessary, the same process would be followed. However, those MPSERS members who use the plan in the interim may not receive appropriate coverage levels. Any reprocessing of claims would require manual intervention and possibly additional costs.

24. What categories or types of claims can be flagged or indexed for review? Provide a list. What categories or types of claims are selected for 100% review? What percentage of claims, exclusive of those requiring 100% review, are selected for review?

All claims are reviewed through a series of automated checks in VSP's claim system after they are processed and keyed. In addition, VSP's Audit Unit pulls a random sample of all claim types and begins an audit process to ensure that the claims were processed accurately and within timeliness standards. The sample size used by the Audit Unit to pull random samples is calculated through a large-sample, statistical equation that provides a high level of confidence in the results. VSP typically audits approximately 1,300 claims per month, which represents approximately .02% of our current monthly claim volume.

25. Can specific providers be flagged or indexed for review? Describe how you verify that services on providers' bills were actually provided.

Yes. To monitor the quality of care rendered by VSP participating doctors, and to ensure that VSP guidelines and protocols are being followed by the doctor and his or her staff, VSP utilizes provider quality assurance reviews. The frequency of these reviews may vary based on the doctor's volume of VSP business and results from previous audits. These include practice site reviews, mail-in reviews and peer reviews.

A. Practice Site Reviews: The participating doctor is notified in advance that his or her office is to have a review performed, and the review is scheduled during the doctor's regular office hours.

During the Practice Site Review, the following items are examined:

- The provider's equipment and instrumentation, office access, safety, infection control and frame selection (participating doctors only).
- A review of the provider's medical records for selected VSP patients, which includes delivery and appropriateness of care, all eye examination procedures, diagnosis, treatment, lens/prescription, and billing accuracies.
- The provider's examination records for randomly selected private (non-VSP) patients to assure that VSP patients are receiving the same level of examination and quality of care. VSP requires that each participating doctor treat VSP patients the same as non-VSP patients.

- The provider's financial records for selected VSP patients to guarantee that optional material items and copayments are properly charged to the patient.
- Compliance with all VSP Office Standards (Provider, Managed Care, Contact Lens, and Infectious Disease Control).

After the practice site review, a detailed letter outlining the results is sent to the participating doctor. Where VSP guidelines and protocols are found to be violated, appropriate disciplinary action may be taken through VSP's corrective action program. In some cases, the provider may be required to refund the patient(s) or VSP. In other cases, the provider may be called to appear before a VSP peer review committee before further action is taken. There are certain situations in which the provider may be suspended from VSP membership.

In rare instances, the quality assurance process uncovers evidence of a serious problem, such as fraud. These cases require a review by VSP's Quality Assurance Committee and/or the Quality Care Committee. Furthermore, if serious enough, VSP is required to report the information to the appropriate regulatory agency.

- B. **Mail-In Reviews:** The mail-in review program provides another method to assist in monitoring care. The purpose of mail-in reviews is to reach low volume and remote participating doctors. It allows VSP to stay in contact with a greater number of participating doctors who would not normally be reviewed by the practice site methods. Mail-in reviews are consistent with in-office reviews

regarding frequency, topics for review and the rating scale

- C. Peer Reviews: Occasionally, through the audit program, patient satisfaction questionnaire, or through a direct complaint or concern, VSP uncovers a questionable activity by a participating doctor. VSP will investigate the situation in a confidential manner and, if warranted, will provide the information to a peer review committee. The peer review committee will discuss the situation in question and take appropriate action.

26. Does your system identify potential COB claim situations? If so, how? Do you have or will you have a computer system which automatically follows-up on pending claims awaiting COB inquiry response? If so, describe. Do you follow the “pursue and pay” approach?

At this time, VSP does not track COB activity or follow the “pursue and pay” approach. However, if VSP is made aware of a COB situation through communication from a participating doctor, we will process the claim according the following guidelines:

- The plan that covers the patient as an employee is primary.
- The plan that covers the patient as a dependent is secondary.
- If the patient is a dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan.

The primary plan must pay or provide its benefits as if the secondary plan(s) do(es) not exist. If a VSP plan is the secondary plan, the patient will receive allowances (examination, lenses and frame) that will be used to pay up to, but no more than, 100% of the patient's out-of-pocket expenses.

27. Do you permit claims to be paid in the absence of COB information? If so, describe the procedure.

Yes. VSP assumes primary coverage for all submitted claims, unless information is available to the contrary. Therefore, our typical claims processing procedures apply.

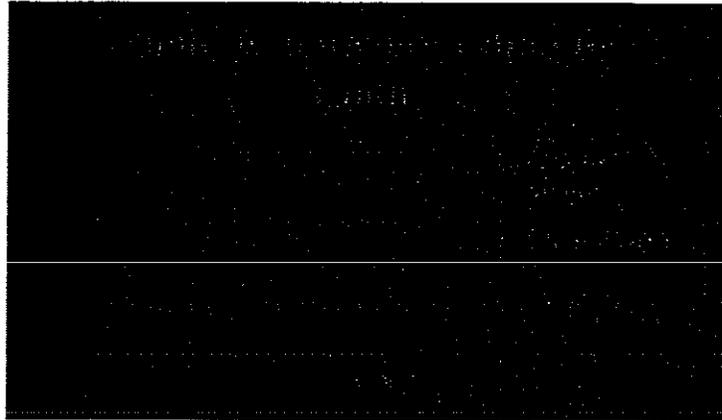
28. Explain how you handle subrogation and third-party reimbursement. Do you actively pursue potential subrogation and third-party payment? Describe your process. How do you credit such amounts? What accounting will you provide to MPSERS?

Subrogation and third-party reimbursement is not applicable to VSP. VSP pays our participating doctors directly and reimburses eligible members directly for out-of-network services.

29. Do you have a program for auditing the quality of your claim processing and customer services operations? Describe the program in detail. Who conducts the audits? How frequently? Provide copies of the most recent quality control audit reports for the office(s) which will administer the MPSERS account.

Claims Audit Program

Vision Service Plan maintains an extensive claims audit program to ensure that claims are quickly and accurately verified for eligibility and processed for payment.



Using statistically valid sampling methods, VSP audits an average of 1,200 claims each month and experiences claim payment errors on less than 2 percent of all claims. That equates to less than one-half of one percent of total claim dollars paid out.

A team of auditors within VSP's Development Department daily analyzes our claim system, as well as individual claim processors and data entry operators. Daily audits include a random sample of all claim types (both in-network and out-of-network claims) VSP conducts claim audits to ensure accuracy in the following categories:

- Out-of-network claim turnaround time
- Financial accuracy
- Claim processing accuracy

Customer Service Audit Program

After extensive study of successful customer service audit programs, VSP developed and implemented an audit program that defines quality

customer service. We identified the components of a quality call, then incorporated these values into a comprehensive audit sheet. Assigning point values and draft definitions allowed us to create an objective, thorough method to ensure quality, accuracy and consistency in our Customer Service Department.

VSP assesses the following areas during a customer service audit:

- proper opening
- identifying the customer's needs
- researching, analyzing and conveying accurate information
- commitment to resolving the issue
- helping the customer to make an informed decision
- professionalism
- proper closing

VSP's customer service supervisors audit representatives eight times per month. Customer service representatives that may require special attention receive additional audits, as well as training and coaching to ensure their performance meets our 95 percent standard.

As requested, copies of the most recent quality control audit reports are included as Exhibits S and T. These reports combine the results of our Eastern Operations Center and corporate offices.

30. Do you have an operational system to determine on a random, or focused, basis whether materials supplied meet quality standards? Describe, and specify any cost implications.

Yes; VSP contracts with more than 350 ophthalmic laboratories throughout the country who agree to rigid quality standards that ensure

VSP prescriptions are fabricated using only the finest quality materials. VSP requires all contract laboratories to follow FDA standards as well as mandating that all lenses and frames supplied through VSP's plans meet the test requirements of the American National Standards Institute (ANSI). Additionally, as a condition of membership, VSP's contract laboratories agree to adhere to all applicable ANSI Z-80 standards. Please see Exhibit U for a sample contract laboratory agreement.

Furthermore, to ensure the integrity and quality of contract laboratories and the materials they provide, VSP conducts regular provider satisfaction surveys regarding contract labs. Using the SERVQUAL measurement system, VSP evaluates the doctor's level of expectation and their perception of the performance received from the contract laboratory. By determining the gap between the two, VSP is able to target any service improvement areas.

VSP's contract laboratory system offers the best in choice, quality and value. We contract with the nation's finest wholesale ophthalmic laboratories. In fact, less than 25% of the country's independent wholesale labs are qualified to participate in VSP's network. Once a member, each lab must compete with other participating labs on cost, quality and service in order to gain and retain business from our doctors, who are free to choose any lab in the network.

31. Describe methods you would use to minimize participant costs for the broadest selection of frames and extra charges for tinted, oversized lenses, etc.

One outstanding feature of VSP's program is its frame selection. Members may choose *any* frame they like, making VSP's frame selection the broadest available. MPSERS' current plan design covers the full cost

(after \$7.50 copay) of frames, wholesaling for \$23 or less. If a more expensive frame is selected, the member is responsible for paying an additional amount, controlled by VSP and agreed to by the participating providers. Typical frame mark-up can run as much as two and one-half or three times the wholesale price. By choosing VSP, MPSERS' members would avoid these mark-ups because we base our frame coverage on wholesale pricing. Unlike other plans that subject members to retail pricing or that limit the member's selection to a "collection" of frames, our wholesale benefits offer numerous advantages, including:

- **Consistency of benefit.** Because the frame allowance is based on wholesale, your members do not deal with the fluctuation in frame mark-up that commonly occurs from doctor's office to doctor's office. With VSP, MPSERS' members receive the same benefit whether choosing a frame in Michigan or Washington, D.C. because the entire system is based on wholesale.
- **Superior coverage.** Your \$23 wholesale allowance represents a substantial benefit, fully covering some 4,200 of the 20,000 frames on the market today. VSP's current "standard" is a \$40 wholesale frame allowance, which covers over 50% of the frames in current manufacture. Please see our comments in answer to question 3 in Section V, regarding plan design changes on possible improvements in this level of coverage. Please see Exhibit V referring to the Frame Facts analysis.
- **Cost controls when the frame chosen exceeds the allowance:** VSP's method of frame coverage clearly provides patients with the best value, as illustrated below:

VSP Wholesale Frame Coverage	
Retail Frame Price	\$ 90
Wholesale price of frame	\$ 30
Wholesale plan allowance	<u>\$ 23</u>
Difference between allowance and cost	\$ 7
Patient's Extra Cost	\$7 x 2 = \$ 14

In the above example, the patient pays only \$14 additional, even though the retail price of this frame may be as much as \$90. Other vision plans may force patients to settle for a limited frame "collection" or accept a minimal *retail* allowance (sometimes as low as \$15), which can result in *substantial* out-of-pocket costs. For example, a \$15 retail allowance covers *less than 1 percent* of the frames available on the market today. Using the \$90 retail frame example above, a patient would pay an extra **\$75** under some competing vision plans, as compared to the additional \$14 paid under VSP for the *same frame*. Clearly, VSP's wholesale frame coverage provides patients with the best in choice and value

Patient Options

Our vision plan is designed to fully cover services necessary for the patient's visual welfare. However, to ensure added value, VSP discounts cosmetic options an average of 20 percent below retail.

Many patients wish to purchase cosmetic options at a discounted price. That's why we offer the most extensive list of cost-controlled cosmetic options in the industry. In fact, for every one option offered by the competition, VSP cost-controls two.

Other plans offer cost controls only on a limited number of cosmetic options, which restricts patients and doctors to certain brands and allows doctors to collect more money from the patient. VSP's cost controls ensure maximum value to patients for *all* services and materials. Because VSP cost-controls all cosmetic options from scratch coating to high-index progressive lenses, patients and doctors are free to choose the brand that best accommodates their needs.

Our vision plan also provides discounts on additional pairs of glasses and contact lens services. These discounts include 20 percent off of the participating doctor's usual and customary fees for additional complete pairs of prescription glasses, and 15 percent off of their professional services for prescription contact lenses (materials not subject to discount.) Offered through the participating doctor who last provided the covered eye examination, these discounts are valid for a period of twelve months following the covered eye exam.

32. Do you have a program for auditing the quality of your claim processing and customer service operations? Describe the program in detail. Who conducts the audits? How frequently? Provide copies of the most recent quality control audit reports for the office(s) which will administer the MPSERS account.

See answer to question 29 above.

1. Do you provide a set of utilization reports as part of your standard ASP package? If so, provide specimen copies. Would these reports produce additional cost to MPSERS if produced? How much?

VSP offers a variety of reports to help you effectively administer your vision plan. Our comprehensive reports typically include utilization, claim detail, service profile, claim summary and/or value reports, provided at no additional charge. These reports are described in our response to question 4 in Section III above, and samples are contained in Exhibits H through L.

2. If you indicated any difficulty with providing all data specified by Appendix C, explain why. How do you propose to meet the requirement?

We do not currently track COB savings for vision claims and our systems are not set up to accommodate this. When we are aware other coverage exists, we will coordinate; but we do not track resulting savings. If this remains a critical issue with MPSERS, we will work with staff to attempt to provide key information.

3. What plan design changes would you propose to better control plan costs without reducing benefits?

The MPSERS program does an excellent job of providing basic vision benefits to its members. While a case may be made to increase coverage, it becomes a matter of economics and necessity. One area that could be improved would be to offer an improved frame allowance. Every dollar improvement in wholesale frame allowance saves your members two dollars in out of pocket. But, MPSERS costs do not increase by the same amount, due to the cost arrangements in place with VSP's providers. We have included a Frame Facts study (Exhibit V) which outlines the number and percent of all frames in current

manufacture by wholesale frame cost. You will note the majority fall within \$40, VSP's current standard allowance. We recommend consideration be given to increasing the allowance to provide a better selection of fully-covered frames. In order to minimize the effect to total program costs, MPSERS may wish to consider a modest increase in co-pays.

As a matter of information, increasing from the current \$23 wholesale frame allowance to the levels indicated will increase total claim costs by the percentages shown:

- A. \$23 w.f.a. to \$30 w.f.a. +3.5%
- B. \$23 w.f.a. to \$40 w.f.a. +8%

Analysis of VSP experience indicates members select certain "extras" or patient options with varying frequencies. Some of these extras and the number of times selected during the first six months of 1997 are:

Patient Option	Number selected from 1/97 to 7/97
Progressive lenses	2,920
Scratch resistant coating	2,711
Plastic photochromic tints	2,108
Gradient and solid tints	2,072
UV protection	1,847

Consideration could be given to covering those most often selected. While progressive lenses are often selected, covering them would be a sizable cost increase. More modest considerations would be scratch coating or photochromics.

Cost increases approximate:

- A. Scratch coating +3%
- B. Photochromics +4.5%

1. Provide the name and title of the Senior Account Manager (SAM) you propose pursuant to Section II-C 7. of the RFP. Include a detailed resume.

Barbara Murphy, Director, MPSERS account

Corporate Key Accounts

Blue Cross Blue Shield of Michigan

Ms. Murphy's experience includes:

- 3.5 years as account manager for MPSERS, BCBSM's third largest account. Responsible for managing MPSERS Master Health Care Plan for approximately 87,000 contracts.
- 5 years as operations administrator for the Michigan Education Special Services Association, BCBSM's fourth largest account. Responsible for operational activities for 85,000 contracts.
- 5 years as corporate project coordinator/chief systems liaison analyst. Responsible for improving operations, increasing efficiency and reducing expenses for the Facility, Professional, Master Medical, Dental, Vision, Hearing and Prescription Drug lines of business for all Michigan accounts

Over the years, Ms. Murphy has received numerous awards recognizing her services. In addition, she is the 12th and most recent recipient of the President/CEO award for her exemplary service to BCBSM. The award is BCBSM's most prestigious.

To reflect the stature and importance of MPSERS, VSP will continue to provide a team of our most senior sales and service management to this account.

John Kackloudis, Regional Vice President, would continue to act as MPERS' VSP "Senior Account Manager," providing local sales and service support. This would include any plan design, financial or pricing issues, as well as contractual matters.

As she has for the past 4 ½ years, Barbara Aikman, Account Executive, will continue to serve as MPERS' service representative. Residing in Lansing, Barbara is readily available for meetings, presentations, or consultations at MPERS' request.

Additionally, John Jacopin, Sales Administrator, will be available to provide day-to-day assistance on the MPERS account. Mr. Jacopin has been employed with VSP for six years and will be responsible for acting as a liaison between MPERS and VSP's corporate offices on administrative issues. Both John Kackloudis and John Jacopin are located at the address below:

Vision Service Plan - Eastern Operations Center

3400 Morse Crossing

Columbus, OH 43219

(614) 471-7511

(800) 462-7009

Exhibit W includes resumes for each member of the account management team.

In addition, Alison Penrose will continue her role as a dedicated Account Manager for MPERS. Ms. Penrose is responsible for facilitating and responding to issues involving MPERS's eligibility, billing, account structure, and customer service aspects on behalf of various departments

within VSP. She is the primary source of contact for all administrative service issues. The role of the account manager is to focus on specific customer needs and expectations and to ensure complete satisfaction with VSP and our program. Ms. Penrose is located in VSP's Account Management Department at our corporate headquarters in Sacramento, California at the address listed below:

Vision Service Plan - Corporate Headquarters

3333 Quality Drive

Rancho Cordova, CA 95670

(916) 851-5000

(800) 852-7600

2. How long has the SAM worked for your firm? In the vision care administration industry? What are his/her special areas of competence?

Barbara Murphy has been with BCBSM 22 years. Her experience is in health care benefits administration, of which vision care administration is one component. Her special areas of competence include:

- the ability to obtain the use of resources within BCBSM to meet account needs
- managing and directing resources within BCBSM
- problem identification and resolution; and
- decision making

In addition, the account management team of John Kackloudis, Barbara Aikman, and John Jacopin have a combined total of more than 20 years of experience with Vision Service Plan. Mr. Kackloudis has over ten years of experience with VSP and services other clients including BCN Southeast, Chrysler Corporation, Healthsource Indiana, FHP of Ohio,

State of Indiana and the active Michigan Public School Employees. Ms. Aikman has been with VSP for 4 ½ years, and has specialized in providing efficient local service to MPSERS and MESSA. A 6-year VSP employee, Mr. Jacopin is highly skilled in administrative matters relating to VSP's customers.

3. How much of the SAM's time will be allocated to the MPSERS account?

Ms. Murphy will be dedicated full time to the MPSERS account.

In addition, as we have in the past, VSP will commit whatever time is necessary to deliver the superior level of service for which we are known. Barbara Aikman is Lansing-based and available day to day, as necessary. In addition, John Jacopin and Alison Penrose are available daily by phone, and John Kackloudis is available as necessary to address any issues.

4. How many other accounts will the SAM work on?

Ms. Murphy will work on no other accounts.

With regard to the VSP team:

John Kackloudis' responsibilities as a Regional Vice President include his personal involvement with only a few very high-profile accounts like MPSERS. In total, John has personal responsibility for less than 10 major accounts. His role requires him to become involved with others as the need or circumstance arises.

Barb has primary service responsibility for MPSERS and MESSA. In addition, she has sales responsibility for new business when she is not

committed to working on MPSERS or MESSA issues. She is available on an as needed basis for MPSERS related issues. On average, she is available to MPSERS 20-25% of her time.

Alison Penrose's time as an Account Manager is committed to a maximum of 20 accounts. She is available daily and can be contacted at any time.

John Jacopin works closely with John Kackloudis and is also available daily. Mr. Jacopin's responsibilities mirror those of Mr. Kackloudis in terms of number of accounts.

5. Provide the name, title, organization and telephone number of two individuals at other accounts who can provide information about the SAM's work to MPSERS.

Warren Culver
Executive Director
Michigan Education Special Services Association
1480 Kendale Blvd.
E. Lansing, Michigan 48223
(517) 337-5502

Elizabeth Lorenzi
Director
Michigan Education Special Services Association
1480 Kendale Blvd.
E. Lansing, Michigan 48223
(517) 337-5452

With regard to the VSP team:

Client	Contact Information	Number of Employees
Michigan Education Special Services Association (MESSA)	Jim Hobson, Director Field Services P O. Box 2860 1480 Kendale Boulevard East Lansing, MI 48823 (517) 332-2581	89,750
Chrysler Corporation	Don Longnecker Manager, Health Care Planning 1000 Chrysler Drive Auburn Hills, MI 48326 (810) 512-2498	33,900

6. Provide the name and title of the individual you propose to back up the SAM. Include a detailed resume.

Arva Overton

MPSERS operations administrator

Corporate Key Accounts

Blue Cross Blue Shield of Michigan

Ms. Overton's experience includes:

- 8 months as operations administrator for MPSERS, BCBSM's third largest account. Responsible for operational activities for 87,000 contracts.
- 7 years as project analyst. Responsible for analyzing, investigating, formulating, developing and authorizing system changes to improve quality, processing time and efficiency for all national accounts. Operations representative for General Motors, BCBSM's largest account. Responsible for meeting on a regular basis with representatives of General Motors to resolve issues.
- 4 years as benefit liaison analyst. Responsible for reviewing and analyzing requests for system changes to assure accuracy and consistency with current benefits. Development of specifications for implementation of new products and new benefits. Identified and resolved system- and benefit-related issues. Managed projects.

Ms. Overton has received numerous awards and letters of acknowledgment for her achievements. One of her outstanding achievements in problem identification and resolution resulted in substantial cost savings to all accounts.

Ms. Overton has 21 years experience in the health care benefits industry.

At VSP, Steve Snyder, Vice President of the Eastern and National Accounts Division, will have overall management responsibility for the MPSERS account. Steve has been with VSP for 23 years and is responsible for other clients such as United Parcel Service, IBM, Bell Atlantic, Rockwell, Walt Disney, and MCI Communications. Steve is located at VSP's Long Beach sales office at the address listed below:

Vision Service Plan - Regional Sales Office

111 West Ocean Blvd., Suite 1625

Long Beach, CA 90802

(310) 495-2032

(800) 367-9618

Please refer to Exhibit X for Mr. Snyder's resume.

1. Do you have contracts or other arrangements with providers that provide favorable pricing of services? If so, describe fully. Does your arrangement operate outside of Michigan? Explain.

VSP maintains the largest provider panel in the vision industry, contracting directly with more than 22,000 participating doctor locations nationwide, with nearly 1,300 locations in Michigan. VSP compensates participating doctors for their professional services on a discounted fee-for-service basis. This variable fee system pays a percentage of each doctor's prefiled usual and customary fees, not to exceed regional caps set by VSP. Because VSP's fees can vary by region and/or doctor, there is no single fee schedule.

On average, VSP pays approximately 20 percent less than usual and customary for professional services, and pays wholesale costs for lenses and frames. As a condition of membership, participating doctors must accept VSP's discounted fees as payment-in-full for covered services. For non-covered options, participating doctors must charge patients according to VSP's patient options price list, which VSP sets and controls.

Here are a few key facts about the VSP network:

- Because of the important eye and general health related aspects of eyecare, we believe strongly that it belongs in highly skilled hands. That is why we contract solely with private-practice optometrists and ophthalmologists because we believe they focus primarily on providing high-quality care, not generating eyewear sales.
- We offer unparalleled doctor access because our satisfaction research shows provider selection to be a key "driver" for our members. The research, conducted by VSP in late 1996 to uncover the attributes that

“drive” satisfaction among patients and groups, found that patients consider doctor selection the second most important factor in judging their vision plan behind the actual care given by the provider.

- All participating doctors must agree to rigid quality and cost controls, including credentialing according to National Committee for Quality Assurance standards.
- Because we want eyecare to be convenient for members, our doctors must agree to provide full services, including not only the eye exam but also materials.
- In order to control the quality and cost of materials, VSP doctors are required to use our 350 contract laboratories nationwide for their prescriptions. With less than 25 percent of the nation’s total number of independent optical labs participating, only the best and brightest ever join our premier system. Even then, gaining membership does not ensure a flow of business. Because our doctors can choose any one of our 350 labs, each facility must deliver the finest quality and service to gain and retain a share of business. We believe our system is far superior to other plans that limit providers to a handful of company-owned labs because they have little competitive incentive to produce a quality product.

In addition to the discounts of approximately 20 percent that VSP achieves through its variable fee system, we have also negotiated additional discounts on materials and certain professional services. They include:

- Cosmetic lens options that are cost controlled an average of 20

percent less than usual and customary charges. These charges are regulated according to VSP's Patient Options Price List. For example, VSP offers the increasingly popular progressive lens (worn by nearly 20 percent of our members) at prices as much as 39 percent below some competing vision plans.

- Additional complete pairs of prescription glasses that are discounted 20 percent off the participating doctor's usual and customary fees.*
- Professional fees associated with the evaluation and fitting of contact lenses by a participating doctor that are discounted 15 percent (materials not subject to discount).*

** Discounts are available through the VSP participating doctor who last provided the covered eye examination for 12 months following the covered eye examination*

2. How many providers participate in your arrangement in Michigan? Outside Michigan, by state? What percentage of Michigan providers participate in your arrangement, by specialty?

VSP currently contracts with a total of 1,166 doctor locations in Michigan. The following table outlines the percentage of providers by specialty.

Specialty	Number of Locations	Percentage of Total Locations
Optometrists (O.D.s)	1,019	87%
Ophthalmologists (M.D.s)	141	12%
Doctors of Osteopathy (D.O.s)	6	<1%

In total, VSP contracts with over 22,000 provider locations nationwide.

Please see Exhibit Y for a map of the United States, indicating the number

of VSP participating provider locations by state. Also enclosed as Exhibit B is a diskette containing information on VSP's national network.

3. How do payment levels to participating providers compare to those of non-participating providers on average?

On average, VSP pays participating doctors approximately 20 percent less than usual and customary for professional services and pays wholesale costs for lenses and frames. Non-participating providers may of course collect their usual and customary fees from patients. Upon request, VSP will reimburse the eligible member directly according to a reimbursement schedule, which is determined by the plan design your organization selects.

4. Do you perform credentialing of participating providers? If so, explain the process and provide a copy of your published standards. Is your credentialing process compliant with NCQA standards?

Yes. VSP's Health Care Services Department is responsible for credentialing all new and existing participating doctors according to NCQA standards, even though current NCQA guidelines do not mandate this standard for optometrists. We do this in the interest of assuring quality care and because we believe it is essential to use the same criteria in credentialing all of our providers.

As of July 1997, 100 percent of VSP's network were credentialed according to NCQA standards. VSP's credentialing process includes an extensive background check on each doctor through the National Practitioner Data Bank, the State Board of Medical Examiners or State Board of Optometry (as applicable), and Medicare/Medicaid (sanction activity).

Vision Service Plan's selection criteria for all participating doctors is detailed in Exhibit D, VSP's Application for Panel Membership and Credentialing Form. Briefly, VSP requires the following:

- The applicant must complete an application for membership.
- The application includes a statement by the applicant regarding the history of loss of licensure and/or felony convictions and history of loss or limitation of privileges or disciplinary activity.
- VSP requires an attestation to correctness/completeness of the application.
- Participating doctors must possess a current, valid license to practice.
- All participating doctors must be a duly licensed optometrist or ophthalmologist accepted for membership by the American Board of Ophthalmology and in good standing in the state of their board licensure.
- Work history is included on the application.
- Doctors of Optometry must submit evidence of their DPA/TPA licensure in their appropriate states.
- The doctor must furnish a certificate of insurance showing that he/she maintains professional liability insurance of not less than \$1 million per occurrence.

Please refer to Exhibit E for a complete copy of VSP's Credentialing Policy and Procedure.

5. If a participant uses a non-participating provider, what is the effect on reimbursement? Does your answer change for out-of-state claims where you have no provider network?

Eighty-seven (87) percent of MPSERS' members receive services through participating doctors. However, because VSP believes that personal choice is important with something as important as one's health, our

organization provides a reimbursement alternative for patients choosing to go out-of-network for services. VSP's out-of-network reimbursement schedule is determined by the group's contract and can be modified upon request. The out-of-network schedule currently in effect for MPSERS is outlined below:

Examination, up to	\$23
Single Vision Lenses, up to	\$16
Bifocal Lenses, up to	\$23
Trifocal Lenses, up to	\$27
Lenticular Lenses, up to	\$75
Frame, up to	\$23
Elective Contact Lenses, up to	\$35
Necessary Contact Lenses, up to	\$96

Since VSP has an established provider network in all 50 states, this schedule would apply to all out-of-network claims, regardless of the state in which they were incurred.

6. It is MPSERS' wish that bidders produce the lowest total cost (both claim dollars and administrative fees) to the plan. MPSERS' paid claim cost per contract (net of administrative fees) was \$64 for the period from July 1, 1996 to June 30, 1997, the last period for which data is available. We estimate that the per contract paid claim cost will be \$74 in 1998, \$78 in 1999 and \$82 in 2000. For purposes of this question contract means an individual or family unit covered by MPSERS' plan. If you wish to provide a guarantee to MPSERS, set out below your guaranteed per contract claim cost for each of the first three years of the contract.

Our assumptions and guarantees assume no changes in the terms and conditions provided in the original RFP issued 7/17/97.

Year	Per Contract Paid Claim Cost
1998	\$ 58.00
1999	\$ 60.00
2000	\$ 62.00

If you guarantee a per contract paid claim cost lower than the estimated costs for each year specified above, the fees you quote in your price proposal will be reduced for purposes of determining your bid price in accordance with Section III-E of the RFP. However, as soon as possible after the end of each year listed above, a comparison will be made between your guaranteed per contract paid claim cost and the actual per contract paid claim cost. If the actual cost is greater, you will be liable to MPSERS for an amount equal to the difference multiplied by the actual number of covered persons (determined as 12 times the monthly average number of contracts).

APPENDIX B

CONTRACTOR'S PRICING

IV-F PRICE PROPOSAL

1. LENGTH OF TIME PRICES ARE TO BE HELD FIRM.

All rates quoted in bidder's response to this RFP will be firm for the duration of the BPO. No price changes will be permitted, however the rates quoted for each contract year may be higher or lower than the rates for the preceding year. That is, bidders may quote different firm rates for each of the five years of the contract.

2. Quote a monthly fee for each enrolled retiree and surviving beneficiary. (A surviving beneficiary is the covered beneficiary of a deceased retiree.) Refer to Section II-H-3-e. Your quoted fee must include all services and materials specified by this RFP. Please quote your fee consistent with the following format.

Michigan Public School Employees Retirement System
Vision Expense Plan
Fee for each enrolled retiree and surviving beneficiary January 1, 1998
through December 31, 2002

The fees quoted below include all services specified in the RFP for the periods stated below.

"Contractor shall be paid a monthly fee for each enrolled retiree and surviving beneficiary for the period from January 1, 1998 through December 31, 2002. The monthly fees below are based on calendar years."

YEAR	MONTHLY FEE
1998	\$ 0.64
1999	\$ 0.64
2000	\$ 0.64
2001	\$ 0.64
2002	\$ 0.64

This cost and price analysis is submitted in full compliance with the provisions of the paragraph titled "Independent Price Determination" in Part III of the RFP to which this proposal is a response.