STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget

525 W. ALLEGAN ST., LANSING, MICHIGAN 48913
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **5**

to

Contract Number **071B4300062**

CONTRACTOR	
	BLUE CROSS AND BLUE SHIELD OF MICHIGAN
	600 Layfayette E. 517J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024314

STATE			
	Program Manager	Bethany Beauchine	MCSC
		517-284-0086	
		BeauchineB@Michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

ADMIN FEES FOR BCBS HEALTH ACTIVE/RETIRE

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
November 1, 2002	September 30, 2007	Successive Annual Renewal Periods	November 30, 2019

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☒ PRC	☐ Other	☒ Yes	☐ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	1-Month	☐		December 31, 2019

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$2,494,707,000.00	$42,225,000.00	$2,536,932,000.00

DESCRIPTION

Effective December 1, 2019, this Contract is exercising 1 month of an option year and is increased $42,225,000.00. The revised expiration date is December 31, 2019.

All other terms, conditions, specifications, and pricing remain the same. Per Vendor and Agency agreement, DTMB approval, and State Administrative Board approval on December 10, 2019.

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
525 W. ALLEGAN ST., LANSING, MICHIGAN 48913
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **4**

to

Contract Number **071B4300062**

CONTRACTOR	
	BLUE CROSS AND BLUE SHIELD OF MICHIGAN
	600 Layfayette E. 517J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024314

STATE			
	Program Manager	Bethany Beauchine	MCSC
		517-284-0086	
		BeauchineB@Michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

STATE HEALTH PLAN PREFERRED PROVIDER ORGANIZATION (SHP PPO) AND CATASTROPHIC HEALTH PLAN INSURANCE ADMINISTRATION

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
November 1, 2002	September 30, 2007	Successive Annual Renewal Periods	September 30, 2019

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	N/A

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☒ PRC	☐ Other	☒ Yes	☐ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	2 months	☐		November 30, 2019

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$2,410,257,000.00	$84,450,000.00	$2,494,707,000.00

DESCRIPTION

Effective October 1, 2019, this Contract is exercising 2 months of an option year and is increased by $84,450,000.00. The revised expiration date is November 30, 2019.

All other terms, conditions, specifications, and pricing remain the same. Per Vendor and Agency agreement, DTMB Procurement approval, and State Administrative Board approval on September 26, 2019.

STATE OF MICHIGAN
ENTERPRISE PROCUREMENT
Department of Technology, Management, and Budget
525 W. ALLEGAN ST., LANSING, MICHIGAN 48913
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **3**

to

Contract Number **071B4300062**

CONTRACTOR	
	BLUE CROSS AND BLUE SHIELD OF MICHIGAN
	600 Layfayette E. 517J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	*******9753

STATE			
	Program Manager	Bethany Beauchine	MCSC
		517-284-0086	
		BeauchineB@Michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 284-7021	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

BASIC (NON HMO) MEDICAL PLAN ADMINISTRATION SERVICES FOR ACTIVE/RETIREES

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
November 1, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2019

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	

ALTERNATE PAYMENT OPTIONS			EXTENDED PURCHASING	
☐ P-Card	☐ Direct Voucher (DV)	☐ Other	☒ Yes	☐ No

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$2,410,000,000.00	$257,000.00	$2,410,257,000.00

DESCRIPTION

Effective May 8, 2017 this Contract is hereby increased by $257,000.00 and:

1) Section II-C Tasks/Plan Requirements is updated to include the following language: Effective October 1, 2016, the Contractor must provide billing and claims administration services for the telemedicine program for Active (excluding Michigan State Police Troopers Association) and Pre-65 Retirees (excluding persons retired from Michigan State Police enlisted unit on or after October 1, 1987).
2) A $.20 per contract per month telemedicine fee is incorporated in the attached Schedule B, Pricing Matrix which updates and replaces the Section titled "Fees" on page 95 of the original Contract.
3) State of Michigan (SOM) Performance Guarantees are updated and replaced with Schedule C SOM Contract Performance Standards with an effective date of October 1, 2016.
4) The term "Program Manager" hereby replaces the original terms "Contract Compliance Inspector (CCI)" and "Contract Administrator" throughout the Contract, and including Article VII, Section D.
5) The Program Manager on the Cover page and Article VII, Section D is updated to Bethany Beauchine, beauchineb@michigan.gov, (517) 284-0086.

6) The Contract Administrator identified on the Cover page and State contact/buyer identified in Article VII, Section D of the Contract is updated to Mary Ostrowski, ostrowskim@michigan.gov, (517) 284-7021.

All other terms, conditions, specifications, and pricing remain the same. Per DTMB, Vendor, and Agency agreements and DTMB Procurement approval.

Change Notice 3
Contract 071B4300062

SCHEDULE B
PRICING MATRIX

1. Pricing includes all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State (e.g., shipping and handling, per piece pricing, and palletizing).

   Contract periods are defined as:

   FY 2016 – October1, 2015 through September 30, 2016
   FY 2017 - October 1, 2016 through September 30, 2017
   FY 2018 - October 1, 2017 through September 30, 2018
   FY 2019 - October 1, 2018 through September 30, 2019

Administrative and Access Fees

	Active & Non-Medicare Retirees	Medicare Supplemental Retirees	Aetna - Medicare Supplemental Retirees	Billing and Claims Administration for Active & Pre-65 Retirees Telemedicine Services Per Contract Per Month
FY16 Administrative Fee	$24.16	$24.16	$9.00	$0.20
FY16Access Fee	$21.88	$21.88	$21.88	
FY17 Administrative Fee	$24.40	$24.40	$9.09	$0.20
FY17 Access Fee	$22.10	$22.10	$22.10	
FY18 Administrative Fee	$24.64	$24.64	$9.18	$0.20
FY18 Access Fee	$22.32	$22.32	$22.32	
FY19 Administrative Fee	$24.89	$24.89	$9.27	$0.20
FY19 Access Fee	$22.54	$22.54	$22.54	

SCHEDULE C
SOM Contract Performance Standards

Performance Standard	Methodology	Percentage of Fees at Risk
Financial Accuracy - The acceptable error rate will be 1%	Defined as the total dollars paid, minus the absolute value of dollars paid incorrectly, divided by the total dollars paid in the audit sample. Biennial audit performed by State of Michigan group.	6%
Payment Incidence Accuracy - The acceptable error rate will be 3%	Defined as the total number of claims audited, minus the number of claims having a payment error (overpayment or underpayment), divided by the total number of claims paid during the audit sample. Biennial audit performed by State of Michigan group.	3%
Procedural Accuracy - The acceptable error rate will be 2%	Defined as the total number of claims audited, minus the number of claims having a non-payment error, divided by the number of claims processed during the audit sample. Biennial audit performed by State of Michigan group.	2%
Overall Claims Processing Accuracy - The acceptable error rate will be 5%	Defined as the total number of claims audited, minus the number of claims having a payment or non-payment error, divided by the total number of claims processed during the audit sample. Biennial audit performed by State of Michigan group.	1%
Claim turnaround time - The maximum time period between date of receipt by the Contractor and date of payment or denial is expected to be no greater than 10 business/14 calendar days for 94% of all claims.	Defined as the percentage of claims processed within the stated number of business or calendar days. Measured monthly. Penalty assessed annually.	2%
99% within 30 calendar days		1%
Average Speed to Answer - The average length of time a caller "waited in queue" must not exceed 30 seconds	Defined as the total amount of time all calls waited to be answered by a customer service representative. Measured monthly. Penalty assessed annually.	2%
Abandonment Rate - The inquiry telephone line for members will have no more than 3% lost calls	Defined as the percentage of calls "abandoned" or for which the called ended the call while waiting for the call to be answered. Measured monthly. Penalty assessed annually.	1%

First Call Resolution - Resolve 90% of all telephone inquires on first contact	Defined as call closed on the same day (includes IVR and live interaction) with no returned call (excludes IVR) by the same person calling back within 7 calendar days for same member in focus and same call category. Measured monthly. Penalty assessed annually.	2%
Finalize 85% of State Benefit Office inquiries in 14 calendar days.	Defined as special handling written inquires received from State Benefit Office within the stated number of calendar days. Measured monthly. Penalty assessed annually.	1%
Finalize 85% of written inquiries from actives/retirees in 21 calendar days.	Defined as all written inquiries (non-priority) received from actives and/or retirees within the stated number of calendar days. Measured monthly. Penalty assessed annually.	2%
Respond to 100% of written inquiries from active/retiree in 30 calendar days	Defined as all written inquiries (non-priority) received from actives and retirees within the stated number of calendar days. Written inquiry issues outstanding at the end of 30 days will be reported to the BCBSM Account Manager for review with the State if deemed necessary. Measured monthly. Penalty assessed annually.	2%
Member Satisfaction - Participant Satisfaction Survey 85% satisfied.	As defined by survey. Penalty assessed annually.	2%
Monthly reports due 60 calendar days following close of month.	Claims lag and the performance guarantee reports are due within the stated number of calendar days. Measured monthly. Penalty assessed annually.	1%
Quarterly reports due 90 calendar days following the close of quarter.	Defined as a financial assessment within the stated number of calendar days. Measured quarterly. Penalty assessed annually.	1%
Annual reports and file due 120 calendar days following close of plan year.	Defined as a financial assessment and year end performance within the timeframe stated. Penalty assessed annually.	1%
Total		30%
Note: Performance is based on a 12-month average for each standard and the penalties are based on the current contract year administrative fee.		

Form No. DTMB-3521 (Rev. 7/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 2
to
CONTRACT NO. 071B4300062
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	PRIMARY CONTACT	EMAIL
BLUE CROSS AND BLUE SHIELD OF MICHIGAN	Arva Overton	aoverton@bcbsm.com
600 Layfayette E. 517J	PHONE	CONTRACTOR'STAX ID NO. (LAST FOUR DIGITS ONLY)
Detroit Mi 48226	313-448-5912	9753

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER / CCI	MSCS	Lauri Schmidt	517-373-9211	schmidtl@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Lance Kingsbury	(517) 284-7017	KingsburyL@michigan.gov

CONTRACT SUMMARY

DESCRIPTION:
Admin Fees for BCBS Health Active/Retire

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILIABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE (S) NOTED BELOW
November 01, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2015

PAYMENT TERMS	DELIVERY TIMEFRAME
N/A	N/A

ALTERNATE PAYMENT OPTIONS	EXTENDED PURCHASING
☐ P Card: ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☐ No

MINIMUM DELIVERY REQUIREMENTS
N/A

DESCRIPTION OF CHANGE NOTICE

EXERCISE OPTION?	LENGTH OF OPTION	EXERCISE EXTENSION?	LENGTH OF EXTENSION	REVISED EXPIRATION DATE
☑	4 years	☐		September 30, 2019

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$1,310,000,000.00	$1,100,000,000.00	$2,410,000,000.00

DESCRIPTION:
Effective October 1, 2015, this contract is extended four years and increased by $1,100,000,000.00. The revised expiration date is September 30, 2019. The Administration Fee increase is as follows (in Fiscal Years): 2016: 2%; 2017: 1%; 2018: 1%; 2019: 1%. Additionally, the new changes and performance guarantees are attached.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Procurement approval, and State Administration Board approval on September 30, 2015.

Contract# 071B4300062 BCBS – Contract Changes:

Unless otherwise stated, the following changes are hereby incorporated into this Contract effective October 1, 2015:

A. Effective January 1, 2015, the following Key Personnel positions to the Key State Accounts will be removed:
   - Back-up Account Manager
   - Contractor Administration Manager
   - Group Service Representative (Retiree Servicing), and
   - Sales Technician

   And the following job titles will be revised as follows:
   - Regional Account Manager (RAM) – Key Account Manager
   - Operations Administrator – Administrator
   - Communications Administrator – Senior Benefit Communications Analyst

   The dedicated State of Michigan team will consist of the following individuals with a dotted-line reporting relationship to the Key Account Manager. Attached is the organization chart for Key State Accounts.
   - Key Account Manager – Arva Overton
   - Administrator – Tina Fields
   - Senior Medical Analyst – Angela Mims
   - Group Service Representative – Treveire Wilson
   - Senior Benefit Communications Analyst – Kristina Williams-Lee

   Tina Fields will act as a back-up to Treveire Wilson during any time-off.

   In addition to the above resources, BCBSM will agree that Angela Croce will provide administrative support to the Key Account Manager as needed.

B. Effective January 1, 2015, add the following changes as it relates to mental health and substance abuse diagnoses:
   - BCBSM is responsible for Evaluation and Management procedure codes rendered by a Primary Care Physician for mental health and substance abuse diagnoses. Claims rejected prior to January 1, 2015, will be handled on an inquiry basis.
   - BCBSM is responsible for all injections for mental health and substance abuse diagnoses for claims. Claims prior to January 1, 2015, is also the responsibility of BCBSM.

C. The attached Final SOM Performance Standards for 2015-2016 is hereby incorporated into this Contract.

D. The Catastrophic Plan and the Aetna retirees (previously transferred to BCBSM coverage) will be subject to the performance guarantees outlined in the health contract.

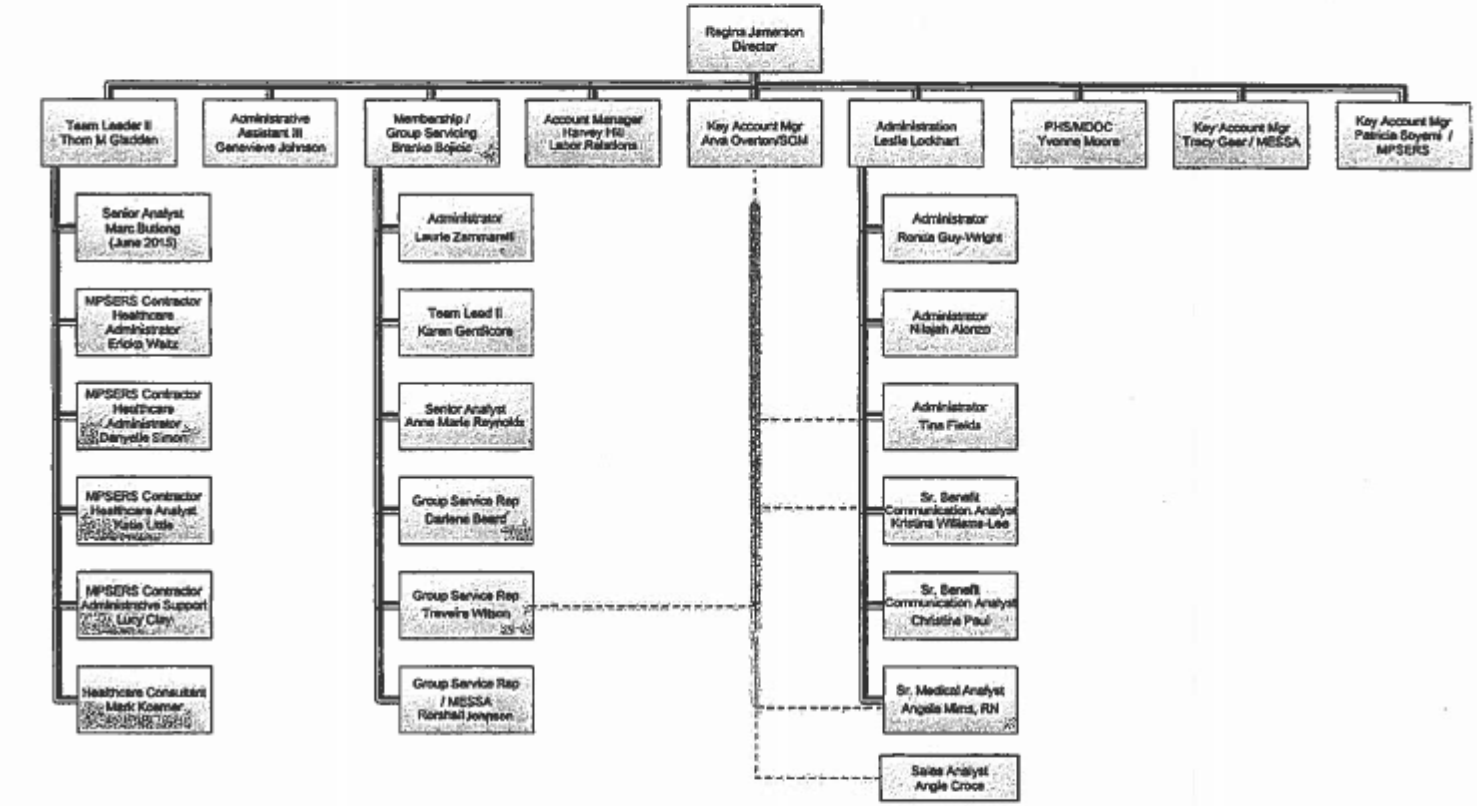
State of Michigan's (SOM) Contract Performance Standards

Performance Standard	Methodology	Percentage of Fees at Risk
Financial Accuracy - The acceptable error rate will be 1%	Defined as the total dollars paid, minus the absolute value of dollars paid incorrectly, divided by the total dollars paid in the audit sample. Biennial audit performed by State of Michigan group.	6%
Payment Incidence Accuracy - The acceptable error rate will be 3%	Defined as the total number of claims audited, minus the number of claims having a payment error (overpayment or underpayment), divided by the total number of claims paid during the audit sample. Biennial audit performed by State of Michigan group.	3%
Procedural Accuracy - The acceptable error rate will be 2%	Defined as the total number of claims audited, minus the number of claims having a non-payment error, divided by the number of claims processed during the audit sample. Biennial audit performed by State of Michigan group.	2%
Overall Claims Processing Accuracy - The acceptable error rate will be 5%	Defined as the total number of claims audited, minus the number of claims having a payment or non-payment error, divided by the total number of claims processed during the audit sample. Biennial audit performed by State of Michigan group.	1%
Claim turnaround time - The maximum time period between date of receipt by the Contractor and date of payment or denial is expected to be no greater than 10 business/14 calendar days for 94% of all claims.	Defined as the percentage of claims processed within the stated number of business or calendar days. Measured monthly. Penalty assessed annually.	2%
99% within 30 calendar days		1%
Average Speed to Answer - The average length of time a caller "waited in queue" must not exceed 30 seconds	Defined as the total amount of time all calls waited to be answered by a customer service representative. Measured monthly. Penalty assessed annually.	2%
Abandonment Rate - The inquiry telephone line for members will have no more than 3% lost calls	Defined as the percentage of calls "abandoned" or for which the called ended the call while waiting for the call to be answered. Measured monthly. Penalty assessed annually.	1%
First Call Resolution - Resolve 90% of all telephone inquires on first contact	Defined as call closed on the same day as received with no returned call regardless of the reason by the same individual within 7 calendar days. Measured monthly. Penalty assessed annually.	2%
Finalize 85% of State Benefit Office inquiries in 14 calendar days.	Defined as special handling written inquires received from State Benefit Office within the stated number of calendar days. Measured monthly. Penalty assessed annually.	1%
Finalize 85% of written inquiries from actives/retirees in 21 calendar days.	Defined as all written inquiries (non-priority) received from actives and/or retirees within the stated number of calendar days. Measured monthly. Penalty assessed annually.	2%
Respond to 100% of written inquiries from active/retiree in 30 calendar days	Defined as all written inquiries (non-priority) received from actives and retirees within the stated number of calendar days. Written inquiry issues outstanding at the end of 30 days will be reported to the BCBSM Account Manager for review with the State if deemed necessary. Measured monthly. Penalty assessed annually.	2%
Member Satisfaction - Participant Satisfaction Survey 85% satisfied.	As defined by survey. Penalty assessed annually.	2%

State of Michigan's (SOM) Contract Performance Standards

Performance Standard	Methodology	Percentage of Fees at Risk
Monthly reports due 60 calendar days following close of month.	Claims lag and the performance guarantee reports are due within the stated number of calendar days. Measured monthly. Penalty assessed annually.	1%
Quarterly reports due 90 calendar days following the close of quarter.	Defined as a financial assessment within the stated number of calendar days. Measured quarterly. Penalty assessed annually.	1%
Annual reports and file due 120 calendar days following close of plan year.	Defined as a financial assessment and year end performance within the timeframe stated. Penalty assessed annually.	1%
Total		30%
Note: Performance is based on a 12-month average for each standard and the penalties are based on the current contract year administrative fee.		

Blue Cross Blue Shield of Michigan



Tina Fields, Kristina Williams-Lee, Treveire Wilson, and Angela Mims, RN all have a dotted line reporting relationship with Arva Overton; Key State Account Manager – State of Michigan – Angie Croce reports directly to Michael McKay but has a dotted line to support Arva and the State of MI Account.

Updated 12/11/2014

Form No. DTMB-3521 (Rev. 4/2012)

AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
525 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 1

to

CONTRACT NO. 071B4300062

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan	Arva Overton	aoverton@bcbsm.com
600 Layfayette E, 517J	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	313-448-5912	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MCSC	Lauri Schmidt	517-373-9211	schmidtl@michigan.gov
BUYER	DTMB	Lance Kingsbury	517-284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
November 1, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2014

PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:	AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☒ Yes ☐ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	One year	September 30, 2015

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$655,000,000.00	$1,310,000,000.00

Effective October 1, 2014, this contract is extended one year; and is increased by $ 655,000,000.00. The revised contract expiration date is September 30, 2015. Additionally, an Administration Fee increase of 2%.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on September 30, 2014.

Form No. DTMB-3524 (Created 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: No further payment will be made to the previous Contractor name and or number.

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48913

CHANGE OF CONTRACTOR NAME AND OR TAX IDENTIFICATION NUMBER

CONTRACT NO. 071B3001060

hereafter referred as

CONTRACT NO. 071B4300062

between

THE STATE OF MICHIGAN

and

CURRENT NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan 600 Layfayette E, 517J Detroit, MI 48226	Arva Overton	aoverton@bcbsm.com
	TELEPHONE	NEW CONTRACTOR #, MAIL CODE
	(313) 448-5912	

PREVIOUS NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan 600 Layfayette E, 517J Detroit, MI 48226	Arva Overton	aoverton@bcbsm.com
	TELEPHONE	PREVIOUS CONTRACTOR #, MAIL CODE
	(313) 448-5912	

DESCRIPTION OF CHANGE NOTICE:
CONTRACT HAS REACHED ITS THRESHOLD. DUE TO THE INTERNAL SYSTEMS RELATED TO THE RELEASE OF CONTRACTOR PAYMENTS, A NEW CONTRACT NUMBER MUST BE ASSIGNED. THE NEW CONTRACT NUMBER IS 071B4300062**. EXCEPT FOR THE NEWLY-ASSIGNED NUMBER, THE CONTRACT TERMS AND CONDITIONS REMAIN IN EFFECT.** **THIS CHANGE IS EFFECTIVE:** February 5, 2014
$655,000,000.00 **REMAINING ON CONTRACT #** 071B3001060 **TO BE TRANSFERRED TO CONTRACT #** 071B4300062.

Form No. DTMB-3524 (Created 4/2012)
Change of Contractor Name or Tax Identification Number

Contract No. 071B3001060 **hereafter referred as Contract No.** 071B4300062

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	MCSC	Lauri Schmidt	517-373-9211	schmidtl@michigan.gov
BUYER:	DTMB	Lance Kingsbury	517-284-7017	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
DESCRIPTION: (Descriptive Contract Title (Not always the same language as provided in MAIN)			
Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission			
INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
5 years	November 1, 2002	September 30, 2007	Successive annual renewal periods
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☒ YES ☐ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

FOR THE CONTRACTOR:	**FOR THE STATE:**
Blue Cross & Blue Shield of Michigan	
Firm Name	Signature
	Jeff Brownlee, Chief Procurement Officer
Authorized Agent Signature	Name/Title
	DTMB Procurement
Authorized Agent (Print or Type)	Enter Name of Agency
Date	Date

Form No. DTMB-3521 (Rev. 4/2012)

AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

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

CHANGE NOTICE NO. 19
to
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan	Arva Overton	aoverton@bcbsm.com
600 Lafayette E, 517J	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(313) 448-5912	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MCSC	Lauri Schmidt	(517) 373-9211	schmidtl@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
November 1, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2014
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS	
☐ P-card	☐ Direct Voucher (DV)	☐ Other	☒ Yes	☐ No

MINIMUM DELIVERY REQUIREMENTS:

N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$3,942,000,000.00

Effective immediately, the attached Retiree Drug Subsidy Agreement is hereby amended and replaces all previous versions.

All other terms, conditions, specifications, and pricing remain the same. Per Contractor and agency agreement and DTMB Procurement approval.

AMENDMENT TO
RETIREE DRUG SUBSIDY AGREEMENT

This Amendment ("Amendment") to the Retiree Drug Subsidy Agreement ("Agreement") entered into on October 1, 2012 between Blue Cross and Blue Shield of Michigan ("BCBSM") and Civil Service Commission, Employee Benefits Division ("Plan Sponsor") is made as of the date last signed below ("Effective Date"). For purposes of this Amendment, each party may be referred to as a "Party" or collectively as the "Parties."

The Parties hereby agree to amend the Agreement as follows:

1. Add the following additional defined terms to Section I, Definitions:

   G. The term "data match" means the match performed by CMS to determine which retirees submitted on Plan Sponsor's Updated lists of qualifying covered retirees are Part D eligible individuals who are not enrolled in a Part D plan and is used in the same context as that term is employed in 42 C.F.R. §423.884.
   H. The term "initial list of qualifying covered retirees" means a list of all individuals Plan Sponsor believes (using information reasonably available to Plan Sponsor when it submits an RDS application) are qualifying covered retirees enrolled in each prescription drug plan (including spouses and dependents, if Medicare-eligible) and that is submitted to CMS with an RDS application required by 42 C.F.R. §423.884(c)(2)(v).
   I. The term "Updated lists of qualifying covered retirees" means the updates to the initial list of qualifying covered retirees required by 42 C.F.R. §423.884(c)(6).

2. Delete Section II, Term, in its entirety and replace it with the following:

   II. Term

   A. Term. The term of this Agreement shall commence on the Effective Date and will continue for 1 year. The Agreement shall be renewed automatically for successive 1 year terms thereafter.

3. Delete Section III, Scope of Services, in its entirety and replace it with the following:

   III. Scope of Services

   A. List of qualifying covered retirees.
      1. Responsibility and standard for determining qualifying covered retirees. Plan Sponsor shall be solely responsible for determining whether an enrollee in Plan Sponsor's qualified prescription drug plan is a qualifying covered retiree using information reasonably available to Plan Sponsor in accordance with 42 C.F.R. §423.884(c)(2). BCBSM shall have no responsibility to determine or confirm whether a particular enrollee is a qualifying covered retiree.
      2. Responsibility for updating lists of qualifying covered retirees. BCBSM shall process response and notification files on behalf of the Plan Sponsor. Plan Sponsor shall be solely responsible for confirmation of accuracy prior to final reconciliation.

3. CMS data match. Plan Sponsor shall receive data match information from CMS. Plan Sponsor shall be solely responsible for cross-checking the CMS data match information against Updated lists of qualifying covered retirees. Plan Sponsor shall provide BCBSM with any additions, corrections or deletions to such lists as required by BCBSM.

B. Data required for RDS payments.
   1. Responsibility for compiling and submitting data to CMS. BCBSM shall compile and submit data in the form and manner specified by CMS based upon the monthly CMS approved retiree listings confirmed by Plan Sponsor. For interim payments, an estimate of the expected rebates known to BCBSM will be provided to CMS, while for final reconciliation, the actual rebate and other price concession data for the plan year of Plan Sponsor's qualified retiree prescription drug plan known to BCBSM will be provided.
      BCBSM shall submit the RDS payment data indicated below to CMS in the form and manner directed by CMS. For the final reconciliation, the actual rebate and other price concession data for the plan year of Plan Sponsor's qualified retiree prescription drug plan known to BCBSM will be provided.
      For interim payments and the final reconciliation, data will be provided for each month of the plan year.
   2. Receipt of RDS payments. Plan Sponsor shall receive all RDS governmental payments directly, and BCBSM shall have no responsibility for receiving or handling such payments.

C. Corrections and modifications. Should BCBSM learn: (i) that any data provided by either party to this Agreement or by any third party is or was inaccurate; (ii) that Plan Sponsor is or has received RDS overpayments; or iii) that Plan Sponsor's RDS application, Part D drug cost data, or any submissions to CMS fail to comply with RDS Requirements; BCBSM shall notify Plan Sponsor, and Plan Sponsor shall have the sole responsibility for making necessary corrections and communications to CMS.
   If, in its sole discretion, BCBSM believes that the data is or may be inaccurate or incomplete, or would otherwise not be in compliance with RDS Requirements, BCBSM shall have no obligation to provide or submit data in support of Plan Sponsor's RDS application or a submission to obtain payment under the RDS.

4. Add Section IX, Compensation:

IX. Compensation

A. Except as provided in subsection (B), BCBSM shall be paid thirty-one percent (31%) of the amount of RDS funds obtained from CMS at final reconciliation in excess of the following interim cost reports:

Baseline 2012 applications
App id 273184 $23,166,892
App id 273336 $991,778

Baseline 2013 applications
App id 297942 $5,186,034
App id 297944 $220,595

Payment shall be based on each individual application independent of the other application results. Such payment, if any, shall be made within 30 days of final reconciliation for each application. If a final reconciliation amount is less than the associated application amount listed above, there will be no fee for that application.

B. BCBSM shall be paid thirty-one (31) percent of the amount that is recovered as a result of any reopening that BCBSM assists Plan Sponsor with for RDS application years prior to 2012.

5. Add Section X, Data Verification:

X. **Data Verification**

It is Plan Sponsor's responsibility to review the data submitted or provided by BCBSM in connection with the RDS data. Plan Sponsor may, at its own expense, retain an independent third party to review the RDS data. BCBSM agrees to cooperate with and make records available to Plan Sponsor or such independent third party retained to review RDS data as permitted by law. Plan Sponsor shall retain responsibility for making any necessary corrections or disclosures to CMS.

Plan Sponsor shall not use any BCBSM RDS data: (i) until it has reviewed and approved the accuracy of the data obtained from BCBSM; (ii) if it is advised by BCBSM that the data is inaccurate or contains inaccuracies until such data has been corrected; or (iii) if it is advised by BCBSM that the data submitted is not being released for RDS payment purposes.

6. All other terms and conditions not addressed in this Amendment shall remain unchanged.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

By: _____

Name: Gary R Gavin

Title: VP, KLab

Date: 11-5-13

PLAN SPONSOR

By: Lauri Schmidt

Name: Lauri Schmidt

Title: Director

Date: 11/4/13

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

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

September 9, 2013

CHANGE NOTICE NO. 18
to
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan	Arva Overton	aoverton@bcbsm.com
600 Lafayette E, 517J	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(313) 448-5912	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MCSC	Lauri Schmidt	(517) 373-9211	schmidtl@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
November 1, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2013
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:	AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☐ No

MINIMUM DELIVERY REQUIREMENTS:

N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☐ No ☒ Yes	☒	☐	1 Year	September 30, 2014

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$655,000,000.00	$3,942,000,000.00

Effective immediately, this Contract is hereby INCREASED by $655,000,000.00 and is utilizing an option year. The new end date is September 30, 2014. The following fee structure is effective October 1, 2013 through September 30, 2014.

All other terms, conditions, specifications, and pricing remain the same.

Per Contractor and agency agreement, DTMB Procurement approval and the approval of the State Administrative Board dated August 20, 2013.

	Active & Non-Medicare Retirees	Medicare Supplemental Retirees	Aetna – Medicare Supplemental Retirees
FY14 Administrative Fee	$23.23	$23.23	$8.65
FY14 Access Fee	$21.03	$21.03	$21.03

The following fee structure is effective October 1, 2013, through September 30, 2014:

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

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

CHANGE NOTICE NO. 17
to
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan	Arva Overton	aoverton@bcbsm.com
600 Lafayette E, 517J	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(313) 448-5912	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	MCSC	Lauri Schmidt	(517) 373-9211	schmidtl@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
November 1, 2002	September 30, 2007	Successive annual renewal periods	September 30, 2013
PAYMENT TERMS	**F.O.B**	**SHIPPED**	**SHIPPED FROM**
N/A	N/A	N/A	N/A

ALTERNATE PAYMENT OPTIONS:	AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ Yes ☐ No

MINIMUM DELIVERY REQUIREMENTS:
N/A

DESCRIPTION OF CHANGE NOTICE:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$3,287,000.00

Effective immediately, the Retiree Drug Subsidy Agreement is hereby incorporated into this Contract.

All other terms, conditions, specifications, and pricing remain the same.

Per vendor and agency agreement and DTMB Procurement approval.

Retiree Drug Subsidy Agreement

This agreement ("Agreement") is effective as of October 1st, 2012 and is made between Blue Cross Blue Shield of Michigan ("BCBSM") and Civil Service Commission, Employee Benefits Division ("Plan Sponsor") for Plan Sponsor's participation in the retiree drug subsidy ("RDS") program administered by the Centers for Medicare and Medicaid Services ("CMS").

I. Definitions

A. The terms "allowable retiree costs," "benefit option," "gross retiree costs," "group health plan," "Part D drug," "qualified retiree prescription drug plan," and "qualifying covered retiree" shall have the meaning as set forth in 42 C.F.R. §423.882.

B. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

C. The term "Part D eligible individual" means an individual enrolled in Plan Sponsor's group health plan who is entitled to Medicare benefits under Part A or enrolled in Medicare Part B and lives in the service area of a Part D plan as defined under 42 C.F.R. §423.4.

D. The term "RDS" means the retiree drug subsidy described in Section 1860D-22 of the Social Security Act.

E. The term "RDS Requirements" means the requirements of 42 C.F.R. Part 423, Subpart R (42 C.F.R. §423.880 et seq.), and the administrative guidance issued by CMS thereunder.

F. The term "rebates" shall mean any manufacturer or pharmacy discounts, chargebacks, rebates, and similar price concessions attributable to covered Part D drugs provided to Plan Sponsor qualifying covered retirees.

II. Term and termination

A. Term. The term of this Agreement shall commence on the Effective Date and shall continue through the completion of the reopening process.

B. Termination of Agreement. Either party may terminate this Agreement in its entirety at any time upon 15 business days' prior written notice to the other party.

III. Scope of services

Reopening of Filings

BCBSM or its vendor shall assist Plan Sponsor with the reopening of previous filings to obtain additional funds as permitted by CMS regulations. BCBSM shall be paid 31% of the amount that is recovered as a result of any reopening. Such payment shall be made within 5 business days of Plan Sponsor's receipt of the additional funds.

VI. Acknowledgement of purpose of data

Pursuant to 42 C.F.R §423.884(c)(3)(iii), Plan Sponsor and BCBSM acknowledge that any submission of data to CMS is for the purpose of obtaining federal funds.

V. Appeals

In the event that CMS makes an adverse determination with respect to Plan Sponsor's RDS eligibility, subsidy application, attestation of actuarial equivalence, RDS payment, or other similar determination, BCBSM shall not be responsible for any procedural or substantive activities associated with Plan Sponsor's appeal rights described in 42 C.F.R §423.890, except as indicated in section (d) and included in this Agreement. BCBSM shall provide Plan Sponsor with reasonable access to information that Plan Sponsor may need to exercise its appeal rights, and also provide reasonable assistance with submitting any request for reconsideration, request for informal hearing, request for review by the CMS Administrator, or request for reopening in accordance with such appeal rights.

VI. Retention of records

BCBSM and Plan Sponsor shall maintain all records required by 42 C.F.R §423.888(d)(3) for a period not less than 10 years after the expiration of the qualified retiree prescription drug plan year in which Part D drug costs were incurred, or as otherwise required by law.

VII. HIPAA compliance

The parties acknowledge and agree that this Agreement involves the use and disclosure of HIPAA protected health information. The parties therefore agree that all uses and disclosures of HIPAA protected health information pursuant to this Agreement shall be undertaken in compliance with all applicable HIPAA requirements.

VIII. Miscellaneous provisions

A. Modifications. All modifications to this Agreement must be agreed to in writing by the parties.

B. Assignment. This Agreement may not be assigned by either party

H. Severability. If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

I. Status as Independent Entities. Nothing in this Agreement is intended to create, or shall be deemed or construed to create, any relationship between BCBSM and Plan Sponsor other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither BCBSM nor Plan Sponsor, nor any of their respective agents, employees, subcontractors or representatives shall be construed to be the agent, employee, subcontractor or representative of the other.

J. Calculation of Time. Unless otherwise specifically stated in this Agreement, the parties agree that for purposes of calculating time under this Agreement, any time period of less than 10 days shall be deemed to refer to business days and any time period of 10 days or more shall be deemed to refer to calendar days.

K. Force Majeure. Neither BCBSM nor Plan Sponsor shall be liable for its failure to perform any obligation under this Agreement because of contingencies beyond its reasonable control, including but not limited to strikes (other than strikes within such party's own labor force), riots, war, fire, acts of God, disruption or failure of electronic or mechanical equipment or communication lines, telephone or other interconnections, unauthorized access, theft, or acts in compliance with any law or government regulation. If a party's failure to perform continues for more than 20 business days, the other party shall have the right to terminate this Agreement immediately.

L. Headings. The headings in this Agreement have been included solely for reference and are to have no force or effect in interpreting its provisions.

M. Counterparts. This Agreement may be executed in counterparts, any of which need not contain the signature of more than one party, but all of which taken together, shall be one and the same agreement.

N. Dispute Resolution. BCBSM and Plan Sponsor agree to resolve any controversy or dispute that may arise out of or relate to this Agreement, or the breach thereof, whether involving a claim in tort, contract or otherwise, pursuant to the dispute resolution provisions, if such exist, of the group health agreement between the parties. Otherwise, any suit arising out of this Agreement

must be filed within 2 years after the cause of action arose and, unless pre-empted by federal law, shall be brought in a Michigan court of competent jurisdiction. If a BCN product line is included in the RDS filing, under no circumstances may a BCN group file suit before exhausting the internal BCN-administered steps of the applicable grievance procedure. However, exercising any such rights shall not extend the 2 year period in which all suits must be filed.

O. Survival. The provisions of Sections Term and Termination, Indemnification, Limitation of Liability, Retention of Records, HIPAA compliance and miscellaneous provisions shall survive the expiration or termination of the Agreement for any reason.

IN WITNESS WHEREOF, the parties have executed this Agreement.

Blue Cross Blue Shield of Michigan	Plan Sponsor
BY:_____	BY: _____
TITLE:_____	TITLE: _____
DATE:_____	DATE: _____

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

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

CHANGE NOTICE NO. 16
to
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross & Blue Shield of Michigan	**Arva Overton**	**aoverton@bcbsm.com**
600 Lafayette E, 517J	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	**(313) 448-5912**	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	**MCSC**	**Lauri Schmidt**	**(517) 373-9211**	**schmidtl@michigan.gov**
BUYER:	**DTMB**	**Lance Kingsbury**	**(517) 241-3768**	**kingsburyl@michigan.gov**

CONTRACT SUMMARY:			
DESCRIPTION: **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS	CURRENT EXPIRATION DATE
November 1, 2002	**September 30, 2007**	**Successive annual renewal periods**	**September 30, 2012**
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	**N/A**	**N/A**	**N/A**
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☒ YES ☐ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

DESCRIPTION OF CHANGE NOTICE:		
OPTION EXERCISED: ☐ NO ☒ YES	IF YES, EFFECTIVE DATE OF CHANGE: **October 1, 2012**	NEW EXPIRATION DATE: **September 30, 2013**
Effective immediately, this Contract is hereby EXTENDED to September 30, 2013, and INCREASED by $655,000,000.00. **All other terms, conditions, specifications, and pricing remain the same.** **Per Civil Service request, contractor agreement, DTMB Procurement approval, and State Administrative Board approval on September 13, 2012.**		
VALUE/COST OF CHANGE NOTICE:	**$655,000,000.00**	
ESTIMATED REVISED AGGREGATE CONTRACT VALUE:	**$3,287,000,000.00**	

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY MANAGEMENT AND BUDGET **October 28, 2011**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 15 (Revised)
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 448-5912 **Arva Overton**
Blue Cross & Blue Shield of Michigan **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Lauri Schmidt (517) 373-9211 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT, EXCEPT FOR THE SERVICES DESCRIBED IN CHANGE NOTICE NO. 11.

NATURE OF CHANGE(S):

Effective immediately, the new service levels are hereby incorporated:

- **90 percent of calls must be answered in 30 seconds or less or penalties will be accessed as follows:**

Performance	Penalty Application
90.0% and above	No Penalty Applied
89.0% - 89.9%	1%
88.0% - 88.9%	2%
87.0% - 87.9%	3%
86.0% - 86.9%	4%
Below 86.0%	5%

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Civil Service request and DTMB Procurement approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $2,632,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY MANAGEMENT AND BUDGET September 20, 2011
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 14
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 448-5912 **Arva Overton**
Blue Cross & Blue Shield of Michigan **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Lauri Schmidt (517) 373-9211 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2012**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT, EXCEPT FOR THE SERVICES DESCRIBED IN CHANGE NOTICE NO. 11.

NATURE OF CHANGE(S):

Effective October 1, 2011, this contract is hereby extended to September 30, 2012 and the contract value is increased by $655,000.000.00. Please also note that the buyer has been CHANGED to Lance Kingsbury and the CCI has been CHANGED to Lauri Schmidt.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Civil Service request, Ad Board approval on 9/15/11, and DTMB/Purchasing Operations' approval.

INCREASE: 655,000,000.00

TOTAL REVISED ESTIMATED CONTRACT VALUE: $2,632,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **October 1, 2010**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 13
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE (248) 448-5912 **Arva Overton** BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2011**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT, EXCEPT FOR THE SERVICES DESCRIBED IN CHANGE NOTICE NO. 11.

NATURE OF CHANGE(S):

Effective October 1, 2010, this contract is hereby extended to September 30, 2011 and the contract value is increased by $594,000,000.00.

The following fee structure is effective October 1, 2010 through September 30, 2011:

	Active & Non-Medicare Retirees	Medicare Supplemental Retirees	Aetna – Medicare Supplemental Retirees
FY10 Administrative Fee	**$22.89**	**$22.89**	**$8.52**
FY10 Access Fee	**$20.72**	**$20.72**	**$20.72**

The following modification to Group Conversion is effective January 1, 2011:

Beginning January 1, 2011, Employees or retiring Employees and their eligible dependents ("Enrollees") will no longer be eligible to obtain coverage through the BCBSM group conversion plan currently available under this Contract No. 071B3001060 ("Contract"). Instead, Enrollees who would otherwise have been eligible for group conversion from BCBSM ("Eligible Enrollees") may select from a BCBSM individual product either (A) as an alternative to COBRA when first eligible for COBRA or (B) at the end of the COBRA eligibility period if all required COBRA payments have been made. Application must be made by an Eligible Enrollee within sixty ~~thirty (30)~~ (60) days after he or she first becomes an Eligible Enrollee or exhausts his or her COBRA ~~-~~benefits as the case may be.

If option A is chosen, BCBSM will waive the preexisting condition exclusion that otherwise would be imposed in accordance with underwriting policy only for certain individual BCBSM products as identified by BCBSM (at least two products then currently marketed will be available as options). All other underwriting requirements will apply. After December 31, 2012, BCBSM will no longer waive the preexisting condition exclusion for any Eligible Enrollees as provided above in this paragraph, and all of BCBSM's normal underwriting requirements will apply.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Civil Service request dated 5/6/10, Ad Board approval on 9/30/10, and DTMB/Purchasing Operations' approval.

TOTAL REVISED ESTIMATED CONTRACT VALUE: $1,977,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

September 24, 2010

CHANGE NOTICE NO. 12
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE (248) 448-5912 **Arva Overton** BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT, EXCEPT FOR THE SERVICES DESCRIBED IN CHANGE NOTICE NO. 11.

NATURE OF CHANGE(S):

Effective immediately, the following language is hereby added to the Contract:
With respect to the Medicare Advantage program, which terminated on December 31, 2009, BCBSM agrees to full transparency and pass through related to CMS revenue payments and claims associated with CSC members in the Medicare Advantage program. Full pass through means that any payments or recoupment made by CMS to BCBSM for CSC members will be promptly credited to CSC in the case of payments and billed to and promptly paid by CSC in the case of recoupment. CSC retains the right to audit BCBSM's claims records and CMS payment records

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Civil Service request dated 6/16/10, and DTMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $1,383,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **July 30, 2010**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 11
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 448-5912 **Arva Overton**
Blue Cross & Blue Shield of Michigan **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT.

NATURE OF CHANGE(S):

Effective immediately, the following Statement of Work is hereby added to the Contract.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per Civil Service request dated 6/16/10, and DTMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $1,383,000,000.00

Blue Cross Blue Shield Blue Care Network of Michigan

AGREEMENT TO PROVIDE ADMINISTRATIVE SERVICES
FOR THE EARLY RETIREE REINSURANCE PROGRAM
Addendum to Contract No. 071B3001060

1. Purpose

This addendum (the "Agreement") is made as of August 4, 2010 (the "Effective Date") by and between Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan, a Michigan health care corporation (collectively as "BCBSM") and the State of Michigan, as the plan sponsor and health care plan (collectively "Sponsor"), for the purpose of delineating the terms and conditions under which BCBSM will provide services related to Sponsor's participation in the early retiree reinsurance program (the "Program") administered by the Department of Health and Human Services.

2. Definitions

A. The terms "Certified," "Claim," "Employment-Based Plan," and "Health Benefits" shall have the same meanings as in 45 C.F.R. § 149.2.

B. The term "Chronic and High-Cost Condition" means any condition for which $15,000 or more in Health Benefits claims are likely to be incurred during a plan year by one Employment-Based Plan participant.

C. The term "HHS" means the United States Department of Health and Human Services, and references to HHS include the Secretary of HHS or the Secretary's designee.

D. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

E. The term "Program" means the Early Retiree Reinsurance Program established in Section 1102 of the Patient Protection and Affordable Care Act and implementing HHS interim final rule at 45 C.F.R. Part 149.

F. The term "Program-Eligible Individual" means an individual who is age 55 or older, enrolled for Health Benefits in a Certified Employment-Based Plan, not eligible for coverage under Medicare (Title XVIII of the Social Security Act), and not an active employee of Sponsor, as well as such individual's enrolled spouse, surviving spouse, and dependents (if applicable).

G. The term "Program Requirements" means the requirements of 45 C.F.R. Part 149, and any administrative guidance there issued.

H. The term "Negotiated Price Concession" means any direct or indirect remuneration (including discounts, direct or indirect subsidies, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits), received by the Sponsor in the case of a self-insured plan; or BCBSM or Sponsor in the case of a fully-insured plan, that would serve to decrease

the costs incurred under the Employment-Based Plan.

3. Term and termination

A. Term. The term of this Agreement will commence on the Effective Date and will expire upon expiration or termination of the Contract(s), unless earlier terminated as set forth below.

B. Termination of Agreement. In addition to the grounds for termination under the Contract(s), this Agreement shall automatically terminate if HHS eliminates or terminates the Program or denies Sponsor's Program application.

4. Scope of services

A. Program application.

1. Responsibility for preparing and submitting Program application. BCBSM or its Subcontractor shall assist Sponsor in the preparation of the Program application and provide necessary data as requested by Sponsor. Sponsor shall designate one of its employees as the authorized representative for the Program application. BCBSM or its Subcontractor and Sponsor will work cooperatively to provide the data needed to complete Sponsor's Program application on a timely basis. BCBSM or its Subcontractor will submit the final ERRP application to HHS.

2. Projection of claims.

(a) Responsibility for preparing projection. BCBSM or its Subcontractor shall prepare and submit to Sponsor a projection of amounts to be received by Sponsor under the Program for the first two plan year cycles, as described in 45 C.F.R. § 149.40.

(b) Data for projection. Sponsor shall provide all information BCBSM or its Subcontractor requests for the projection including, without limitation, information regarding retiree contributions, demographic data, and benefit options related to Sponsor's coverage of Program-Eligible Individuals under the Employment-Based Plan. Sponsor shall also provide BCBSM or its Subcontractor with a list of all Plan members and Program-Eligible Individuals or, at the option of BCBSM or its Subcontractor, another suitable method of identifying all Program-Eligible Individuals.

3. Fraud, waste, and abuse policies. BCBSM has implemented policies and procedures to detect and reduce fraud, waste, and abuse in connection with the Employment-Based Plan, in accordance with 45 C.F.R. § 149.40. Upon request by HHS for Sponsor or BCBSM to substantiate the existence of such policies and procedures, pursuant to 45 C.F.R. § 149.40(f)(4)(iii), BCBSM shall provide such substantiation information directly to HHS. BCBSM will include a summary of its policies and procedures as part of such substantiation information to the extent required by HHS.

4. Programs that generate savings for Chronic and High-Cost Conditions.

BCBSM shall provide Sponsor with a summary explanation describing the procedures or programs it has in place that have generated or have the potential to generate cost savings with respect to Employment-Based Plan participants with Chronic and High-Cost Conditions. Such summary shall be provided not later than thirty (30) days after the Effective Date.

B. Claims submission.

1. Responsibility for compiling and submitting data. BCBSM or its Subcontractor shall compile and submit Claims data to HHS on a monthly basis, in accordance with Program Requirements, but in no event more frequently than permitted by

HHS. At least 3 days in advance of the date that BCBSM or its Subcontractor will submit the Claims data to HHS, Sponsor shall provide to BCBSM or its Subcontractor Sponsor's current list of Program-Eligible Individuals or, at the election of BCBSM or its Subcontractor, another suitable method of identifying such Program-Eligible Individuals;

Sponsor shall be solely responsible for identifying, obtaining, and providing to BCBSM or its Subcontractor any Claims data that originates with Sponsor or with any third party that is not subcontracted by BCBSM in a format acceptable to BCBSM or its Subcontractor.
If BCBSM receives any post-point-of-sale price concessions with respect to Health Benefits for which Claims data has previously been submitted to HHS, BCBSM or its Subcontractor shall disclose the amount of such post-point-of-sale price concessions to HHS in accordance with 45 C.F.R. § 149.110(b).
If Sponsor receives any post-point-of-sale price concessions with respect to Health Benefits for which Claims data has previously been provided to BCBSM or its Subcontractor, Sponsor shall, in a time frame consistent with 45 C.F.R. § 149.110(b), notify BCBSM or its Subcontractor of such post-point-of-sale price concession. BCBSM or its Subcontractor shall disclose the amount of such post-point-of-sale price concessions to HHS in accordance with 45 C.F.R. § 149.110(b).

2. Duty to monitor. With regard to any re-adjudicated claims, BCBSM will submit updated cost data to HHS with its next Claims submission, or at such other time as may be required pursuant to 45 C.F.R. § 149.110(b).

3. Receipt of Program payments. Sponsor shall receive all Program payments from the United States directly, and BCBSM shall have no responsibility for receiving or handling such payments.

C. No obligation to submit inaccurate or incomplete data. BCBSM or its Subcontractor shall have no obligation to provide or submit data in support of Sponsor's Program application or a submission to obtain payment under the Program when the data is or may be inaccurate or incomplete, or would otherwise not be in compliance with Program Requirements. BCBSM shall contact Sponsor to discuss the accuracy of data if it believes that the data is or may be inaccurate or incomplete, or would otherwise not be in compliance with Program Requirements.

D. Corrections and modifications. Should BCBSM learn that any data provided by either party to this Agreement or by any third party is or was inaccurate, that Sponsor is or has received Program overpayments, or that Sponsor's Program application, reimbursement data, or any submissions to HHS fail to comply with Program Requirements, then except as specifically provided in Section 4(B)(2), BCBSM shall notify the Sponsor.

5. Compensation

Sponsor shall notify BCBSM of the first Program payment received for each Plan year immediately after receipt. Sponsor shall pay BCBSM the applicable fees set forth in the following table:

Compensation Summary	**Total Fee**
Year 1	
Immediately upon Sponsor's receipt of the first Program payment, Sponsor will pay BCBSM $375,000 for year 1 of this Agreement.	$375,000
Year 2	
Sponsor shall pay to BCBSM 12 monthly installments of $10,500 during year 2 of this Agreement. The total amount to be paid shall be capped at	$125,000

$125,000. HHS termination of this Program or depletion of Program funds during year 2 of this Agreement will terminate Sponsor's monthly payment obligations that follow such date of termination or fund depletion.	

Upon final reconciliation, HHS may determine an overpayment for the relevant Plan Year was made to the Sponsor and demand return of such overpayment. The Sponsor shall be financially responsible for the return of any and all overpayments made by HHS.

6. Acknowledgement of purpose of data

Pursuant to 45 C.F.R § 149.40(f)(4)(ii), BCBSM acknowledges that information it provides to Sponsor pursuant to this Agreement may be used by Sponsor for the purpose of obtaining federal funds.

7. Appeals

In the event that HHS makes an adverse reimbursement determination, BCBSM will provide Sponsor, at Sponsor's request, reasonable access to information that Sponsor may need to exercise its appeal rights, but Sponsor shall be solely responsible for submitting any request for appeal under 45 C.F.R. § 149.500(e).

9. Limitation of liability

BCBSM and its agents, officers, employees, directors, and subcontractors, shall not be liable to Sponsor or Plan if HHS terminates or denies Sponsor's Program application for any reason, and BCBSM shall not be liable to Sponsor for any amounts that are not paid or reimbursed by HHS under the Program or that HHS recoups or withholds for any reason. Any information provided by BCBSM should not be considered advice, legal or otherwise, regarding Sponsor's compliance with any or all Program Requirements, and BCBSM shall not be liable, in whole or in part, for Sponsor's reliance on such information. In all events, BCBSM's liability to Sponsor under this Agreement is limited to the amount of compensation paid by Sponsor under Section 5 of this Agreement. Under no circumstances shall BCBSM be liable for indirect, consequential, special, or punitive damages.

No guarantee of Program Participation or Reimbursement

BCBSM does not represent, warrant or guarantee that Sponsor is eligible to participate in the Program, that Sponsor's application for the Program will be accepted and Certified, that Sponsor will receive any funds in connection with the Program, or, if Sponsor does receive funds in connection with the Program, the amount of such funds.

10. Standard of care, cooperation, and regulatory changes

A. Standard of care. The parties recognize that because the Program is new, the Program Requirements and procedures are not fully defined and developed, and subsequent administrative guidance or requirements from HHS may materially alter the scope of services or manner in which the services contemplated by this Agreement are to be provided. In light of these factors, BCBSM will make a good faith effort to compile and provide information in accordance its best understanding and interpretation of the Program Requirements. Group agrees that BCBSM is not acting as a fiduciary under the Employee Retirement Income Security Act ("ERISA"), common law, or otherwise with respect to its actions under the Program. BCBSM does not undertake to act, and shall not act, as a fiduciary. Any fiduciary obligations under ERISA or otherwise with respect to the Program shall be the duties of Sponsor.

B. In satisfying its obligations under this Agreement, BCBSM may utilize and/or obtain and/or provide data that is developed and maintained by third parties and BCBSM does not warrant or assume responsibility for the accuracy of such data.

C. The parties recognize that BCBSM's existing data sources, and those of its subcontractors, were not designed for purposes of the Program. Thus, BCBSM can not and does not guarantee the accuracy of such information and data.

D. Cooperation. The parties recognize that they must mutually cooperate to perform the services required under this Agreement, and that BCBSM shall not be responsible if it is unable to complete any tasks because Sponsor, or any third party contracted by Sponsor, fails to meet its obligations, including providing required data.

E. Regulatory changes. If either party believes that subsequent guidance or requirements from HHS have materially altered the scope of services or manner in which the services contemplated by this Agreement are to be provided, or that any provision of this Agreement is inconsistent with Program Requirements, that party shall promptly notify the other party in writing, and the parties shall negotiate to amend this Agreement.

11. Retention of records

BCBSM and Sponsor shall maintain all records required by 45 C.F.R § 149.350(b) for a period not less than six years after the expiration of the Employment-Based Plan's plan year in which Program-reimbursable costs were incurred (without regard to the date the Agreement terminates), or as otherwise required by law.

12. HIPAA compliance

The parties acknowledge and agree that this Agreement involves the use and disclosure of HIPAA protected health information. The parties therefore agree that all uses and disclosures of HIPAA protected health information pursuant to this Agreement will be undertaken in compliance with all applicable HIPAA requirements. BCBSM shall disclose HIPAA protected health information to a third party, other than HHS or other federal government agency in connection with the Program, only upon Sponsor's written certification that such disclosure is permitted under HIPAA. BCBSM and Sponsor agree that this Agreement satisfies the requirements of 45 C.F.R. § 149.35(b)(2).
BCBSM shall provide HIPAA protected health information directly to Sponsor or Sponsor's designee under Section 4 only if Sponsor certifies in writing that: (A) appropriate HIPAA business associate agreements are in effect between BCBSM, Sponsor, Sponsor's designee, and the Employment-Based Plan; (B) the plan documentation for the Employment-Based Plan permits such disclosure; and (C) the Sponsor has taken all other steps required by HIPAA in order to legally receive such protected health information.

13. Miscellaneous provisions
A. Amendments. All amendments to this Agreement must be agreed to in writing by the parties.
B. Calculation of time. Unless otherwise specifically stated in this Agreement, the parties agree that for purposes of calculating time under this Agreement, any time period of less than ten days will be deemed to refer to business days and any time period of ten days or more will be deemed to refer to calendar days.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **July 8, 2010**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 10
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (248) 448-5912 **Arva Overton**
Blue Cross & Blue Shield of Michigan **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DTMB / Civil Service Commission**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

THIS CONTRACT IS EXTENDED TO LOCAL UNITS OF GOVERNMENT.

NATURE OF CHANGE(S):

Effective immediately, the following terms and conditions are hereby added to the Contract:

A new contract section is hereby added to Article VII of the Contract:

O. Extended Purchasing

1. MiDEAL

A. 1984 PA 431 permits DTMB to provide purchasing services to any city, village, county, township, school district, Intermediate school district, non-profit hospital, institution of higher education, community or junior college. A current listing of approved program members is available at www.michigan.gov/mideal. Unless otherwise stated, the Contractor must ensure that the non-state agency is an authorized MiDEAL member before extending the State Contract to them.

B. The Contractor must make the Contract available to any MiDEAL member that request to participate in the Contract. The Contractor must honor terms of the Contract when providing pricing to any MiDEAL member. The Contractor must negotiate in good faith with any MiDEAL member to offer the Services for a reasonable administrative fee. The administrative

fee should be transparent, with no hidden costs or fees. The Contractor and the local unit of government may negotiate only the scale of the administrative portion of the State Contract in their administrative fee negotiations. Changes to the Article 2 Terms and Conditions, or Plan Design are not allowed.

C. The Contractor must submit its invoices to, and be paid by the local unit of government on a direct and individual basis.

2. Civil Service Rule

A. The Contractor must support the State in compliance with Civil Service Rule 5-11.1,

Section (e)(2), in that the State Personnel Director may approve agreements with other public entities to permit their employees to participate in group insurance plans authorized by the Civil Service Commission if 100 percent of any additional total cost of participation is paid by the participating public entities or their employees.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON: Executive Directive 2010-1, vendor agreement dated 6-14-10, and Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $1,383,000,000.00

FOR THE CONTRACTOR:	**FOR THE STATE:**
Blue Cross & Blue Shield of Michigan	
Firm Name	Signature
	Melissa Castro, Acting Division Director
Authorized Agent Signature	Name/Title
	Services Division, Purchasing Operations
Authorized Agent (Print or Type)	Division
Date	Date

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **January 4, 2010**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 9
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 241-4225 **Kevin Dunn**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
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 1, 2009, through December 31, 2009, the Administrative Fee for Medicare Advantage retirees is $13.50.

NOTE: The DMB Buyer for this Contract is now KevinDunn (517) 241-4225.

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per Agency/Contractor agreement and DMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $1,383,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **November 6, 2009**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 8
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 373-1080 **Melissa Castro, CPPB**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
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 November 3, 2009, this Contract is hereby INCREASED by $523,000,000.00.

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request (PRF dated 6/5/09), Ad Board approval on 11/3/09, and DMB/Purchasing Operations' approval.

REVISED CURRENT AUTHORIZED SPEND LIMIT: $1,383,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **October 15, 2009**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 7
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 373-1080 **Melissa Castro, CPPB**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2010**	
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 1, 2009, this Contract is hereby EXTENDED through September 30, 2010.

Also effective October 1, 2009:

- **The Administrative Fee for Medicare Supplemental Aetna Transfers is $9.00;**
- **The Administrative Fee for Medicare Supplemental Non-Aetna Transfers is $23.46;**
- **The Administrative Fee for Non-Medicare Retirees and Active Employees is $23.46;**
- **The Access Fee for Non-Medicare Retirees and Active Employees is $20.72.**

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request (PRF dated 6/5/09) and DMB/Purchasing Operations' approval.

CURRENT AUTHORIZED SPEND LIMIT REMAINS: $860,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **February 24, 2009**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 6 (REVISED)
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 373-1080 **Melissa Castro, CPPB**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2009**	
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 September 30, 2008, this Contract is hereby EXTENDED through September 30, 2009. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request, and DMB/Purchasing Operations.

TOTAL REVISED ESTIMATED CONTRACT VALUE: $860,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **October 9, 2007**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 373-1080 **Melissa Castro, CPPB**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** 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 October 1, 2007, this Contract is hereby EXTENDED through September 30, 2008, and INCREASED by $510,000,000.00. Additionally, effective immediately, the language in Article 2-E ("State Audit") is hereby removed and replaced with the attached "State Audit" language. NOTE: The buyer for this Contract is changed to Melissa Castro (517) 373-1080.

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request, Ad Board approval on 9/18/2007, and DMB/Purchasing Operations.

TOTAL REVISED ESTIMATED CONTRACT VALUE: $860,000,000.00

Errors

(a) If the audit demonstrates any errors in the statements provided to the State, then the amount in error shall be reflected as a credit or debit on the next invoice and in subsequent invoices until the amount is paid or refunded in full. However, a credit or debit may not be carried for more than four (4) quarterly statements. If a balance remains after four (4) quarterly statements, then the remaining amount will be due as a payment or refund within 45 days of the last quarterly statement that the balance appeared on or termination of the contract, whichever is earlier.

(b) In addition to other available remedies, the difference between the payment received and the correct payment amount is greater than 10%, then the Contractor shall pay all of the reasonable costs of the audit.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **January 10, 2007**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 4
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR **Blue Cross & Blue Shield of Michigan** **600 Lafayette East, B491** **Detroit, MI 48226** **aoverton@bcbsm.com**	TELEPHONE: (248) 448-5912 **Arva Overton** BUYER/CA (517) 241-1647 **Irene Pena, Buyer**
Contract Compliance Inspector: Susan Kant (517) 335-3068 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 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, the Contract Compliance Inspector for this Contract is:

Susan Kant
Department of Civil Service
(517) 335-3068
KantS@michigan.gov

BCBS Contacts are as follows:

Areva Overton (Change Notices)
27000 West 11 Mile Road
Southfield, MI 48034
(248) 448-5912
aoverton@bcbsm.com

Ken Dallafior (Signature of Contract)
27000 West 11 Mile Road
Southfield, MI 48034
(248) 448-7342
kdallafior@bcbsm.com

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $ 350,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

December 12, 2006

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE
Blue Cross & Blue Shield of Michigan **B491** **600 Lafayette East** **Detroit, MI 48226** **jsspears@bcbsm.com**	BUYER/CA (517) 241-1647 **Irene Pena, Buyer**
Contract Compliance Inspector: Jan Winters (517) 373-3020 **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 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, the Contract Compliance Inspector for this Contract is:

Jan Winters
Department of Civil Service
(517) 373-3020
WintersJ@michigan.gov

All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:

Per agency request and DMB/Purchasing Operations approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $ 350,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **July 6, 2004**
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO.2
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE
Blue Cross & Blue Shield of Michigan **B491** **600 Lafayette East** **Detroit, MI 48226** **jsspears@bcbsm.com**	BUYER/CA (517) 241-1647 **Irene Pena, Buyer**
Contract Compliance Inspector: Peggy Moczul **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 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, the attached documents are hereby incorporated into this contract.

All other terms, conditions, specifications and pricing remain unchanged.

AUTHORITY/REASON:

Per vendor (Julie Smith-Spears) and agency (Peggy Moczul) agreement on 5/4/04.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: $ 350,000,000.00

May 4, 2004

Ms. Peggy Moczul, CEBS, Director
Employee Benefits Division - DCS
Capitol Commons Center - 4th Floor
400 South Pine
Lansing, MI 48909

Re: Mutual agreement on SOM/BCBSM health care contract changes

Dear Ms. Moczul:

Per your request, I have documented below the health care contract items which have been revised. Based on previous discussion and mutual agreement, the changes are effective retroactively to the original November 1,2002 contract effective date. Your signature on the last page of this letter constitutes formal agreement to these changes until the State can generate a formal contract Change Notice reflecting the same:

1. **Systems and Reporting Requirements - Reports Pg. 32- sect. 7.D.**
   The following report types and frequency will replace those as stated in the contract:
   - Monthly Report(s):
     1. Claims Lag Report as per Appendix F in the Nov. 2002 contract
   - Quarterly Reports
     1. Enrolled Contract and Claims Experience report shown by line of business inclusive of dependent children and sponsored dependents.
     2. Age/Sex Exposure Report showing the ratio of male to female membership
     3. Age/Sex Contract Report showing paid claims by age/sex categories and by contract type and by line of business
     4. Claims Summary Report showing total claims paid by line of business and by number of services and/or cases billed
     5. Benefit Breakdown Report showing paid claims by line of business and by sub categories of service and procedure codes
     6. Excess Claims Report showing payments by specified dollar ranges
     7. Settlement Accounting Report showing a reconciliation of claim payments fees and other financial transactions
     8. Details claims filed formatted as required for the State's specified data vendor through April 30, 2004.
     9. COB Activity Summary Report showing savings resulting from COB activity
     10. Administrative and Access Fee Summary Reports (will be included as a part of the quarterly reconciliation report)
   - Annual Reports (based on the SOM fiscal year)
     Full financial and enrollment summary of the above reports and additional clinical/medical findings which may be approved by the State as pertinent to the report. Reporting timeframes are as follows:
     - Monthly reports will be produced within 45 to 60 calendar days of the end of the month.
     - Quarterly reports will be produced with 60 to 90 calendar days of the end of the quarter.
     - The Annual report will be produced within 120 calendar days of the end of the year.

2. **Performance Guarantees - Claims Accuracy Section 8. C. Pg. 34 -**
Regarding audit frequency , the State shall perform an audit of health care claims every *other* year, auditing claims processed for the previous two fiscal years according to the contract and audit agreement guidelines in place for those respective years.

   Example: Audit Year 2004 for claims processed during FY's 10/2001 thru 9/2003; Claims processed under the State Health Plan *Advantage* are subject to the contract and Audit Agreement and Performance Guarantees in place for those respective years. Claims processed under the State Health Plan Advantage (October through December 2002) will be audited according to the audit agreement in place for the Advantage Plan prior to November 1, 2002. (Appendix C)

   Audit Year 2006 for claims processed during FY's 10/2003 through 9/2005)
   Claims processed under the new State Health Plan contract (January 1, 2003 through September 2005) are subject to the PPO Contract and Performance Guarantees effective January 1, 2003. (contract pages 97 and 98)

3. **Performance Guarantees Section 8 Pg. 33**
BCBSM and SOM agree that the period, January through June 2003, is exempt from performance penalties **in addition to penalties that would be applied as result of the audit results for the same time period. (See correspondence dated January 7, 2003 regarding Health Care Audit relief.)**

4. **Performance Guarantees Section 8. D Inquiry Handling Page 49**

   BCBSM commits to 85% of **priority /** special handling written inquiries received from the Employee Benefits Division **(State Benefit Office)** will be **finalized** within 14 calendar days. **This standard is reported monthly with penalties assessed annually.**

   Eighty-five percent of all written inquiries (non-priority) will be finalized within 21 days. **This performance standard will be reported monthly with penalties assessed annually.**

   One hundred percent (100%) of all written inquiries will be responded to within 30 days. Written inquiry issues outstanding at the end of 30 days, will be reported by BCBSM SOM Service Unit to SOM Account Managers to review with the State. A second report showing closed inquiries over 30 days with final disposition will also be provided to the State by the Account Managers for review. The response time is calculated from the date of receipt by the BCBSM to final resolution of the inquiry.

   100% of phone inquiries will be returned within 24 hours. **(Not subject to financial penalty)**

   The State of Michigan customer service telephone inquiry unit will maintain sufficient staffing to respond to telephone calls by not allowing in excess of 30 seconds on hold for more that 80% of the calls received.

   At least 85% of participants must be satisfied with BCBSM's customer service.

At least 7.2% of the annual administrative fees are at risk if the financial accuracy standards' claim payments are not met. Penalties will be based on a twelve month average performance per standard and assessed on accumulative performance annually.

Example: Penalty applied
BCBSM finalizes 85% of all SOM claims in 14 calendar days for the first nine out of twelve months of the year. For the remaining three months BCBSM performance for this standard is 83%, 82%, and 84.5% respectively. The twelve month average for this standard is 84.54%, which is under the standard required. **A 1% penalty of the 5% of the total 18% of administrative fee at risk will be applied accumulatively to any other twelve-month averaged standards not met and paid annually.**

Example: Penalty not applied
BCBSM finalizes 85% of all SOM claims in 14 calendar days for the first six out of twelve months of the year. For the remaining next three months BCBSM performance for this standard is 83%, 82%, and 84.5% respectively. For the final three months of the years performance is 88%, 90%, and 93%. The twelve month average for this standard equals 85.87%. Because the average performance for that standard is over 85%, **no penalty is applied**.

5. **Performance Guarantees** **Risk and Performance Chart** **Pg. 97 - 98**
   Revised attached copy reflects changes above named changes. See #4 above.

6. **Required Staffing** **Section 9 - Account Management/ Servicing Staff** **Pg. 36**
   BCBSM and the SOM agree the Contract Administrator position will not be a required position as indicated in the contract, but can be added to the administrative team as budgetary constraints are relieved.

Please advise if you have questions.

Sincerely,

Julie Smith-Spears
Manager - Sales
State of Michigan Unit
Corporate Key Accounts

Signature of Agreement: _____

Peggy Moczul, CEBS
Director, Employee Benefits Division

Cc: L. Schmidt
A. Overton
C. Deuel
L. Ketchum

MAY 4, 2004

SOM Performance Guarantee Effective 1/1/03

Performance Standard	Financial Penalty*	Recommended Performance	Monitoring Method & Frequency**	Penalty Application
1. Finalize 85% of all claims in 14 calendar days**	5% of the total 18% administrative fee at risk ($153,000)*	85.0% and Above 84.0%-84.9% 83.0%-83.9% 82.0%-82.9% 81.0%-81.9% Below 81%	BCBSM Corporate Quality Assessment produces report on monthly basis. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
2. Finalize 98% of all claims in 30 calendar days**	5% of the total 18% administrative fee at risk ($153,000)*	98.0% and Above 96.0%-97.9% 94.0%-95.9% 92.0%-93.9% 90.0%-91.9% Below 90.0%	BCBSM Corporate Quality Assessment produces report on monthly basis. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
3. 99.3% Financial Accuracy of Claims (Biennial Audits)	50% of the total 18% administrative fee at risk ($1,530,000)*	99.30% and Above 99.00%-99.29% 99.75%-98.99% 98.50%-98.74% 98.25%-98.49% 98.00%-98.24% 97.75%-97.99% 97.50%-97.74% 97.25%-97.49% 97.00%-97.24% Below 97.00%	Biennial Audit Performed by SOM Group. Penalties will be assessed annually.	No penalty applied 5% 10% 15% 20% 25% 30% 35% 40% 45% 50%
4. Telephone Lost Calls (ABN) <5%**	5% of the total 18% administrative fee at risk ($153,000)*	5.0% or Less 5.1%-6.0% 6.1%-7.0% 7.1%-8.0% 8.1%-9.0% Above 9.0%	BCBSM produces monthly report from ASPECT. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
5. Telephone Blocked Calls <3% (based on MTM standards)**	6% of the total 18% administrative fee at risk ($183,600)*	3.0% or Less 3.1%-4.0% 4.1%-5.0% 5.1%-6.0% 6.1%-7.0% Above 7.0%	BCBSM produces monthly report from ASPECT. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
6. TSF- Respond to 80% of calls in 30 Seconds (80/30)**	4% of the total 18% administrative fee at risk ($122,400)*	80% and Above 79.0%-79.9% 78.0%-78.9% 77.0%-77.9% 76.0%-76.9% Below 76.0%	BCBSM produces monthly report from ASPECT. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
7. Resolve 90% of all inquiries (telephone / written) on first contact **	5% of the total 18% administrative fee at risk ($153,000)*	90.0% and Above 89.0%-89.9% 88.0%-88.9% 87.0%-87.9% 86.0%-86.9% Below 86.0%	BCBSM Corporate Quality Assessment produces report on monthly basis. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%

SOM Performance Guarantee Effective 1/1/03 cont'd

Performance Standard	Financial Penalty*	Recommended Performance	Monitoring Method & Frequency**	Penalty Application
8. Finalize 85% of SBO inquiries in 14 calendar days**	5% of the total 18% administrative fee at risk ($153,000)*	85% and Above 84.0%-84.9% 83.0%-83.9% 82.0%-82.9% 81.0%-81.9% Below 81%	BCBSM will produce a monthly report. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
9. Finalize 85% of all written inquiries (non-priority) in 21 calendar days.**	5% of the total 18% administrative fee at risk ($153,000)*	85% and Above 84.0%-84.9% 83.0%-83.9% 82.0%-82.9% 81.0%-81.9% Below 81%	BCBSM Corporate Quality Assessment will produce a monthly report. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
10. Respond to 100% of all written inquiries with final status within 30 days. **	5% of the total 18% administrative fee at risk ($153,000)*	100% 99.0%-99.9% 98.0%-98.9% 97.0%-97.9% 96.0%-96.9% Below 96.0%	BCBSM Corporate Quality Assessment will produce a monthly report. Any penalties will be assessed annually.	No penalty applied 1% 2% 3% 4% 5%
Participant Satisfaction Survey 85% satisfied- Operations Manager to change questions on survey!	5% of the total 18% administrative fee at risk ($153,000)*	85% and Above 84.0%-84.9% 83.0%-83.9% 82.0%-82.9% 81.0%-81.9% Below 81%	BCBSM Produces Annual report. Survey conducted each year.	No penalty applied 1% 2% 3% 4% 5%
1. Monthly reports due 45 to 60 days following close of month	2% of the administrative fee at risk	0-8 reports late 9-16 reports late 17-24 reports late 25-31reports late 32-38 reports late 39-44 reports late 45 reports late	BCBSM will produce reports as indicated in performance standard	No Penalty .33% of 2% .66% of 2% 1.0% of 2% 1.33% of 2% 1.66% of 2% entire 2.0%
2. Quarterly reports due 60 to 90 days following close of quarter				
3. Annual reports & file due 120 days following close of year				

Note: The new performance guarantee is effective 1/1/03 with the BCBSM PPO product. The current audit period will end effective 12/31/02.

*Although the Financial Penalties are indicative of current performance guarantees, they are subject to change.

** All performance monitoring will be conducted by BCBSM, unless otherwise indicated, and based on the 12 month performance average for each standard. Any penalties will be assessed on accumulative performance annually.

AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **March 24, 2003**
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO.1
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE
Blue Cross & Blue Shield of Michigan **B491** **600 Lafayette East** **Detroit, MI 48226**	BUYER (517) 241-1647 **Irene Pena, Buyer**
Contract Administrator: Peggy Moczul **Basic (Non-HMO) Medical Plan Administration – DCS**	
CONTRACT PERIOD: From: **November 1, 2002**	To: **September 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):

The contract administrator is now:

Peggy Moczul, DCS
Director, Employee Benefits Division
Department of Civil Service
(517) 373-1846

TOTALESTIMATED CONTRACT VALUE REMAINS: $ 350,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **January 23, 2003**
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

NOTICE
TO
CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE
Blue Cross & Blue Shield of Michigan **B491** **600 Lafayette East** **Detroit, MI 48226**	BUYER (517) 241-1647 **Irene Pena, Buyer**
Contract Administrator: **Basic (Non-HMO) Medical Plan Administration – Office of State Employer**	
CONTRACT PERIOD: From: **November 1, 2002**	To: **September 30, 2007**
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 this Contract Agreement and the vendor's quote dated October 23, 2002 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.

Estimated Contract Value: $ 350,000,000.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

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

CONTRACT NO. 071B3001060
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE
Blue Cross & Blue Shield of Michigan **B491** **600 Lafayette East** **Detroit, MI 48226**	BUYER (517) 241-1647 **Irene Pena, Buyer**
Contract Administrator: **Basic (Non-HMO) Medical Plan Administration – Office of State Employer**	
CONTRACT PERIOD: From: **November 1, 2002** To: **September 30, 2007**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION: **The terms and conditions of this Contract are those of this Contract Agreement and the vendor's quote dated October 23, 2002 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.** **Estimated Contract Value: $ 350,000,000.00**	

FOR THE VENDOR:	**FOR THE STATE:**
Blue Cross & Blue Shield of Michigan	
Firm Name	Signature
	Kathryn Jones, Director
Authorized Agent Signature	Name
	Acquisition Services
Authorized Agent (Print or Type)	Title
Date	Date

ADMINISTRATIVE SERVICES CONTRACT (ASC) - WEEKLY WIRE PROGRAM

between

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

and

STATE OF MICHIGAN
SECTION I – TERMS AND CONDITIONS

THIS ADMINISTRATIVE SERVICES CONTRACT, effective as of November 1, 2002, is between BLUE CROSS AND BLUE SHIELD OF MICHIGAN (BCBSM), a Michigan non-profit corporation, whose address is 600 Lafayette East, Detroit, Michigan 48226, and the State of Michigan (State), the plan sponsor and administrator of the State of Michigan State Health Plan (SHP), whose address is Employee Benefits Division, 400 South Pine, 4thFloor, Lansing, Michigan 48909. The term "State" includes the "SHP" where the context reasonably requires a reference to both.

The intent of this Contract is to establish the criteria for eligibility of individuals for health care Coverage provided by the State; to describe health care Coverage available to such individuals through the State; to set forth the general responsibilities of the parties; and to set forth the financial responsibilities of the State for health care Coverage administered by BCBSM under this Contract.

THEREFORE, in consideration of their mutual promises, BCBSM and the State agree as follows:

ARTICLE I
DEFINITIONS

For purposes of this Contract, defined terms are:

A. **"Amounts Billed"** means the amount the State owes in accordance with BCBSM's standard operating procedures for payment of Enrollees' claims.

B. **"Contract"** means this Contract, as may be amended from time to time, and any Schedules, Exhibits and Addenda attached hereto.

C. **"Contract Year"** means the Initial Term of this Contract and each Renewal Term. In the event of termination other than at completion of the Contract Year, a Contract Year means that period from the Effective Date or the most recent Renewal Date through the termination date.

D. **"Coverage(s)"** means the health care benefits selected by the State on Schedule C - Coverage(s).

E. **Disputed Claim(s)"** means Amounts Billed used to determine the State's liability which the State believes should not be so used.

F. **"Effective Date"** means November 1, 2002**.**

G. **"Employees"** means the following who are eligible and enrolled for Coverage: (i) employees of the State as designated by the State in Schedule B, Group Enrollment Profile; (ii) if applicable, retirees and their surviving spouses as designated by the State in the Retiree Agreement; and (iii) COBRA beneficiaries.

H **"Enrollees"** mean Employees and dependents of Employees who are eligible and enrolled for Coverage.

I. **"Estimated Outstanding Liability (EOL)"** means an estimate of the State's liability for the amount of Incurred But Not Reported Claims (IBNR) which will be paid by BCBSM after the date of termination, and which is the State's obligation to pay pursuant to the provisions of this Contract.

J. **"IBNR Claims"** means Enrollees' claims which are incurred pursuant to this Contract but have not been reported as paid to the State and for which Amounts Billed will remain the State's responsibility pursuant to this Contract.

K. **"Initial Term"** means the first Contract Year commencing on the Effective Date.

L. "**Provider Network Fee**" means the amount allocated to the State for the expenses incurred by BCBSM in the establishment, management and maintenance of its participating hospital, physician and other health care provider networks.

M. "**Quarterly Payment Period**" means each three (3) month period, commencing on the Effective Date and continuing during the Term(s) of this Contract and, for purposes of Article IV.F. only, also includes the first three (3) months following termination.

N. **"Renewal Date"** means the first day of each Renewal Term stated in Schedule A.

O. **"Renewal Term"** means a period commencing on the first day following the end of the Initial Term and of each subsequent Contract Year as stated in Schedule A.

P. **"Term(s) of this Contract"** means the period(s) beginning with the Effective Date and continuing thereafter until terminated as provided in Article VII.

ARTICLE II
GENERAL RESPONSIBILITIES

A. Standards.

BCBSM shall administer Enrollees' health care Coverage(s) in accordance with BCBSM's standard operating procedures for comparable coverage(s) offered under a BCBSM underwritten program, any operating manual provided to the State, and this Contract. In the event of any conflict between this Contract and such standard operating procedures, this Contract controls.

The responsibilities of BCBSM pursuant to this Contract are limited to providing administrative services for the processing and payment of claims. BCBSM shall have no responsibility for: the failure of the State to meet its financial obligations; to advise Enrollees of the benefits provided; and to advise Enrollees that Coverage has been terminated for any reason, including the failure to make any payments when due.

If the State's health care program is subject to the Employee Retirement Income Security Act of 1974 (ERISA), it is understood and agreed that BCBSM is neither the Plan Administrator, the Plan Sponsor, nor a named fiduciary of the State's health care program under ERISA. The provisions of this paragraph, however, shall not release BCBSM from any other responsibilities it may have under ERISA.

B. Enrollment.

The State will, prior to the Effective Date of this Contract, notify BCBSM of all Enrollees eligible and enrolled for Coverage and will, thereafter, promptly notify BCBSM of all changes in eligibility/enrollment according to procedures established by BCBSM. BCBSM will not have any obligation as to changes in eligibility/enrollment prior to proper notification. BCBSM will continue to process and the State will continue to reimburse BCBSM for claims of Enrollees which were incurred through the last day of the month in which BCBSM had at least five (5) business days notice of Enrollee ineligibility.

However, if the State employs an automated means, acceptable to BCBSM, for providing enrollment and eligibility information to BCBSM, the changes will be effective on the first day following the day such changes have been properly reflected on the data base used by BCBSM to process Enrollees' claims.

C. Claims.

BCBSM will process and pay, and the State will reimburse BCBSM for all Amounts Billed related to Enrollees' claims incurred during the Term(s) of this Contract.

Following termination of Enrollee eligibility, or following termination of this Contract, as set forth in Article VII.B.1., BCBSM will continue to process and pay Enrollees' claims which are incurred during the Term(s) of this Contract; and following termination for Nonpayment or Partial Payment, as set forth in Article VII.B.2., or in the event of Enrollee ineligibility, BCBSM may, in its discretion, continue to process and appropriately pay IBNR claims and the State will reimburse BCBSM for any claims so paid.

Notwithstanding any other Contract provisions, BCBSM will have no obligation whatsoever as to claims which are incurred following termination of this Contract.

D. Dispute Resolution.

The State will, within sixty (60) days of receipt of a claims listing, notify BCBSM in writing with appropriate documentation of any Disputed Claim(s) and will, upon request, execute any documents required for collection of amounts that third parties owe. BCBSM will investigate and within a reasonable time, respond to such Claim(s). Additionally, BCBSM will,

(1) following the recovery of an amount from a third party, due to Worker's Compensation or other provider/program/party responsibility or

(2) following BCBSM's determination that any other disputed amount is not the State's liability or that an amount shown on a claims listing and invoice is incorrect,

credit the recovered or corrected amount, reduced by any Stop Loss payments relating to such Claim(s) or any amounts currently overdue, on a subsequent monthly invoice.

BCBSM, as administrator under this Contract, is subrogated to all rights of the State/Enrollees relating to Disputed Claim(s) but is not obligated to institute or become involved in any litigation concerning such Claim(s).

E. State Audits.

The State, at its own expense, shall have the right to audit Enrollee claims incurred under this Contract; however, audits will not occur more frequently than once every twelve (12) months and will not include claims from previously audited periods or claims paid prior to the last twenty-four (24) months. Both parties acknowledge that claims with incurred dates over two (2) years old

may be more costly to retrieve and that it may not be possible to recover over-payments for these claims; however, BCBSM will use best efforts to retrieve such claims.

All audits will be conducted pursuant to BCBSM corporate policy and other requirements at the time of the audit. The parties acknowledge staffing constraints may exist in servicing concurrent State-initiated audits. Therefore after notice from the State requesting an audit, BCBSM will have 60 to 90 days, depending on scope and sample size, to begin gathering requested documentation and to schedule the on-site phase of the audit.

Sample sizes will not exceed 200 claims and will be selected to meet standard statistical requirements (i.e., 95% Confidence Level; precision of +/- 3%). The State will reimburse BCBSM for claims documentation in excess of 200 claims at $20 per randomly selected claim and $50 per focused or electronically selected claim. However, reimbursement will be waived for any agreed-upon error claims.

Following the on-site activity and prior to disclosing the audit findings to the State, the auditor will meet with BCBSM Management and present the audit findings. BCBSM, depending upon the scope of the audit, will be given a reasonable period of time to respond to the findings and provide additional documentation to the auditor before the auditor discloses the audit findings to the State.

BCBSM shall have no obligation to make any payments to the State unless there has been a recovery from the provider, Enrollee, or third-party carrier as applicable. No adjustments or refunds shall be made on the basis of the auditor's statistical projections of sampled dollar errors. An audit error will not be assessed if the claim payment is consistent with BCBSM policies and procedures, or consistent with specific provisions contained in this Contract or other written State instructions agreed to by BCBSM.

Prior to any audit, the State and BCBSM must mutually agree upon any independent third party auditor that the State wishes to perform the audit. Additionally, prior to audit, the State and any third party auditor will sign all documents BCBSM believes necessary for the audit which will, at a minimum, provide for: the scope of the audit; the costs for which BCBSM is to be reimbursed by the State; the protection of confidential and proprietary information belonging to BCBSM and of any patient specific information; and the indemnification and hold harmless by the auditor of BCBSM from any claims, actions, demands or loss, including all expenses and reasonable attorney fees, arising from any suit or other action brought by an individual or provider arising out of any breach by the State and/or its auditor.

F. Disclosure.

The State will disclose to Employees: the services being provided by BCBSM; the fact that BCBSM does not insure the Coverage provided to Enrollees; if BCBSM certificates are used for the purpose of selecting the Coverage(s) to be provided by the State, the fact that Enrollees are not covered under these BCBSM certificates and that BCBSM assumes no liability for the Coverage(s) so selected; the party liable for benefits; the party liable for future changes in benefits; the fact that information concerning Enrollees may be reviewed by parties other than BCBSM; and any other matters mandated by law. Also, the State will, prior to issuance to

Enrollees, submit such disclosure materials as well as all Enrollee materials regarding health Coverage to BCBSM.

G. Statutory and Contractual Interest.

BCBSM's enabling legislation and participating provider contracts may require payment of interest to Enrollees and providers. Any interest required to be paid to Enrollees will be made in

addition to and at the time of late payment of a satisfactory claim and to providers pursuant to contract.

The State shall reimburse BCBSM for any interest paid if BCBSM did not pay the claim(s) due to: BCBSM's exercise of its contractual right to cease processing claims; the failure of the State to timely notify BCBSM of Enrollees' eligibility; or specific instructions from the State not to pay claims. BCBSM shall pay any interest otherwise incurred.

H. Confidentiality.

BCBSM and the State shall strictly adhere to all applicable federal and state laws regarding confidentiality of data relating to specific Enrollees. BCBSM shall not disclose to the State an Enrollee's "protected health information" or "PHI," as defined in the Health Insurance Portability and Accountability Act of 1996 and applicable regulations ("HIPAA"), unless (i) it is "summary health information," as defined in HIPAA, and is disclosed for the purposes permitted by 45 Code of Federal Regulations (CFR) § 164.504(f)(1)(ii), (ii) the State provides the certification in the paragraph immediately below, or (iii) BCBSM is given the prior written consent or authorization of the Enrollee. If BCBSM discloses PHI to the State, the State shall use and disclose Enrollee's PHI only for plan administration purposes or such purposes specifically authorized in the written consent or authorization from the Enrollee.

Health Insurance Portability & Accountability Act of 1966("HIPAA"). Federal law governing the privacy of certain health information requires certain provisions governing the disclosure of Protected Health Information. 45 CFR 160 and 164. The parties agree to negotiate in good faith and execute an Addendum containing the necessary provisions within one hundred twenty (120) days of the effective date.

The State may have access to proprietary information of BCBSM; however, in obtaining such access, they agree that they will hold all such proprietary information confidential and shall use such information only for purposes related to Enrollees' claims administered by BCBSM pursuant to this Contract and, further agrees, that no such proprietary information shall be released to any third party without such party having first executed an indemnification and confidentiality agreement in a form acceptable to BCBSM. In releasing any proprietary information, BCBSM does not waive any protection it may have regarding trade secrets and other proprietary information pursuant to either the State or Federal Freedom of Information (FOIA) Acts.

All other confidential information designated as such by a party and made available by it to another party or which becomes available to the other party in the course of this Contract shall be protected by the other party from unauthorized use and disclosurewith at least the same degree of care and the same procedural requirements as the other party uses for the protection of its own confidential information.

Neither party shall be required under the provisions of this section to keep confidential, (1) information generally available to the public, (2) information released by a party generally, or to the other party without restriction, (3) information independently developed or acquired by the other party or its personnel without reliance in any way on otherwise protected information of the first party. Notwithstanding the foregoing restrictions, the other party and its personnel may use and disclose any information which it is otherwise required by law to disclose, but in each case only after the first party has been so notified, and has had the opportunity, if possible, to obtain reasonable protection for such information in connection with such disclosure.

Each party acknowledges that a breach of its confidentiality obligations as set forth in this Section II.H shall be considered a material breach of the Contract and that the other party may be irreparably harmed. Accordingly, if a court should find that a party has breached or attempted to

breach any such obligations, that party will not oppose the entry of an appropriate order restraining it from any further breaches or attempted or threatened breaches. This remedy shall be in addition to and not in limitation of any other remedy or damages provided by law.

I. Medicare Secondary Payer.

The State will be responsible for determining whether any person should be covered under this Contract or under the Medicare Program and to identify to BCBSM all persons subject to the Medicare Secondary Payer statute and regulations so that BCBSM may properly pay any Enrollee claim as primary or secondary under the Medicare Program.

J. Certification of Creditable Coverage; HIPAA Business Associates Requirements.

State SOM, or BCBSM, by its initials, agrees to assume all responsibility for issuing automatic certificates of creditable coverage to terminated participants and dependents as required by HIPAA and further agrees to respond to any requests for such certificates and related inquiries. The State will be responsible for notifying BCBSM of all terminations of coverage as set forth in Article II.B. Also, if applicable, the State will retain responsibility for issuing certificates of coverage to persons entitled to elect COBRA no later than when the State provides the COBRA notice.

HIPAA requires "covered entities" to have contracts with its "business associates." Since the SHP is a covered entity, it must have a contract with BCBSM as its business associate. Exhibit 1, which is attached, is a business associate agreement and is hereby added to and deemed a part of the Contract. The meanings of the terms "covered entities," "business associates," and "group health plan" are defined in HIPAA.

K. News Releases.

News releases pertaining to this Contract or the services, study, data, or project to which it relates will not be made without prior written consent of all the parties.

L. FOIA Disclosure.

All information in BCBSM's proposal and 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.

M. Accounting Records.

BCBSM will 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 and agreeable to BCBSM. Financial and accounting records shall be made available, upon request, to the State, its designees, or the Michigan Auditor General at any time during the Term and any extension thereof, and for three (3) years from the expiration date and final payment on the Contract or extension thereof.

N. Representations by BCBSM.

BCBSM represents and warrants that:

1. BCBSM will perform the services in a manner that complies with all applicable laws and regulations;

2. BCBSM has duly authorized the execution, delivery and performance of the Contract;

3. BCBSM has not provided any gifts, payments or other inducements to any officer, employee or agent of the State.

O. Limitation of Liability.

Except as set forth herein, neither BCBSM nor the State shall be liable to the other party for lost profits or indirect or consequential damages, even if such party has been advised of the possibility of such damages. Such limitation as to indirect or consequential damages shall not be applicable for claims arising out of gross negligence, willful misconduct, or indemnification responsibilities under this Contract.

P. Staffing Obligations.

BCBSM shall use its best efforts to (i) provide adequate numbers of qualified individuals with suitable training, education, experience and skill to perform the services, (ii) use efficiently any resources or services necessary to provide the services that are separately chargeable to the State, and (iii) perform the services in the most cost effective manner consistent with the required level of quality and performance. The State reserves the right to approve BCBSM's assignment of Key Personnel to this project and to recommend reassignment of personnel deemed unsatisfactory by the State.

BCBSM shall not remove or reassign, without the State's prior written approval any of the Key Personnel until such time as the Key Personnel have completed all of their planned and assigned responsibilities in connection with performance of BCBSM's obligations under this Contract. BCBSM agrees that the continuity of Key Personnel is critical and agrees to the continuity of Key Personnel. Removal of Key Personnel without the written consent of the State may be considered by the State to be a material breach of this Contract. The prohibition against removal or reassignment shall not apply where Key Personnel must be replaced for reasons beyond the reasonable control of BCBSM including but not limited to illness, disability, resignation or termination of the Key Personnel's employment.

The State and BCBSM agree that the following personnel are Key Personnel for purposes of this Contract:

Name Julie Smith-Spears
Title Account Manager

Name Arva Overton
Title Account Manager

Q. Liability Insurance.

BCBSM shall purchase and maintain such insurance as will protect it from claims set forth below which may arise out of or result from BCBSM's operations under the Contract, whether such operations be by itself 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.

(2) Claims for damages because of bodily injury, occupational sickness or disease, or death of its employees.

(3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than its employees, subject to limits of liability of not less than $300,000.00 each occurrence and, when applicable $1,000,000.00 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

$50,000.00 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 $300,000.00 each occurrence and when applicable, $1,000,000.00 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 BCBSM's obligations under its indemnification obligations under this Contract.

UPON CONTRACT EXECUTION, BCBSM'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF ACQUISITION SERVICES, 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 State of Michigan’s Director of Purchasing.

R. Modification of Service.

The State reserves the right to request from time to time, any changes to the requirements and specifications of the Contract and the work to be performed by BCBSM under the Contract. BCBSM shall provide a change order process and all requisite forms. The State reserves the right to negotiate the process during contract negotiation. At a minimum, the State would like BCBSM to provide a detailed outline of all work to be done, including tasks necessary to accomplish the deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

1. Within five (5) business days of receipt of a request by the State for any such change, or such other period of time as to which the parties may agree mutually in writing, BCBSM shall submit to the State a proposal describing any changes in products, services, timing of delivery, assignment of personnel, and the like, and any associated price adjustment. The price adjustment shall be based on a good faith determination and calculation by BCBSM of the additional cost to BCBSM in implementing the change request less any savings realized by BCBSM as a result of implementing the change request. BCBSM's proposal shall describe in reasonable detail the basis for BCBSM's proposed price adjustment, including the estimated number of hours by task by labor category required to implement the change request.

2. If the State accepts BCBSM's proposal, it will issue a change notice and BCBSM will implement the change request described therein. BCBSM will not implement any change request until a change notice has been issued validly. BCBSM shall not be entitled to any compensation for implementing any change request or change notice except as provided explicitly in an approved change notice.

3. If the State does not accept BCBSM's proposal, the State may:
    a. withdraw its change request; or

b. modify its change request, in which case the procedures set forth above will apply to the modified change request.

If the State requests or directs BCBSM to perform any activities that are outside the scope of BCBSM's responsibilities under the Contract ("New Work"), BCBSM must notify the State promptly, and before commencing performance of the requested activities, that it believes the requested activities are New Work. If BCBSM fails to so notify the State prior to commencing performance of the requested activities, any such activities performed before notice is given by BCBSM shall be conclusively considered to be in-scope services, not New Work.

If the State requests or directs BCBSM to perform any services or functions that are consistent with and similar to the services being provided by BCBSM under the Contract, but which BCBSM reasonably and in good faith believes are not included within the scope of BCBSM's responsibilities and charges as set forth in the Contract, then prior to performing such services or function, BCBSM shall promptly notify the State in writing that it considers the services or function to be an "Additional Service" for which BCBSM should receive additional compensation. If BCBSM does not so notify the State, BCBSM shall have no right to claim thereafter that it is entitled to additional compensation for performing such services or functions. If BCBSM does so notify the State, then such a service or function shall be governed by the change request procedure set forth in the preceding paragraph.

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

ARTICLE III
FINANCIAL RESPONSIBILITIES

A. General Obligations.

The State will immediately assume: all risks; all financial obligations, including but not limited to Amounts Billed, court costs, and attorney's fees; and all other liabilities BCBSM may assume or which might otherwise attach with respect to processing Coverage pursuant to this Contract. The State will make full payment and satisfaction to BCBSM for all amounts resulting from such risks, financial obligations, and liabilities. State responsibility will not, however, include amounts resulting directly from any negligent processing/payment of claims by BCBSM.

B. Specific Obligations.

The State will, for each Contract Year, pay BCBSM the total of the following amounts:

(1) Amounts Billed during the current Contract Year.

(2) The hospital prepayment reflecting the amount BCBSM determines is necessary for its funding of the prospective hospital reimbursement.

(3) The actual administrative charge.

(4) The group conversion fee.

(5) Any late payment charge.

(6) Any statutory and/or contractual interest.

(7) Stop Loss premiums, if applicable.

(8) Cost containment program fee, if applicable.

(9) Any other amounts which are the State's responsibility pursuant to this Contract, including but not limited to risks, obligations or liabilities, deficit amounts relating to previous agreements, and deficit amounts relating to settlements.

The Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in Amounts Billed.

C. Indemnification Obligations.

1. General Indemnification

   BCBSM shall indemnify, defend and hold harmless the State from and against all lawsuits, liabilities, damages and claims or any other proceeding brought against the State by any third party (which for the purposes of this provision shall include, but not be limited to, employees of the State, BCBSM and any of its subcontractors), 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 gross negligence or intentional tortious act by BCBSM or any of its subcontractors, or by anyone else for whose acts any of them may be liable, in the performance of this Contract;

   b. The death or bodily injury of any person or the damage, loss or destruction of any real or personal property in connection with the performance of this Contract by BCBSM, or any of its subcontractors, or by anyone else for whose acts any of them may be liable, provided and to the extent that the injury or damage was caused by the fault or negligence of BCBSM.

   c. Any act or omission of BCBSM or any of its subcontractors in their capacity as an employer in the performance of this Contract;

   d. Any claim, demand, action or legal proceeding against the State arising out of or related to occurrences, if any, that BCBSM is required to insure against as provided in this Contract.

2. Indemnification Obligation Not Limited
   In any and all claims against the State by any employee of BCBSM or any of its subcontractors, the indemnification obligation under this Article III.A shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for BCBSM or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or any other employee 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.

3. Continuation of Indemnification Obligation
   The duty to indemnify will continue in full force and effect, not withstanding the expiration or early cancellation of this Contract, with respect to any claims based on facts or conditions that occurred prior to expiration or cancellation..

ARTICLE IV
PAYMENT OF FINANCIAL RESPONSIBILITIES

A. Timely Payment and Remedies.

The State assumes no responsibility or liability for costs incurred by BCBSM prior to the Effective Date. Total liability of the State is limited to the terms and conditions of any resulting Contract.

All amounts owed pursuant to this Contract will be paid timely. All amounts shown on the Schedule A will be paid by the State by the weekly payment day/date. Any separately invoiced amounts will be paid within fifteen (15) days of invoice or settlement receipt. BCBSM will pay any amounts due within fifteen (15) days of the settlement.

BCBSM will promptly notify the State of any overdue payments.

Payments received will first be applied to any amounts overdue. BCBSM may cease processing and paying Enrollees' claims if any payment is ten (10) days overdue retroactive to the last date for which full payment was made.

The payment day, the payment dates and estimated amounts owed for the first Quarterly Payment Period, the statutory and contractual interest rate, and the late payment charge are stated in Schedule A.

B. Scheduled Payments.

1. Schedule A - Initial Term. The scheduled payments to be paid by the State during the Initial Term (first Contract Year) are listed in Schedule A, which shows the following:

   (1) administrative fee per Employee,

   (2) Stop-Loss premiums per Employee, if applicable,

   (3) estimated number of Employees,

   (4) covered lines of business, including those with Stop Loss if applicable,

   (5) the hospital prepayment necessary to maintain the prospective hospital reimbursement funding,

   (6) estimated weekly payments, including Stop Loss premiums if applicable, and

   (7) the schedule and method of payment.

2. Schedule A - Renewal Term. Annually, approximately thirty (30) days before the end of each Contract Year, BCBSM will present the State with a revised Schedule A listing items (1) through (4) for the next Contract Year. The remaining items are adjusted as necessary in the quarterly settlements.

3. Estimated Weekly Payments. During the first two Quarterly Payment Periods, the State will, as stated in Schedule A - Initial Term, weekly pay:

   (1) the pro rata cost of estimated Amounts Billed for the Quarterly Payment Period;

(2) the pro rata costs of the estimated administrative charge and, if applicable, of the Stop Loss premiums for the Contract Year;

(3) the amount BCBSM determines necessary to maintain the prospective hospital reimbursement funding for the Quarterly Payment Period; and

(4) any other amounts owed by the State pursuant to this Contract.

Thereafter, BCBSM will, approximately thirty (30) days before each Quarterly Payment Period, notify the State of any adjustments in the above amounts to be paid during the next Period. The estimated amounts owed relating to claims for each Quarterly Payment Period are based on the total of Amounts Billed during the prior available twelve (12) months, adjusted for costs and utilization.

4. Claims Listings. The Amounts Billed for each month are shown on monthly claims listings provided on approximately the twentieth (20th) of each month by line of business as follows:

(1) Facility claims listings showing charges by claim and in total, and the total Amounts Billed.

(2) Claims listings for each other line of business showing Amounts Billed by claim and in total.

Each listing will also show any credits for Disputed Claim(s) which have been resolved and any other adjustments.

C. Scheduled Settlements.

1. Quarterly. In conjunction with the payment development for the next Quarterly Payment Period, BCBSM will, approximately sixty (60) days after the close of each Quarterly Payment Period, provide a detailed settlement showing Amounts Billed to and owed by the State during the prior available Quarter including any surplus or deficit amounts.

2. Annual. For each Contract Year, BCBSM will provide an annual settlement of the estimated and actual administrative charges based on the actual number of Employees. Any deficit or surplus resulting from this settlement will be reflected in the quarterly settlement for the Quarterly Payment Period during which the annual settlement was completed. Stop Loss premiums, if applicable, will be settled in the same manner.

D. Changes in Enrollment or Coverages.

In the event of a more than ten (10%) percent change in Enrollment and/or a change in Coverages, the monthly administrative fee, estimated number of employees and, if applicable, Stop Loss premiums may be revised to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning with the next Quarterly Payment Period following thirty (30) day notification by BCBSM to the State.

E. Hospital Settlement Adjustments.

Reconciliations of the original and settled hospital reimbursements are made periodically by BCBSM for its participating hospitals. Any hospital settlement adjustments for the State will be based upon reconciliations made for those hospitals in which services were received by Enrollees and reflected in Amounts Billed. Depending on whether these reconciliations result in a savings or deficit, BCBSM may make either a credit or charge to a special hospital savings account maintained for the State. If for a given calendar year, any cumulative credits and charges made to this account reflect a positive balance, one half of such cumulative balance, net of any applicable Aggregate Stop Loss settlement payments and/or any other amounts owed BCBSM, plus interest at the then rate for short term government treasury bonds (STIGB), which is currently calculated as a rolling twelve-month average of the 90-day T-Bill yield rate, will be refunded to the State. It is understood that BCBSM has the right to change the STIGB calculation methodology provided that such change is applied uniformly and consistently to similar Administrative Services Contracts of other BCBSM clients. Only the positive cumulative balance of this special account, if any, will be reflected in any calculations of the Estimated Outstanding Liability (EOL) or in the final settlement for the last Contract Year under Article IV.F. below.

In the event the cumulative balance to this account reflects a negative balance, such balance will not be considered as an amount owed by the State; however, any negative balance will be charged STIGB and netted against any positive facility settlements. Also, if this Contract is terminated and as part of the settlement for the last Contract Year under Article IV.F.3., any provider refunds or settlements due the State will be charged first against any such negative balance. Any excess of such refunds or settlements will be credited to the State.

F. Post Termination.

Notwithstanding anything contained herein to the contrary, the State's obligations to pay amounts incurred under this Contract will survive termination, and the State will continue to timely pay all amounts owed. Because of the special arrangements and agreements for payment of services between BCBSM and its participating health care providers, all Enrollee claims incurred under this Contract will be processed by BCBSM pursuant to the terms and conditions herein and the State agrees that it will have no right to have any such claims processed by a replacement carrier or administrator.

1. Weekly Wire Payments. For the first three (3) months following termination the State will continue to make weekly wire payments in the same manner as, and as determined before termination; however, if the termination occurs before a settlement has been made for the last Quarterly Payment Period, the weekly amounts then being made will continue to be made during the first three (3) months following termination unless BCBSM determines a different amount is to be so paid.

   In addition, the State will, for each such first two (2) months only, continue to pay the administrative fee in the same manner as determined prior to termination.

2. Estimated Outstanding Liability. Within ninety (90) days following termination, BCBSM will prepare a settlement in the form of a quarterly settlement, for the period from the last quarterly settlement through the date of termination, and make an initial calculation of the Estimated Outstanding Liability (EOL), which will take into account the weekly payments during the first three (3) months following termination and advise the State of its continuing liability for the EOL so estimated.

   If the total amount of the weekly payments made during the first three (3) month period following termination exceed the Amounts Billed during the period, BCBSM will pay the State STIGB on the average monthly balance of any excess. The total amount of any excess will be included as gains in the settlement for the last contract year as provided in Subsection F. 3. below.

3. Settlement - Last Contract Year. Within ninety (90) days after the first three (3) month period following termination, BCBSM will prepare a total settlement for the last Contract Year and such three (3) month period which will include: if applicable, a final settlement for Stop Loss Premium(s) and Aggregate Stop Loss Attachment Point; a final settlement of administrative fees, except that the settlement for the first two (2) months following termination will be based on the average monthly number of Employees during the last Contract Year; the amount of any gain and losses for Amounts Billed during the first three (3) months following termination; the hospital prepayment; the positive balance in the hospital savings account, if any, and other credits due the State, net of any amounts owed by the State; and the amount of any STIGB interest credited to the State. If the summation of the above shows a loss for the State, the State shall pay that amount within thirty (30) days net of, if applicable, any surplus as recalculated below and, if not so paid, shall be subject to late payment charges.

   The EOL will also be recalculated at this time, which will take into account gains, if any, resulting from the total settlement as determined above. If the recalculation shows a deficit over any funds then held by BCBSM, the State will be advised of the amount of the deficit and of its continuing obligation for payment of the EOL. If the recalculation shows a surplus over any funds then held by BCBSM, the amount of the surplus will be refunded to the State by BCBSM within thirty (30) days net of, if applicable, any losses resulting from the total settlement as determined above.

   BCBSM will first charge any Amounts Billed against any funds then held by it and, after exhausted, will monthly invoice the State for Amounts Billed. All monthly invoices will be paid within thirty (30) days of invoice or be subject to late payment charges. BCBSM will continue to pay the State STIGB interest on any positive balance as set forth in Subsection F. 2. above.

4. Interim Calculations and Notifications of EOL. Within sixty (60) days after each of the six (6) month, twelve (12) month and eighteen month periods following termination, BCBSM will prepare settlements for each period, also in the form of quarterly settlements, and make new calculations of the EOL. The purpose of these interim EOL calculations is so that the State will be aware of any potential liability for Amounts Billed and plan accordingly.

If any interim calculation shows a deficit over any funds then held by BCBSM, the State will be so advised and of its continuing obligation for payment. If any calculation shows a surplus over any funds then held by BCBSM, the amount of the surplus will be refunded to the State by BCBSM within thirty (30) days. Any Amounts Billed will first be charged against any funds then held by BCBSM and, after exhausted, BCBSM will monthly invoice the State for Amounts Billed.

BCBSM will continue to pay the State STIGB interest on any positive balance as set forth in Subsection F. 2. above, and any monthly invoices will be subject to late payment charges if not paid within thirty (30) days.

5. Final Calculation and Notification of EOL. Within ninety (90) days after the twenty-four month period following termination, BCBSM will prepare a settlement, also in the form of a quarterly settlement, make a final calculation of the EOL and advise the State of its continuing liability for payment. Any funds then held by BCBSM will be returned to the State within thirty (30) days.

6. Subsequent Claims. Any claims received thereafter will be billed to the State and payable within thirty (30) days of receipt.

G. Conversion to Underwritten Group.

The provisions of Sections F., 1. through 6., inclusive shall also apply if the State converts from a self-funded group to a BCBSM underwritten group. Any EOL so calculated shall remain the obligation of the State, and shall be timely paid as set forth in such Sections in addition to any premium payments as a BCBSM underwritten group.

ARTICLE V
GROUP ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

This Contract is between the State and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by entering into this Contract, the State agrees that it has made this Contract based solely only on its relationship with BCBSM or its agents. The State further agrees that BCBSA is not a party to, nor has any obligations under this Contract, and that no obligations of BCBSA are created or implied by this language.

ARTICLE VI
BLUECARD PROGRAM SERVICES PROCESSED AND PAID BY OTHER BCBS PLANS

Exhibit 2 attached to this Contract describes the BlueCard Program available through the Blue Cross Blue Shield Association (BCBSA). If the BCBSA revises the disclosure in Exhibit 2, BCBSM will give the State notice with a new Exhibit 2, which will automatically become part of this Contract sixty (60) days after notice has been given.

ARTICLE VII
AGREEMENT, TERM, TERMINATION, AMENDMENT, AND LAW

A. Entire Agreement.

This Contract includes and incorporates any Schedules, Addenda, Exhibits, and Amendments and represents the entire understanding and agreement of the parties regarding matters contained herein, supersedes any prior agreements and understandings, oral or written, between the parties and shall be binding upon the parties, their successors or assigns.

B. Termination.

1. Normal. Either party may with or without cause, upon the first (1st) day of the month following thirty (30) days written notice, terminate this Contract as to claims incurred after termination.

2. Nonpayment/Partial Payment. Notwithstanding any other Contract provisions, in the event that the State fails to timely pay any amounts owed, BCBSM may, after five (5) days notice, terminate this Contract.

C. Term and Option to Extend.

This Contract shall be effective for a term of five (5) years from January 1, 2003 through December 31, 2007, unless sooner terminated.

Subject to the negotiation of mutually agreeable terms, the State will, upon at least sixty (60) days prior written notice to BCBSM, have the option to extend the Term of this Contract for an additional three (3) years. Alternatively, the State will, upon at least sixty (60) days prior written notice to BCBSM, have the option to extend the Term of this Contract through the exercise of successive annual Renewal Periods beginning on December 31, 2007, and annually thereafter.

The State fiscal year is October lst through September 30th. BCBSM realizes that payments in any given fiscal year are contingent upon enactment of legislative appropriations.

D. Amendment and Notice.

This Contract may be amended at any time, but only by written agreement duly executed only by authorized representatives of the parties.

The State of Michigan, Department of Management and Budget (DMB), Office of Acquisition Services the "Office of Acquisition Services" or ("OAS") 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 Acquisition Services is the only office authorized to change, modify, amend, alter, clarify, etc., the prices, specifications, terms, and conditions of this Contract. The Office of Acquisition Services will remain the SOLE POINT OF CONTACT until such time as the Director of Purchasing shall direct otherwise in writing. All communications or notices concerning this Contract must be in writing and addressed to:

For the State	For BCBSM
Irene Pena, Buyer: Strategic Purchasing Division DMB, Office of Acquisition Services 2nd Floor, Mason Building P.O. Box 30026 Lansing, MI 48909 Email: Penai1@michigan.gov Phone (517) 241-1647	Julie Smith-Spears Blue Cross and Blue Shield of Michigan 600 Lafayette East, MC B491 Detroit, MI 48226 Email: Phone:

Any notice given to a party under this Contract shall be deemed effective, if addressed to such party as addressed above upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile 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.

Upon receipt at the Office of Acquisition Services of the properly executed Contract, it is anticipated that the Director of Purchasing will direct that the person named below or any other person so designated be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of any Contract resulting from this Request 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 Acquisition Services. The Contract Administrator for this project is:

Peggy Moczul, Director
Employee Benefits Division
Office of State Employer
Department of Management and Budget
P. O. Box 30026
Lansing, MI 48909

Email: Moczulp2@Michigan.gov

E. Severability.

The invalidity or nonenforceability of any provision of the Contract shall not affect the validity or enforceability of any other provision of the Contract.

F. Waiver.

The waiver by a party of any breach of this Contract by the other party shall not constitute a waiver as to any subsequent breach.

G. Law.

This Contract is entered into in the State of Michigan and, unless preempted by federal law, will be construed according to the laws of Michigan.

H. Force Majeure.

Neither party shall be liable for any default or delay in the performance of its obligations under the Contract if and to the extent such default or delay is caused, directly or indirectly, by: fire, flood, earthquake, elements of nature or acts of God; riots, civil disorders, rebellions or revolutions in any country; the failure of the other party to perform its material responsibilities under the Contract (either itself or through another contractor); injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of such party; provided the non-performing party and its subcontractors are without fault in causing such default or delay, and such default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans. In such event, the non-performing party will be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay provided such party promptly notifies the other party in writing of the inception of the excusable failure occurrence, and also of its abatement or cessation.

If any of the above enumerated circumstances substantially prevent, hinder, or delay performance of the services necessary for the performance of the State's functions for more than 14 consecutive days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected services from an alternate source, and the State shall not be liable for payments for the unperformed services under the Contract for so long as the delay in performance shall continue; or (b) the Contract will be canceled as of the date specified by the State in a written notice of cancellation to BSBCM. BCBSM will not have the right to any additional payments from the State as a result of any excusable failure occurrence or to payments for services not rendered as a result of the excusable failure condition, except as described in Article IV.F. Defaults or delays in performance by BCBSM which are caused by acts or omissions of its subcontractors will not relieve BCBSM of its obligations under the Contract except to the extent that a subcontractor is itself subject to any excusable failure condition described above and BCBSM cannot reasonably circumvent the effect of the subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

I. Assignment and Delegation.

No party may assign this Contract or 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 other parties to this Contract, which consent will not be unreasonably withheld. Any purported assignment in violation of this section shall be null and void. Further, BCBSM may not assign the right to receive money due under the Contract or delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid without the prior written consent of the Director of Acquistion Services, which consent will not be unreasonably withheld, provided, however, that BCBSM may use its subsidiaries and affiliates to provide administrative services upon giving prior written notice to the State. The parties recognize that due to the unique BCBSA licensing arrangements for Blue Cross plans and Blue Shield plans throughout the United States, such plans are not subcontractors of BCBSM and BCBSM will utilize such plans to administer this Agreement and to provide administrative services.

J. Non-Discrimination Clause.

In the performance of this Contract, BCBSM 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 disability unrelated to the individual's ability to perform the duties of the particular job or position. BCBSM 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 37.2101, et seq, and the Persons with Disabilities 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.

K. Headings.

Captions and headings used in the 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.

L. Relationship of the Parties.

The relationship between the State and BCBSM is that of client and independent contractor. No agent, employee, or servant of a party or any of its subcontractors shall be or shall be deemed to be an employee, agent, or servant of the another party for any reason. Each party 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.

M. 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.

BCBSM, 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 the Contract if, subsequent to award of the Contract, the name of BCBSM as an employer, or the name of the subcontractor, manufacturer or supplier of BCBSM appears in the register.

N. Survival of Provisions.

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to, indemnity and other obligations shall survive the expiration or cancellation of this Contract for any reason.

SECTION II

WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

The State provides health benefit services through the State Health Plan (SHP – the traditional, non-HMO medical plans) to employees, retirees, and their eligible dependents.

Certain components of health plan service are "carved out" and provided by separate, stand-alone plans, including outpatient prescription drugs (retail and mail order), and mental health/substance abuse (MHSA) services. With the exception of MHSA services for a defined group of employees*, these services are not included under the medical plans included in this *contract*.

*Note: MHSA services for active Michigan Sergeants and Troopers (MSPTA), and MSPTA who retire or retired on or after 10/1/1987, are not carved out, but are provided through the SHP medical plan.

The State provides a "traditional" or "Basic Plus Major Medical", non-HMO medical plan to approximately 36,000 active employees and COBRA participants, plus their 58,000 dependents, as well as 33,000 retirees, plus their 20,000 dependents, for a total covered membership (employees/retirees, plus dependents) of 147,000. This plan is also called the State Health Plan (or SHP).

For active employees and their dependents, the SHP program includes a feature called the Advantage program, under which reimbursements to non-participating physicians may be made in full (i.e., based on charges) in counties with physician participation in a particular specialty that is under 75%.

In addition to the SHP, approximately 1,000 active enrollees, plus their dependents, are enrolled in a Catastrophic Health Plan (CHP). The SHP and CHP plans are self-funded by the State. The SHP program is currently administered by Blue Cross Blue Shield of Michigan (BCBSM), and (for about one-third of retirees) by Aetna US Healthcare (Aetna). The CHP plan is currently administered by Aetna.

Effective January 1, 2003, the "Basic Plus Major Medical" health plan for active employees (except the MSPTA) and pre-Medicare retirees is being converted to a Preferred Provider Organization (PPO) health plan. For eligible MSPTA, the current Advantage health plan continues unchanged, pending future collective bargaining action.

The State is establishing a contract with BCBSM for the SHP health plan, for all components except the CHP, and the portion of the Medicare supplement program currently administered by Aetna. The initial contract period requested will be for the period of November 1, 2002 to September 30, 2007, and may be renewable after that.

II-B OBJECTIVES

The objectives of this SHP medical plan contract are:

1. To provide for administration of the SHP benefit programs, in accordance with the terms of the Plans' designs, for active employees, COBRA participants, retirees, and eligible dependents;
2. To obtain competitive pricing for medical plan services through a broad network of participating providers offering convenient access to employees, retirees, and their dependents;
3. To have valid claims paid on an accurate and timely basis;
4. To maintain a high level of member satisfaction with the program;
5. To obtain timely, accurate financial and utilization data reporting;
6. To provide programs in which the SHP members may participate in effort to improve their health care;
7. To improve service with expanded customer and account service features, including performance guidelines and at-risk administrative fees; and
8. To achieve the lowest total plan cost (claims plus administration) consistent with objectives 1 through 7.

The objective of this contract is to provide and manage administration of the SHP benefit program for the State. The contract as stated herein will identify and define services to be provided, performance objectives, and administrative fees.

II-C TASKS/PLAN REQUIREMENTS

This subsection contains the requirements the Contractor must meet in order to be awarded the contract. These requirements will be included in the contract.

1. **Capability and Qualifications**

   The State 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 health plan administration industry. The Contractor must have substantial experience with accounts of similar size and characteristics as SHP. The Contractor must maintain an experienced staff capable of providing efficient, convenient, high quality service to participants and the State at all times and under all circumstances.

a. Service

The Contractor must maintain in Michigan at least one fully staffed office where the principal service representative for the State will be located. In addition, key Contractor personnel who are not located in Michigan must be made available to the State at this office (or at another convenient location in Michigan) on a reasonably frequent basis.

b. Timeliness

(Not Applicable)

c. Subcontracting

Provisions regarding use of subcontractors are given in Section I-D. The State expects that all essential services associated with delivery of this program will be provided directly by the Contractor, and that use of subcontractors will be minimal, with the possible exception of certain peripheral services such as printing, communications design, etc.

2. **Plan Design**

The Contractor must be able to provide the current plan designs (see Appendix A for more details).

For the majority of active employees and retirees, the plan design will change to the Preferred Provider Organization (PPO) program, described in Appendix A, effective January 1, 2003.

For the MSPTA, however, the current "Basic Plus Master Medical" plan, also described in Appendix B, which includes the 2003 benefit enhancements, will remain in effect.

It should be noted that, in addition to the carve-outs for drugs and MHSA services (with the exception of one bargaining unit), the current SHP for active employees includes a number of unique features, including the Advantage program, the Disease Management program, and the Health Screening program. (The Health Screening program will be phased out by the end of 2002.)

Under the Advantage program, services from non-participating specialists, for approximately 34 defined specialties, may be reimbursed at charges (i.e., eliminating balance billings to members) if fewer than 75% of physicians in that specific specialty practice are participating physicians in that particular Michigan county. A review of participating specialists by county is performed annually, and reimbursement policies adjusted accordingly. Provider participation materials are distributed to employees twice a year. This plan feature must be duplicated by the Contractor.

Under the Disease Management (DM) program, participants identified as receiving treatment for certain disorders (CHF, ischemic heart disease, diabetes and asthma) are offered, on a voluntary basis, participation in a targeted disease management program. Administering this program will require the Contractor to partner with the prescription benefit managers (PBMs, currently ExpressScripts and BCBSM/Medco) to obtain drug utilization data in order to identify eligible DM program participants with these specified disorders. This will require an agreement (not addressed in this document) between the Contractor and the PBMs.

As an alternative to the SHP, active employees may elect coverage under the Catastrophic Health Plan (CHP), a high-deductible plan that covers most inpatient hospital but few outpatient or physician services.

All of these plan features must be administered by the Contractor.

It should be noted that this plan is a bargained benefit, and is subject to change, depending on the results of future bargaining agreements (the next collective bargaining agreements will be effective October 1, 2005, with others effective January 1, 2006). Historically, non-bargained employees and retirees have received the same benefits as bargaining employees, but this is not guaranteed.

When changes are mandated by the State either administratively or through collective bargaining, the Contractor must be able to accommodate such changes within 90 days.

Limitations and Exclusions:

In addition to the exclusions described in the benefit booklet found in Appendix A, benefits *will not* be paid for:

a. Services provided or covered by any state or governmental agency, by Worker's Compensation or similar occupational law, or for which no charge is made to the employee.
b. Services provided while the member is not covered for this benefit.
c. Services provided that the health professional or facility is not licensed to provide.
d. Services which are not medically necessary, or are experimental or research in nature, according to accepted standards of practice.
e. Services received as a result of an act of war, declared or undeclared.
f. Completion of any insurance form.

3. **Administrative Services**

Administrative services must include, but need not be limited to, the following:

a. Information Systems:

- Ability to administer eligibility and claims administration in accordance with the plan design.
- Confidentiality of all data by the Contractor.
- Maintenance of records for auditing and management information reporting and analysis.
- Monthly, quarterly and annual reporting, on an accurate, timely basis, of plan activity and experience data to the State.
- Conduct a coordination of benefits (COB) canvassing on an annual basis, and provide a copy of the results to other SOM health plan vendors, such as the MHSA vendor.

b. Financial Arrangements:

- Competitive contracted reimbursement rates with participating providers.
- Maintenance of schedules of maximum payment levels, based on maximum allowable amount as shown on the Contractor's schedule of fees and reimbursement policies or other basis, for reimbursing non-participating providers.

- A contracted fixed administrative fee per covered employee or retiree per month (the same fee for actives and retirees).
- Accept electronic fund transfers of claims costs on a weekly basis, and administrative fees on a monthly basis.

c. Customer/Member Services:

- Customer service activities to include but not be limited to:
  - a dedicated service unit,
  - access 24 hours per day, 7 days a week,
  - a single front-end toll-free 800 telephone number with touch-tone routing (if necessary) for member services to respond to requests for participating provider locations, referrals, authorizations for care, inquiries on claims, and complaints about provider practices and services,
  - a voice response system (if necessary) with a user-friendly menu that customers find easy to understand,
  - separate 800 numbers for participants and providers, and
  - development of same services through the Internet.
- Comprehensive patient and provider education services.

d. Participating Provider and Utilization Management:

- Maintenance of a network of providers participating in the Preferred Provider network.
- Credentialing, monitoring, and re-credentialing of participating providers.
- Vigorous recruitment of additional participating providers in underserved areas.
- Periodic on-site audits of participating providers as necessary.
- The proposal must contain statements describing the steps that the Contractor will take to ensure accuracy, quality control, timeliness, and benefit cost effectiveness.
- The quality assurance component of the program must contain, at the minimum, the following elements:
  - Patient/provider satisfaction surveys,
  - Criteria to evaluate provider performance, such as waiting times for routine and emergency care appointments, patient load, and arrangements for non-emergency or urgent care.

e. Customer/Member Communications, Solicitation Materials and Information

The Contractor must:

(i) Customized participant communications (with all communications subject to the State's approval).

(ii) Prepare and print at its own expense plan description booklets and claim form for enrollees (95,000 each) and booklets and claim form for enrollments during the first contract year (6,000 each). These materials must be comparable in size and quality to the brochure and claim form presented in Appendix A. These materials must be available for distribution within three months of award of the Contract.

(iii) Plan description booklets should also be available via the Internet

(iv) Mail plan description booklets and claim forms (as part of the basic administrative services) to all enrollees prior to the effective date of the new PPO plan, and to new participants as part of the enrollment process.

(v) Prepare and bear the cost of all announcements, letters, notices, forms, postage, other supplies and services for the administration of the Plan.

(vi) The Contractor will be responsible for publishing and mailing newsletters (separate editions for active and retired employees) at least four times each contract year. These newsletters will inform SHP participants about current events and health and wellness topics. The contractor will bear all expense relating to laying out, printing and distributing the newsletter. The newsletter will typically be about eight pages and of the size and quality shown in Appendix P.

All announcements, form letters, notices and brochures (with the exception of routine member communications i.e. form letters) must be prior-approved by the State. The State will supply enrollment materials to all new employees and process applications.

The Michigan printing law applies to all these materials. A copy of the law is enclosed in Appendix Q.

If substantial additional, or special, materials should be required in any Plan year, the cost for the additional materials will be a negotiable expense.

4. **Eligibility and Enrollment**

a. Eligibility System

The Contractor must maintain an on-line eligibility system which interfaces with its claim processing system.

Eligibility data for active participants will be supplied through the Human Resource Management Network (HRMN, format attached as Appendix I) on a weekly basis. Data for COBRA and direct pay participants will be supplied through COBRA-EAS on a weekly basis. Data for retirees will be supplied by the DMB Office of Retirement Systems on a monthly basis. All data will be provided in suitable, mutually agreed-upon formats.

The Contractor will process application forms as needed. The Contractor will also provide and maintain on the State's premises a functional computer terminal for access by the State to eligibility and claims data.

b. Customer Service
(See Section IIC-3e-ii).

c. Exception Reports
The Contractor must produce a monthly exception report to identify discrepancies between monthly data submitted by the State 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 (See Appendix K for sample)

Unless otherwise agreed between the Contractor and the State, the Contractor must provide a State-specific identification card for each enrollee and adult dependent. The card must be made of durable plastic. If the card is not accepted by providers as acceptable evidence of coverage, it must contain a toll-free telephone number that providers can use to verify coverage during normal business hours. The card must also contain a toll-free number which can be used by participants to obtain information about the plan.

d. Enrollment Summaries
From time to time, the Contractor may be required to provide summary enrollment statistics by various categories and other enrollment data. The Contractor must agree to provide such reports on a timely basis without additional charges to the State.

5. **Financial Arrangement and Reporting**

The State will fund the SHP program on an administrative services only (ASO) basis, for the duration of the contract.

Claims are to be paid weekly via Manual wire. Treasury may specify some other method such as Electronic Funds Transfer (EFT) in the future. BCBSM will submit a summary of health claims for the previous week (Saturday through Friday) to a designated State official. The State Treasury department will be instructed to wire these funds to the bank specified by BCBSM. The contractor will provide all the banking information needed to process the wire such as the bank name, routing number, account number, and account name.

a. Security
The Contractor shall have and maintain in place a system of financial controls and electronic data processing security, compliant with HIPAA and other regulations, to ensure the integrity of the State account and the data used to establish the State's financial obligations.

b. Requests for Funds
Upon requesting a wire transfer for cleared drafts and access fee, 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 obligation of the State for cleared drafts for the period in question.

c. Documentation
Not later than sixty (60) calendar days following the end of each month, the Contractor must provide in hard copy and on diskette, CD-ROM, e-mail attachment or other electronic medium, in a format to be agreed upon between the parties, a summary of claims processed during the preceding month. The Contractor must provide such reconciliation reports as may be required by the State.

d. Annual Reports
Not later than one hundred and twenty (120) 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 diskette, CD-ROM, e-mail attachment or other electronic medium. In addition, the Contractor must provide such of its standard financial and statistical reports as may be requested by the State.

e. Payment

The State will make payments for administrative fees based on the number of enrolled employees, retirees and surviving beneficiaries, reported by the State.

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 the State.

g. Legal Activity

(See Section I)

h. Timing of Fee Payments

It is anticipated that the State 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 fee in full payment of the State's obligation without imposition of penalties or late charges.

i. Provider Discounts

If the Contractor contracts directly with providers for services to be provided to Plan participants, then the State shall be entitled to the full benefit of any such contractual arrangements. In no event shall the State (or Plan participants) be charged more than the amount actually owing to a provider plus access fees under the terms of such contract.

j. Audits

To establish whether the Contractor is in compliance with the requirements of this *contract*, the State reserves the right to audit the books and records of the Contractor at such reasonable times and frequencies as it shall determine to be appropriate, and as set forth in the Audit Letter of Agreement. (see Appendix R)

k. Conversion Policies

The State does not pay for group conversions for Plan participants who lose coverage. Employees have the option of entering into a conversion agreement with BCBSM upon termination of State employment or upon exhaustion of COBRA eligibility.

6. **Claims Administration**

a. Claim Adjudication and Payment

The Contractor must administer claims in conformity with the State Health Plan. Provisions of the Plan are set forth in the Plan Description document in Appendix A. If any significant plan provisions are not reflected in the Plan Description document at the time this RFP is released, an addendum describing such provisions will be included in Appendix A. The Contractor must issue payment to both participants and providers on a timely and accurate basis.

Unless specifically stated in the plan design, the Contractor is authorized to apply corporate payment rules for claims payments.

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 processing error, provide security against unauthorized entry, track provider Licensing status and maintain appropriate history on-line.

c. Claims Processing and Customer Assistance

The Contractor must maintain an adequate claims processing staff of qualified employees to administer the Plan. The Contractor must also have a qualified customer service staff to answer both telephone and written inquiries from enrollees and providers and have an adequate number of toll-free telephone lines available at reasonable hours. The State requires that the claim processing and customer service staffs be dedicated exclusively to the State account and managed separately from customer service staffs of other Contractor accounts.

The Contractor must maintain a "nurse hotline" which allows members to talk on a toll-free line to registered nurses about their health concerns. The program should include at least the following:

i. Phone response to members' health concerns using established clinical patterns designed by physicians

ii. Health counseling on any medical topic, including outbound follow up calls by nurse counselor

iii. Information on Michigan providers and community resources

iv. Hard copy health education library for home mailing; audio library for on line listening

v. Medical history collected at call time and stored for future reference

vi. Selected medical claims data available on line.

This service is subject to annual review by the State.

d. Payments in Accordance With Plan

The Contractor must not charge against the State's account for claim payments not authorized under the Plan, except that the Contractor may charge such payments for an individual who was formerly covered under the plan if such payments were made prior to notification of the individual's ineligibility. If such unauthorized payments are made and can be identified, the Contractor must recover such payments from participants or reimburse the State for such payments from its own funds. The State may, in the interest of the Plan and the members, agree to accept a settlement of such obligations.

e. Claim History

The Contractor must maintain its data in such a manner that it can provide to the State or any subsequent administrator a current claim history file on CD-ROM or other acceptable electronic medium within 30 days of the date of request. Moreover, in the event of the transfer of administration to another vendor, the Contractor must provide on acceptable electronic medium a monthly claim history update until all runout claims are closed out.

7. **Systems and Reporting Requirements**

a. Claim Information

Maintenance of detailed claims information is necessary to facilitate claims review and cost containment functions. It is also essential to produce reports to be submitted to the State for use in effectively administering the program.

Data collected on behalf of the State program is not to be distributed to any party without the written consent of the State and is not to be used by the Contractor for any purposes unless specifically approved by the State. All data identifying specific enrollees or their dependents are highly confidential and are to be treated accordingly, compliant with HIPAA and other regulations.

Appendix E contains a list of data elements that must be maintained by the Contractor to meet the State's claims review and reporting requirements. While the list reflects current needs, capture of additional claim items may be required by the State. It will be the responsibility of the Contractor to maintain records in such a manner that will allow reporting of claims submitted by providers.

The State reserves the right to examine the Contractor's database structures to determine whether the Contractor is in compliance with the data elements requirement.

b. Claims Records File

To provide the State with an in-house capacity to conduct detailed analysis of activities related to SHP, the Contractor will be required to provide, on a quarterly basis, a CD-ROM or other suitable electronic media a file containing detailed claim records in a format suitable for use by a contractual claims analysis company. Adequate protection of the confidentiality of the data, consistent with State, Federal and other guidelines, must be maintained.

The file is to be produced quarterly, and provided to the State, or to a data consolidation vendor specified by the State (currently, Medstat). The detailed data elements covering the production of the claims file are contained in Appendix E.

The Contractor must retain in a safe place at least one copy of each data file provided to the State, for the duration of the Contract. Upon termination or expiration of the Contract, the Contractor must deliver all such retained files to the State within five working days of the request by the State.

c. Contractor/State

The following are additional Contractor requirements related to the necessary systems interface between the selected Contractor and the State.

1. Capability to accept the State's computerized enrollment files (see Appendix I) and process change transactions to maintain up-to-date information for claims certification.

2. Designation of a high-level management staff member to serve as the Systems Information Manager, to serve as liaison with the State and to be responsible for systems related matters.

3. A designated staff of systems professionals to provide timely service covering systems analysis and programming required to implement system changes and produce reports.

4. On-line eligibility access for State staff, with limited access capabilities to claims utilization data.

d. Reports

The State expects to receive the Contractor's standard report package and those reports described below. Failure to adhere to the timeframes indicated will result in penalties.

- Monthly reports, including:
  - A summary of cash calls, by week or other checkwriting cycle, for the month, produced within 5 business days of the end of the month,
  - A brief summary (in letter form) of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months,
  - Claims Report, showing claims paid in the month, split between Actives, COBRA and Retirees (split by Medicare-eligibles and non-Medicare), showing number of admissions, days/visits/services, charges, employee copays, and plan payments, by categories of hospital services, professional services, etc.,
  - Claims "lag" report, accumulated year-to-date in the format shown in Appendix F,
  - Number of subscribers and number of dependents covered, split between Actives, COBRA and Retirees,
  - Produced within 60 calendar days of the end of the month.

- Quarterly reports, including:
  - Quarterly and YTD summaries of Monthly Claims Report items,
  - Activities and results in administering the Coordination of Benefits (COB) provisions of the Plan, including:
    … number of claims during the period for which other coverages (other than Medicare) were reported,

… number of claims for which other coverage was not reported but was identified upon investigation, and
… the dollar amount and % of total claims dollars saved as a result of COB administration,

- Amount of "retention reallocation," or access fees, included in claim payment amounts for the quarter,
- A reconciliation report to assist in an on-going reconciliation of claim payments, fees and other financial transactions,
- Detailed claims file, in the format described in Appendix E, provided to the State's specified data vendor,
- Produced within 60 calendar days of the end of the quarter, except the reconciliation report, which may be produced within 90 days of the end of the quarter.

- Annual Report (results through September 30th), including:
  - Management summary,
  - Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis,
  - Produced within 120 calendar days of the end of the year.

The State may also request certain other ad-hoc reporting, in formats and on time schedules as mutually agreed upon between the State and the contractor.

The State is very interested in on-line or electronic reporting capabilities. A description of capabilities is requested in Section IV.

A minimum of 2% of monthly administrative fees, will be at risk for failure to meet any of the reporting timeframes.

8. **Performance Guarantees**

The conditions and penalties of this Section must be agreed to as presented below.

The State will require the contractor to agree to Performance Standards. The objective of these standards is to encourage an acceptable level of performance in key contract administration areas. These include:

- Eligibility,
- Claim turnaround time,
- Claim payment accuracy on both a dollar and per occurrence basis,
- Member satisfaction, and
- Inquiry handling.

Note: The Contractor has the right to request a waiver of penalties in the event any performance guarantees cannot be met because of unforeseen circumstances.

a. Eligibility

The Contractor will update (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) eligibility files with the State eligibility input within 1 business day of receipt.

At least 85% of the identification cards will be created and distributed through the U.S. Mail within 10 business days of receipt of the State eligibility files, and 100% within 15 business days, with an accuracy rate of 99% or better for the ID cards.

The Contractor will issue additional identification cards within 10 business days of request from enrolled members.

b. Claim Turnaround Time

1. The maximum time period between date of receipt by the Contractor and the date of payment (or denial) is expected to be no greater than 14 calendar days for 85% of all claims, and 30 calendar days for 98%. Requests for additional data from either the beneficiary or the provider shall comply with the criteria outlined in PA 350.

2. The Contractor must ensure that the performance guarantees are measurable using the Contractor's standard systems in place.

c. Claims Accuracy

The State shall audit the Contractor's administration of SHP claims for accuracy. The State's approach has been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. This approach may change without prior notice.

The Contractor will not be liable for errors caused by the State, nor will the State be liable for errors caused by the Contractor. The errors will be established by using statistically significant sampling methods resulting in a 95% confidence level with precision of +/- 3%. The State will include adjustments made up to four months after the close of the audited year. If claims samples are selected using a financially stratified methodology, the results will be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.

Financial Payment Accuracy: measures the dollar value of errors. Calculated as total audited paid dollars minus the absolute value of over- and underpayments, divided by total audited paid dollars. The acceptable error rate will be 0.7% (99.3% accuracy rate).

If the error value for a review period exceeds the acceptable error value and the difference is statistically significant, the Contractor will be liable up to the midpoint of the difference between the acceptable error value and the statistically determined

value. The acceptable error value is the acceptable error rate multiplied by net paid claims during the review period. The standards, incentives, and penalties shall be as shown below:

FINANCIAL PAYMENT ACCURACY

Review Period	Error Standard as a % of Dollars Paid	Penalty Charged for Each Error Above Standard
Year One	*0.7% of net claims*	Amount above standard
Year Two and after	0.7% of net claims	Amount above standard

Payment Incidence Accuracy: Measures the incidence of claims processed without payment error. It is defined as the percentage of audited claims process without payment error. The definition of error includes any type of error (e.g., coding, procedural, system, payment, etc.) that results in a payment error. It is calculated as the total number of audited claims minus the number of claims processed with "payment" errors, divided by the total number of audited claims. The acceptable error rate will be and 2.5% (97.5% accuracy rate).

Claims Processing Accuracy: Measures the overall claims processing accuracy, based on whether or not the claims was processed without an error. Claims processing accuracy is calculated as the total number of audited claims minus the number of claims with errors, divided by the total number of audited claims. The acceptable error rate will be 4% (96% accuracy rate).

At least 10.8% of annual administrative fees will be at risk if these standards are not met.

d. Inquiry Handling

85% of written inquiries that the Contractor receives either from the Employee Benefits Division or members will be answered within 14 calendar days, and 100% within 30 calendar days. The response time is calculated from the date of receipt by the Contractor to final resolution.

100% of phone inquiries will be returned within 24 hours.

The inquiry telephone line for members will have no more than 5% lost calls.

The inquiry telephone system must maintain sufficient staffing to respond to telephone calls by not allowing in excess of 30 seconds on hold for more than 80% of the calls received.

At least 85% of participants must be satisfied with the contractor's customer service.

At least 7.2% of administrative fees are at risk if these standards are not met.

9. Account Management/Client Servicing Staff

The Contractor shall provide an experienced regional account manager (RAM) support staff. The successful performance of the services under this contract depends significantly upon the capabilities of the RAM, his/her reporting relationship within the organizational hierarchy of the Contractor, direct reporting staff support and indirect reporting support throughout the Contractor's organization. Because State initiatives to address issues with the cost and quality of health care delivery may require changes with the Contractor's policies, procedures and process, it is critical that the RAM have effectual and responsible reporting relationships with senior executive level management. Qualifications will be measured by education and experience, with particular reference to reporting relationship, authority and ability to meaningfully coordinate the strategic planning needs of both the Contractor and the State.

The RAM shall have the ability within the Contractor organization to obtain the use of such resources, both direct and indirect, as are necessary to meet the State's needs.

Among other responsibilities, the RAM will be expected to provide the State with educational information about new programs in the industry, federally mandated programs relating to health related benefits, and changes in state laws affecting coverage.

The RAM shall have at least one qualified back-up account manager or assistant who shall be involved in this account management and who is capable of performing the responsibilities of the RAM in the event that the RAM is unavailable.

The RAM shall not be changed by the Contractor without the approval of the State.

In addition to the services of the RAM and the back-up account manager, the State requires the following support staff to ensure that the needs of administering the State Health Plan are met. They are:

- SOM Customer Service Center Manager
- Contract Administration Manager
- Operations Administrator
- Senior Medical Analyst
- Account Manager
- Communications Administrator
- Group Service Representatives (2)
  - Employee Benefit Office
  - Retiree Servicing
- Administrative Technician

From time to time, assistance from Contractor support staff (underwriters, statisticians) in assessing the cost impact of changes arising out of discussions with unions, pending legislation, etc. Time is often limited in responding to these requests, and the Contractor will be expected to respond to these requests with all reasonable speed.

The Contractor must submit an organizational chart showing all staff directly being proposed to service the State account for the first year of the contract and for each of the following years of the contract if changes are anticipated. Also, the Contractor must submit showing reporting relationships of the account management staff within the context of the Contractor's full organization with areas furnishing indirect support highlighted.

10. Audits

It is the State's intention to periodically (no less often than once every three years) perform on-site audits of plan administrators. The Contractor will make records associated with the administration of the State plan available to, and must cooperate with, such auditors and audits as the State may designate. The State's current approach has been to audit two (2) Plan Years at one time, conducted within 12 months of the end of the second year audited. This approach may change without prior notice.

II-D PROJECT CONTROL

1. The Contractor will provide these services under the direction and control of the Department of Civil Service**.**

2. Although there will be continuous liaison with the Contractor team, the Employee Benefits Director will meet quarterly during the first contract year as 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.

3. The Contractor will submit, as part of the monthly report (see II-C 8.d.) brief written summaries of significant activities during the month, issues or problems, real or anticipated, which should be brought to the attention of the client agency's project director, and significant activities anticipated for subsequent months.

II-E PRICE PROPOSAL

All rates quoted in bidder's response to the RFP will be firm for the duration of the Contract. No price changes will be permitted.

II-F CONTRACT PAYMENT SCHEDULE

The specific payment schedule for any Contract(s) entered into as the result of this RFP 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.

The Contractor must have the capability to accept electronic fund transfers weekly for claims costs, and monthly for administrative expenses.

BCBSM Response to the
State of Michigan's request for proposal

Section III

III -A. Business organization (Background/Problem Statement)

State the full name and address of your organization and, if applicable, the branch office or other subordinate element that will perform, or assist in performing, the work hereunder. Indicate whether it operates as an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated. If appropriate, state whether it is licensed to operate in the State of Michigan.

As an attachment, include your most recent financial statement. If your firm files form 10-k, attach the most recent report.

Response

Name and address of organization:

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

State of Michigan Service Unit:
Blue Cross Blue Shield of Michigan
1405 Creyts Road, Lansing, MI 48917

Blue Cross Blue Shield of Michigan is a Michigan nonprofit corporation organized under Public Act 350 of the Public Acts of Michigan of 1980. The mission of Blue Cross and Blue Shield of Michigan is to excel in the delivery of health care-related products and services that emphasize access to quality health care at affordable prices. We are committed to meeting our public responsibilities and maintaining our nonprofit status.

Other essential components of our mission are to:

- Develop new approaches to the challenge of assuring all citizens of Michigan access to reasonably priced, quality health care.
- Assure older and disabled citizens that supplemental coverage will always be available to group and nongroup Medicare enrollees.
- Work actively as a committed partner with business, providers of care, organized labor, and state government groups representing older people and subscribers to solve specific health care problems.
- Operate efficiently and fairly represent the interests of program beneficiaries in the role of administrator of government-sponsored health programs.
- Cultivate with physicians, hospitals and other providers, relationships characterized by mutual respect, trust, confidence and a shared interest in the welfare of the people of the State of Michigan to improve and enhance the overall delivery of health care.
- Design and administer competitive, quality, cost-effective health care benefit programs and to provide superior service to all customers, subscribers and providers.
- Strive to succeed as a business enterprise in order to fulfill the other aspects of our mission.

A copy of our Annual Report 2001 is included in Appendix S. It can also be found at www.MiBlue.TV.

III-B. Objectives

The objectives of the BCBSM/SHP medical contract are:

1. To provide for administration of the SHP benefit programs, in accordance with the terms of the Plans' designs, for active employees, COBRA participants, retirees, and eligible dependents;

2. To provide competitive pricing for medical plan services through a broad network of participating providers offering convenient access to employees, retirees, and their dependents;

3. To pay valid claims on an accurate and timely basis;

4. To maintain a high level of member satisfaction with the program;

5. To provide timely, accurate financial and utilization data reporting;

6. To provide programs in which the SHP members may participate in an effort to improve their health care;

7. To improve service with expanded customer and account service features, including performance guidelines and at-risk administrative fees; and

8. To achieve the lowest total plan cost (claims plus administration) consistent with objectives 1 through 7.

III-C. Management summary (Tasks/Plan Requirements)

1. Narrative (Capability and Qualifications)

Please refer to Section III-G.1.A-D for detail regarding Capability and Qualifications.

Include a narrative summary description of the proposed effort and of the product(s) that will be delivered. If any support is to be provided by a subcontractor, said subcontractors are to indicate their capability and willingness to carry out the work. In addition, the information requested in III-A above and III-G below should be provided for each potential subcontractor.

Response

On November 1, 2002, Blue Cross Blue Shield of Michigan will begin a new benefit plan year with the State of Michigan and continue with the existing Advantage health plan design through the end of December. For eligible MSPTA (Michigan State Police and Troopers Association), the current Advantage health plan continues unchanged, with the exception of enhanced preventive benefits, pending future collective bargaining action.

Effective January 1, 2003, we will implement a PPO (preferred provider organization) health care plan for State of Michigan employees and retirees. A PPO allows members to go in or out-of-network for covered services. A network is a group of physicians; hospitals and other providers who have agreed to accept BCBSM's approved amount as payment in full for covered services.

The *BCBSM Community Blue/Blue Preferred PPO Network* covers all 83 Michigan counties and is the largest PPO network in Michigan. It has more than 18,000 physicians, including specialists, and 147 hospitals.

Members will receive maximum benefits with the lowest out-of-pocket costs when they choose network providers. When members see a PPO network provider for covered services, out-of-pocket costs are limited to in-network deductibles and copayments.

A detailed benefit description in the form of the *Group Benefit Summary/Application Agreement* is included in Appendix A.

a. Service

There is a fully dedicated service center located in Lansing and the marketing client team is located in Southfield.

b. Timeliness

N/A

c. Subcontracting

It is the State's expectation that all essential services associated with delivery of this program will be provided directly by the Contractor, with the possible exception of certain peripheral services, such as printing, communications design, etc. List here all subcontractors; include firm name and address, contact person, complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization and abilities.

Response

All essential services associated with the delivery of this program will be provided directly by BCBSM and the use of subcontractors will be minimal, with the possible exception of certain peripheral services such as printing, communications design, etc.

With the addition of a disease management program, Coordinated Care Management program, BCBSM uses the following contracted agents to provide services for its members enrolled in CCM.

- AirLogix
- CorSolution

AirLogix is an independent, national disease management company specializing in chronic disease and health management. Currently, their focus is on respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) and Asthma. Clinical research and their own clinical outcomes demonstrate that a coordinated, proactive, disease-specific approach to these health concerns can accomplish improved quality of life while reducing healthcare costs. AirLogix was founded in 1994 and is privately owned.

Address: AirLogix
9461 LBJ Freeway
Dallas, Texas 75243

CorSolutions, Inc. is a disease management organization and an agent of Blue Cross, used in its CCM program to provide enrolled members with cardiovascular disease, diabetes, congestive heart failure and chronic obstructive pulmonary disease with disease management services. CorSolutions programs' services are designed to offer a highly coordinated and ongoing approach to improving a member's clinical condition and quality of life, while reducing unnecessary health care costs.

Address: CorSolutions, Inc.
1371A Abbott Court
Buffalo Grove, IL 60089

A copy of the CCM letter of agreement between BCBSM and the SOM is included in **Appendix E.**

2. Plan Design

The Plan design for the SHP PPO and the enhanced benefits for the MSPTA Advantage are found in Appendix A and Appendix B respectively.

When changes are mandated by the State either administratively or through collective bargaining (the next collective bargaining agreements will be effective October 1, 2005, with others effective January 1, 2006), BCBSM will be able to accommodate such changes within 90 days.

Under the Disease Management (DM) program, participants are identified as receiving treatment for certain disorders (CHF, ischemic heart disease, diabetes and asthma) and are offered, on a voluntary basis, a targeted disease management program. To administer this program, BCBSM will partner with prescription drug benefit managers to obtain drug utilization data in order to identify eligible DM program participants with these specified disorders.

3. Administrative Services

a. Information Systems:

Confidentiality:

BCBSM adheres strictly to all applicable federal and state laws regarding confidentiality of data relating to specific enrollees. BCBSM will not disclose to the Group an Enrollee's "protected health information" or PHI as defined in the Health Insurance Portability and Accountability Act of 1996 and applicable HIPAA regulations, unless:

(a) it is summary health information, as defined by HIPAA and is disclosed for the purposes permitted by 45 Code of Federal Regulations (CFR) 164.504 (f) (1) (ii)

(b) the State provides the written certification as agreed in Article II.H of the Confidentiality draft of the Administrative Service contract.

(c) BCBSM is given the prior written authorization of the Enrollee

If BCBSM discloses PHI to the State, the State must use and disclose Enrollee's PHI only for plan administration purposes or such purposes specifically authorized in the written authorization from the Enrollee.

Administration of eligibility, claims administration, information management, reporting & analysis, and experience data reporting are all addressed later in this document in sections IV- G and H.

BCBSM will conduct a coordination of benefits canvass on an annual basis, and provide a copy of the results to other SOM health plan vendors.

b. Financial Arrangements (see section III. J)

c. Customer/Member Services (see section III. G)

d. Participating Provider and Utilization Management (see section III. G)

e. Customer/Member Communications, Solicitation Materials and Information

BCBSM will:

(i) Provide customized participant communications as approved by the State

(ii) Prepare and print plan description booklets and claim forms for enrollees and comparable brochures and materials for open enrollment during the first contract year as approved by the State.

(iii) Provide access to benefit information via the Internet once available

(iv) Mail plan description booklets and claim forms as requested to all enrollees prior to the effective date of the new PPO plan design, and to new participants as part of the enrollment process

(v) Assume costs for all announcements, letters, notices, forms, postage, other supplies and services as provided per the administrative fees agreement.

(vi) Publish and mail a quarterly active and a quarterly retiree newsletter informing members about current State Health Plan events and other health and wellness topics. Expenses relating to the layout, printing and distribution of these newsletters are included as a part of the administrative fees agreement found in the price proposal **(section III. J).**

All announcements form letters, notices and brochures with the exception of routine member communications (i.e. form letters) will be presented to the State for prior approval before they are sent to State Health Plan members (active and retired).

4. **Eligibility and Enrollment**

a. Eligibility System – Refer to Section III-G for details.

b. Customer Service - Refer to Section III-G for details.

c. Exception Reports

BCBSM will produce a monthly retiree exception report to identify discrepancies between monthly data submitted by the State and data contained in its complete eligibility file. BCBSM Group Service Representatives will resolve discrepancies. They are available at the BCBSM State of Michigan dedicated service center.

d. Identification Cards

BCBSM will provide a State-specific identification card for each enrollee and adult dependent. The card will be made of durable plastic and will contain a toll-free telephone number that providers can use to verify coverage during normal business hours. The card will also contain a toll-free telephone number that can be used by participants to obtain information about the plan.

e. Enrollment Summaries

BCBSM agrees to provide additional summary enrollment statistics in a timely manner based on existing reporting capabilities BCBSM will produce a monthly exception report to identify discrepancies between monthly data submitted by the State and data contained in its complete eligibility file. BCBSM Group Service Representatives will resolve discrepancies. They are available at the BCBSM State of Michigan dedicated service center.

5. **Financial Arrangement and Reporting**

Claims will be paid weekly via Manual wire. If Treasury specifies some other method such as Electronic Funds Transfer (EFT) in the future, BCBSM will comply. BCBSM will submit a

summary of health claims for the previous week (Saturday through Friday) to a designated State official. The State Treasury department will be instructed to wire these funds to the bank specified by BCBSM. BCBSM will provide all the banking information needed to process the wire such as the bank name, routing number, account number and account name.

Additional information regarding financial arrangements and reporting mutually agreed to between the State and BCBSM can be found in Sections III. G, and III. J, unless otherwise noted. Subjects referenced are:

a. Security (see section III. C -3. Confidentiality)
b. Requests for Funds
c. Documentation
d. Annual Reports
e. Payment
f. Government forms
g. Legal Activity (see Section One -Contract Terms and Conditions)
h. Timing of Fee Payments
i. Provider Discounts
j. Audits
k. Conversion Policies

6. <u>Claims Administration</u>

Addressed in Section III.G-5 a-d are the following subjects as found in Section II.C.6:

A. Claim Adjudication and Payment

B. Claims System

C. Claims Processing and Customer Assistance

In addition to the dedicated State of Michigan Service Center, BCBSM maintains a "nurse hotline" called Blue HealthLine that allows members to talk on a toll-free line to registered nurses about their health concerns.

This program includes:

i. Phone response to members' health concerns using established clinical patterns designed by physicians

ii. Health counseling on any medical topic, including outbound follow up calls by nurse counselors

iii. Information on Michigan providers and community resources

iv. Hard copy health education library for home mailing; audio library for on line listening

v. Medical history collected at call time and stored for future reference

vi. Selected medical claims data available on line.

The Blue HealthLine program may be reviewed, as is mutually agreed upon by the parties, annually by the State.

D. Payments in Accordance with Plan

BCBSM will process and pay for claims in accordance with the State Health Plan. BCBSM will process and pay for claims for an individual who was formerly covered under the plan, if such payments were made prior to notification of the individual's ineligibility as described in Section I.

BCBSM will recover such payments from participants or providers or reimburse the State for payments if those payments were made and identified as unauthorized. BCBSM agrees that the State may in the interest of the Plan and its members, agree to accept a settlement of such obligations.

E. Claim History

BCBSM will maintain the State's current claims history data in a mutually agreed upon format (electronic or otherwise), so that a claims history file can be provided to the State or any subsequent administrator within 30 days of the date of request. In the event of transfer to another vendor, BCBSM will provide monthly claims run-out reports for the first 12 months, after the transfer of administration. BCBSM will provide claims run-out every 60 days during the second 12 months after transfer and will provide claims run-out every 90 days thereafter, until all run out claims are closed.

7. Systems and Reporting Requirements

a. Claim Information

Please reference Section III.8.a-c for a detailed response.

b. Claims Records File

BCBSM will continue to provide detailed analysis of activities related to the State Health Plan on a quarterly basis in a mutually agreed upon format suitable to be used by a contractual claims analysis company. Confidentiality of this data is subject to State, Federal (HIPAA) guidelines.

c. Contractor/State

1. **Please reference Section III-G.3.for a detailed response.**
2. **Please reference Section III-C.9 for a detailed response.**
3. **Please reference Section III-C.9 for a detailed response.**
4. **Please reference Section III-G.3.c for a detailed response.**

d. <u>Reports</u>

BCBSM agrees to provide the monthly, quarterly, and annual reports as listed below:

- Monthly reports, including:
  - A summary of cash calls, by week or other check writing cycle, for the month, produced within 5 business days of the end of the month,
  - A brief written summary of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months,
  - Claims Report, showing claims paid in the month, split between Actives, COBRA and Retirees (split by Medicare-eligible and non-Medicare), showing number of admissions, days/visits/services, charges, employee copays, and plan payments, by categories of hospital services, professional services, etc.,
  - Claims "lag" report, accumulated year-to-date in the format shown in **Appendix F,**
  - Number of subscribers and number of dependents covered, split between Actives, COBRA and Retirees,
  - Reports will be produced within ***60*** calendar days of the end of the month.

- Quarterly reports, including:
  - Quarterly and YTD summaries of Monthly Claims Report items,
  - Activities and results in administering the Coordination of Benefits (COB) provisions of the Plan, including:
    … number of claims during the period, for which other coverages (other than Medicare) were reported,
    … number of claims for which other coverage was not reported but was identified upon investigation, and
    … the dollar amount and % of total claims dollars saved as a result of COB administration,
  - Amount of "retention reallocation," or access fees, included in claim payment amounts for the quarter,
  - A quarterly financial settlement report to assist in an on-going reconciliation of claim payments, fees and other financial transactions,
  - Detailed claims file, in the format described in **Appendix I**, provided to the State's specified data vendor,
  - Quarter reports will be produced within ***60*** calendar days of the end of the quarter, *except the reconciliation report, which may be produced within 90 days of the end of the quarter*.

- The State Health Plan Annual Report (based on the State's plan year October through September), including:
  - Management summary,
  - Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis,
  - Produced within ***120*** calendar days of the end of the year.

The State may also request certain other ad-hoc reporting, in formats and on time schedules as mutually agreed upon between the State and the BCBSM.

BCBSM agrees that a maximum of 2% of monthly administrative fees, will be at risk for failure to meet the reporting timeframes. **Details can be found in the price proposal Section III-J**

Please reference Section III-G.8.a for a listing of standard additional reports that are also available at the State's request.

8. Performance Guarantees

a. Eligibility

BCBSM agrees to meet the following conditions without financial penalty:

Active Members:
BCBSM will update the State's weekly eligibility files within 3 business days of receipt. Any eligibility errors from the weekly file will finalize within five to seven business days.

At least 85% of the identification cards will be created and distributed through the U.S. mail within 10 business days of receipt of the State eligibility files, and 100% within 15 business days, with an accuracy rate of 99% or better for the ID cards.

BCBSM will issue additional identification cards within 10 business days of request from enrolled members.

Retired Members:
BCBSM will manually update retiree membership changes within ten business days of receipt.

b. **Claim Turn-a-round Time**

1. BCBSM will process claims within 14 calendar days for 85% of all claims and 30 calendar days for 98% of all claims. Requests for additional data from either the beneficiary or the provider shall comply with the criteria outlined in PA 350.

2. BCBSM ensures that the performance guarantees are measurable using current standard systems in place.

c. Claim Accuracy

BCBSM agrees to a claims audit for accuracy using the States approach of auditing two plan years at one time conducted within 12 months of the last year audited. BCBSM agrees that should the State desire to change this approach, both parties should agree upon guidelines.

It is further agreed that BCBSM will not be liable for errors caused by the State and that the State will not be liable for errors caused by BCBSM. Errors will be established by using statistically significant sampling methods resulting in a 95% confidence level with precision of +/- 3%. Both parties agree that the State will include adjustments made up to four months after the close of the audited year. And, if claims samples are selected using a financially stratified methodology, the results will be extrapolated to the entire population of claims during the audit period using a weighted average method for each category.

The State's auditor and BCBSM will sign an audit letter of agreement documenting the process for each audit prior to each audit. **A copy of the Audit Agreement can be found in Appendix R.**

Standards for financial payment accuracy, payment incidence accuracy, and claims processing accuracy are addressed in the Price Proposal **Section III.J**. However, the following summarizes the audit agreement.

Financial Payment Accuracy: measures the dollar value of errors. Calculated as total audited paid dollars minus the absolute value of over- and underpayments, divided by total audited paid dollars. The acceptable error rate will be 0.7% (99.3% accuracy rate).

At least 9% of annual administrative fees will be at risk if the financial payment accuracy standard is not met.

At least 1.8% of annual administrative fees will be at risk if for claims timeliness.

At least 2% of the annual administrative fees will be at risk for reporting as identified in Section III-J.

If the error value for a review period exceeds the acceptable error value and the difference is statistically significant, BCBSM's administrative fee will be at risk up to the midpoint of the difference between the acceptable error value and the statistically determined value. The acceptable error value is the acceptable error rate multiplied by net paid claims during the review period. The standards, incentives, and penalties shall be as shown below:

FINANCIAL PAYMENT ACCURACY

Review Period	Error Standard as a % of Dollars Paid	Penalty Charged for Each Error Above Standard
Year One	*0.7% of net claims*	**Amount above standard**
Year Two and after	0.7% of net claims	Amount above standard

Payment Incidence Accuracy: Measures the incidence of claims processed without payment error. It is defined as the percentage of audited claims process without payment error. The definition of error includes any type of error (e.g., coding, procedural, system, payment, etc.) that results in a payment error. The total number of audited claims calculates it as the total number of audited claims minus the number of claims processed with "payment" errors, divided. The acceptable error rate will be 2.5% (97.5% accuracy rate).

Claims Processing Accuracy: Measures the overall claims processing accuracy, based on whether or not the claims was processed without an error. Claims processing accuracy is calculated as the total number of audited claims minus the number of claims with errors, divided by the total number of audited claims. The acceptable error rate will be 4% (96% accuracy rate).

The aggregate amount for total risk for performance is 20% of the administrative fee of which 18% is directed toward claims and 2% toward reporting.

d. Inquiry Handling:

BCBSM commits to 85% of written inquiries received either from the Employee Benefits Division or members will be answered within 14 calendar days, and 100% within 30 calendar days. The response time is calculated from the date of receipt by the BCBSM to final resolution of the inquiry.

100% of phone inquiries will be returned within 24 hours.

The inquiry telephone line for members will have no more than 5% lost calls.

The State of Michigan customer service telephone inquiry unit will maintain sufficient staffing to respond to telephone calls by not allowing in excess of 30 seconds on hold for more than 80% of the calls received.

At least 85% of participants must be satisfied with BCBSM's customer service.

At least 7.2% of the annual administrative fees are at risk if the financial accuracy standards claim payments are not met.

A complete listing of performance guarantees and at risk penalties can be found in **Section III-J.**

9. Key Personnel / Account Management /Client Servicing

Supply names, resumes' (including education, experience, and other assigned groups), and expected portion of time assigned to the State account, for the following Key Personnel to be assigned to the State account:

- **Manager- Regional Sales**
- **Manager- Sales**
- **Manager - SOM Service Center**
- **Manager - Contract Administration**
- **Administrator - Operations**
- **Senior Analyst - medical**
- **Manager- Account**
- **Administrator - Communications**
- **Group Service Representative (2)**
- **Administrative Technician**

[Servicing organization]

1. **Submit an organizational chart showing all staff directly being proposed to service the State account for the first year of the contract and for each of the following years of the contract if changes are anticipated.**

2. **Submit an organizational chart showing reporting relationships of the account management staff within the context of the Contractor's full organization with areas furnishing indirect support highlighted.**

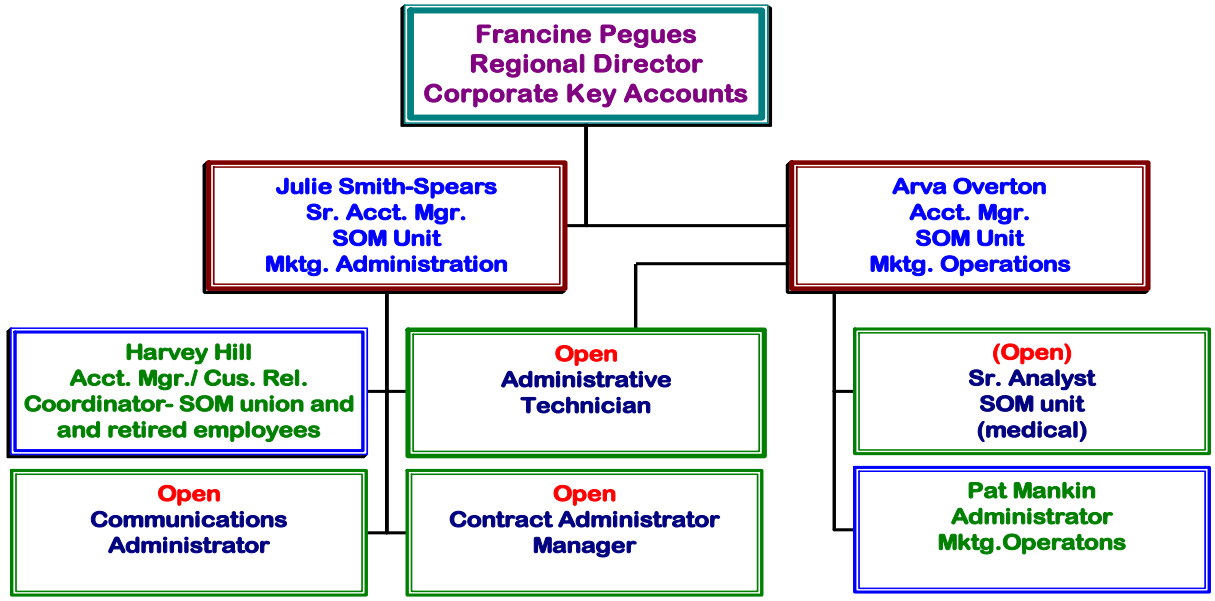
Response

Blue Cross Blue Shield of Michigan is committed to providing the State of Michigan the best possible service. As evidence of our dedication, Blue Cross will expand the current servicing team as requested above and indicated below:

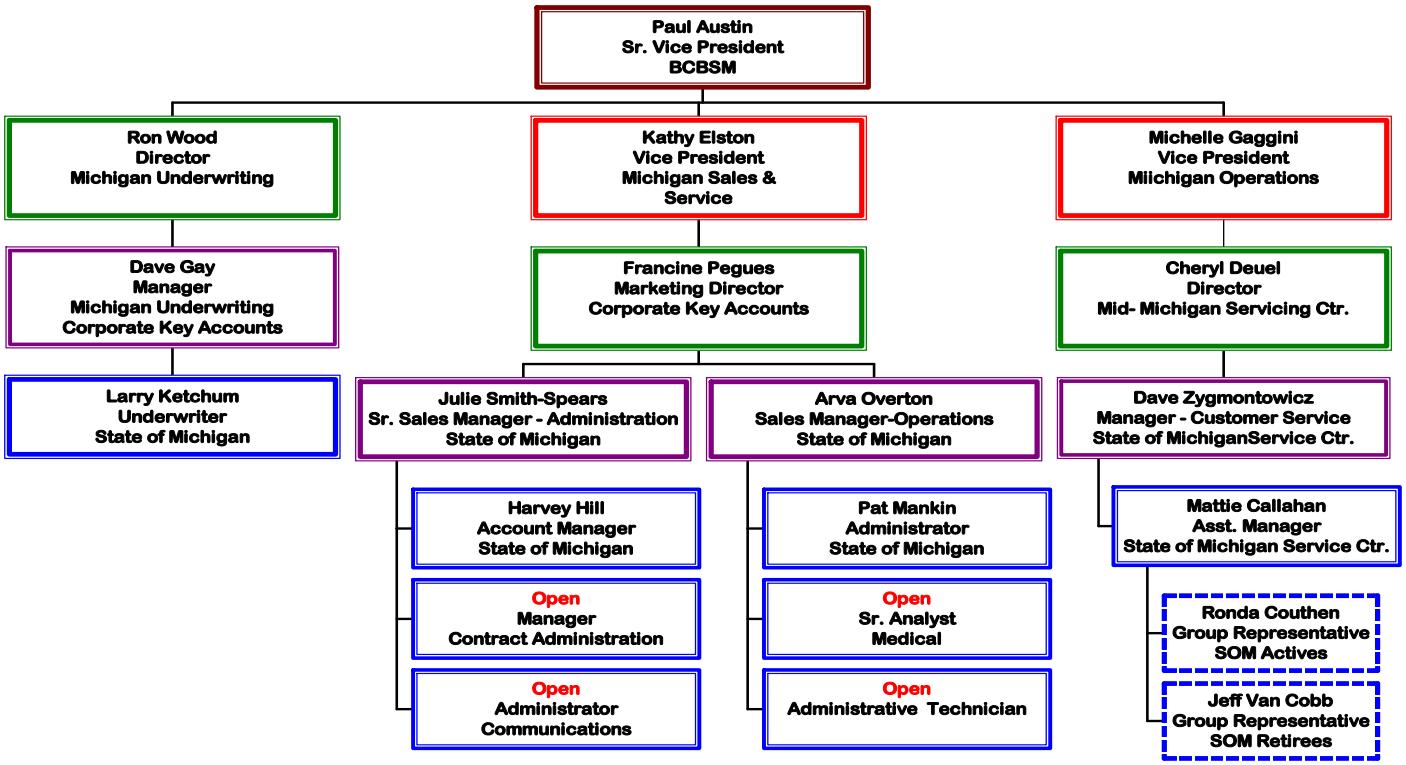
- **Regional Account Manager**
- **Back-up Account Manager**
- **SOM Customer Service Center Manager**
- **Contract Administration Manager**
- **Operations Administrator**
- **Senior Medical Analyst**
- **Communications Administrator**
- **Group Service Representative - Employee Servicing**
- **Group Service Representative - Retiree Servicing**
- **Administrative Technician**

Following is an organizational chart showing all staff which make up the client servicing team being proposed to directly service the State account, and an organizational chart showing the reporting relationships of the account management staff within the context of BCBSM's full organization.

BCBSM Client Servicing Team



BCBSM Servicing Structure for the State of Michigan
January 1, 2003



Current Client Servicing Team:

Julie Smith-Spears has been a dedicated manager to the State of Michigan for nine years, and has primary responsibility for administrative and financial issues for the State account. Julie has been with BCBSM for 16 years, during which time she has also worked as an account manager in Corporate Key Accounts, National Accounts and local as an account representative local Michigan Marketing. Each of these departments has contributed to her knowledge of BCBSM delivery systems, financial arrangement options and a variety of health care products.

While at BCBSM, Julie has received many awards for sales performance, including the following:

- Account Executive of the Year-National Accounts – 1992
- Vice Presidents Club award – 1987, 1990, 1991, 1992, 1994, 1995, 1997 and 1999
- Top Team Honors – 1994, 1996 and 1999
- Quota Achievers Award – 1990, 1994, 1995, 1996, 1997, 1999 and 2000

Julie has 28 years of experience in marketing, communications and sales. Before coming to BCBSM, she was a licensed special agent with New York Life Insurance and Annuity Corporation. She held sales positions with Travenol Laboratories and Wyeth Pharmaceuticals, worked as assistant director for Public Information at the Wayne County Department of Social Services and was a Marketing Communications/Audio Visual Specialist with General Electric Company Specialty Materials department in Worthington, Ohio.

Julie has a Bachelor of Science degree from Indiana University and a Master of Arts degree from Ohio State University. She is a Dale Carnegie graduate and has served as a teaching assistant for the course. Julie has been a dedicated manager for the State account since 1993 and currently spends 100 percent of her time ensuring that the State Health Plan is administered as smoothly as possible. Located in Southfield, Julie expedites the resolution of State health Plan issues as they arise, through coordinating efforts between the dedicated State of Michigan Service Center and other internal BCBSM departments.

Arva Overton is the dedicated sales manager who has primary responsibility for State of Michigan operation and information system activities. Arva has 25 years experience in the health care benefits industry. She has been dedicated to the State of Michigan account since summer 1999. During her first year on the State of Michigan account (1999), she shared in the Top Team and Quota Achievers Award.

Before her current position with the State of Michigan, Arva was the operations administrator for Michigan Public School Employees Retirement System (MPSERS) at BCBSM. As an operations administrator, she was responsible for operational activities for 95,000 contracts.

Prior to serving as the operations administrator for MPSERS, Arva spent seven years as a project analyst. As such, she was responsible for analyzing, investigating, formulating, developing and authorizing system changes to improve quality, processing time and efficiency for all national accounts. Arva also spent four years as a benefit analyst and has received numerous awards and letters of acknowledgment for her achievements.

Arva has been dedicated to the State of Michigan account since 1999 and devotes 100 percent of her time to the State of Michigan account.

Harvey Hill is the account manager on the State of Michigan account. Harvey began his career with the Blues at Blue Care Network in 1986, then joined BCBSM in 1993. At BCN, Harvey was responsible for local unions and related functions on a statewide level. His previous responsibilities at BCBSM included servicing the Ford and Rouge Steel accounts, both hourly and salary. As a result, Harvey has gained

extensive experience in working with and servicing unions. Harvey devotes 100 percent of his time to servicing the State of Michigan. He has an Associates Degree in General Studies from Macomb Community College.

Pat Mankin is the administrator on the State of Michigan account. Pat has been with BCBSM for 22 years. Her primary responsibility is for operational activities. Pat has also served as a performance consultant, PPO coordinator, supervisor and analyst. Pat has a Bachelor of Science Degree from Michigan State University and a Master's Degree in Interdisciplinary Technology from Eastern Michigan University. Pat devotes 100% of her time to the State of Michigan account.

Holly Golightly Rhoder is the communications administrator for the State of Michigan. Her responsibilities including writing and editing communications for the State. These communications include quarterly newsletters, benefit books, charts, letters, brochures and other communications as assigned. Holly also coordinates the design, printing and mailing of these communications.

Holly has a Bachelor of Arts degree from Kalamazoo College and a Master of Social Work from the University of Michigan. She is also a Dale Carnegie graduate.

Holly has been a Blues employees for 12 years and has worked on the State of Michigan account for almost two years. Prior to working on State communications, Holly worked on a variety of BCBSM accounts producing marketing materials. Prior to joining the marketing communications staff, Holly worked in Provider Publications writing and editing provider manuals primarily for psychiatric and substance abuse providers.

Customer service team members:

David Zygmontowicz is the manager of the dedicated State of Michigan Service Center. David, known to many as "Ziggy", is in his 35th year at BCBSM. He began his career as a Clerk and has been a Claims Processor, Supervisor, Auditor, Assistant Manager and Senior Analyst. He has BA Degree from Wayne State University, a Master's Degree from Aquinas College, a Certified Manager Designation from the National Management Association and is in the process of obtaining a Para-Legal Certificate from Lansing Community College.

David recently received the National Shield of Excellence Award from National Management Association for his motivation of others to practice the principles of the Association's Code of Ethics.

Ronda Couthen is the Group Service Representative dedicated to the State of Michigan account. Her primary responsibility is to respond to problems and issues relative to health benefits from the State benefit office, unions and personnel office staff.

Ronda has been a Blue Cross employee for 18 years and has worked on the State account for 16 years. She has spent the last six plus years as the group service representative. She also worked in the State's major medical, phone, and written customer service units. In addition, Ronda worked approximately 1 1/2 years in regular business marketing department.
Ronda attended Ferris State University for two years and is currently pursuing a Bachelor's Degree in Business Management from the University of Phoenix's Livonia Campus.

Jeff Van Cobb is also a dedicated Group Service Representative for the State account. Jeff's primary responsibility is to respond to retiree issues and concerns as presented by the State Benefit Office, unions and the Personnel Office staff.

Jeff has been an employee of Blue Cross for 16 years and worked on the State account for 14 years. Prior to the new State Health Plan PPO benefit design, Jeff spent the last four years as the State's dedicated group service representative for the State's retiree retail and active and retiree mail order prescription drug benefits.

Jeff has also worked in the State of Michigan distribution and control unit, professional processing unit and the phone and written customer service units. In addition, Jeff worked approximately two years in the customer service phone unit where he serviced other Blue Cross customers in the central Michigan area.

10. Audits

The parties mutually agree to periodic audits as set forth in the Audit Letter of Agreement in Appendix R.

III-D PROJECT CONTROL AND REPORTS

1. Project Control

   The Regional Account Manager will meet monthly with the Benefit Administrator to provide updates on current events and future planned activities, and quarterly during the first year to provide a status on post- implementation projects.

III-E PRICE PROPOSAL

BCBSM agrees that all rates quoted in bidder's response to this RFP will be firm for the duration of this Contract, and that no price changes will be permitted unless mutually agreed upon by the parties. See Section IV J for additional detail.

III-F CONTRACT PAYMENT SCHEDULE

The mutually agreed upon contract payment schedule will be detailed for each quarter in the settlement for the previous quarter. A sample of the quarterly settlement accounting package can be found in **Appendix F**.

III-G. Questionnaire

1. Company Overview

A. Provide a brief history of your organization. Describe the number of years your organization has been in business, the number of years it has been providing medical benefit services, and the number of covered members in each of the past three years.

Response

The genesis of Blue Cross Blue Shield of Michigan began in the mid-1930s, when middle-class, working individuals were encountering difficulty covering the expense of hospital and physician care. For-profit commercial insurance companies had little interest in covering the vast majority of Americans. So across the nation, groups of workers and community leaders began to organize nonprofit "prepaid" plans to cover member's health care needs.

In 1939 the "Michigan Hospital Service," which became "Blue Cross," was organized as a prepayment plan for hospital care. The "Michigan Physician Service," which became "Blue Shield," was organized as a prepayment plan for physician care in 1940.

By the 1950s, with the support of labor unions, the Michigan Cross and Shield plans were on their way to becoming national trendsetters and leaders. In 1975 the two plans merged to become Blue Cross Blue Shield of Michigan.

Through the 60s and 70s the Blues expanded covered health benefit options to include vision, hearing, prescription drug and dental care. In 1980, Public Act 350 took effect, which restructured our board of directors to ensure that our policies and practices kept our members' interests paramount.

Today, Blue Cross Blue Shield of Michigan continues its commitment to the people of the State of Michigan. In 1999 we covered 4,756,291 members. In 2000, we covered 4,836,548, members and in 2001, we covered 4,812,310.

We have more than 26,000 participating providers. And our PPO network of providers has more than 18,000 physicians and specialists, and more than 147 hospitals.

As proven by our history, Blue Cross Blue Shield of Michigan is dedicated to providing State of Michigan employees, retirees and dependents with a quality health care program.

B. Describe your company's medical benefit delivery philosophy and approaches to provider contracting, administration, quality control and customer service.

Response:

The Blue Cross Blue Shield of Michigan philosophy is that all citizens of Michigan are entitled to quality health care. That philosophy is reflected in our mission statement, which is outlined in Section III-A of this response, as well as in our history, which we described above.

In our PPO program, our philosophy is reflected in what we offer — comprehensive care that promotes wellness through preventive services so health care problems are detected **before** they become major problems.

Our philosophy is evidenced in the steps we take to credential and contract with our providers, and then confirmed through our customer service, where quality service is ensured due to extensive training of our customer service representatives.

The Blue Cross Blue Shield of Michigan philosophy extends to all citizens of Michigan. And we're confident that members of the PPO program will benefit from the steps we've taken to be true to that philosophy.

C. If you have a rating from A.M. Best, specify it. If you have an "ability to pay" rating from S&P, Moody's or other major financial rating organization, specify it. If not, indicate either why not, or describe where you are in the application.

Response

BCBSM is a nonprofit company and therefore does not have an A.M. Best rating. We also do not have an "ability to pay" rating. We do have a BBB+ credit and financial strength rating from Standard & Poor's.

D. Describe any features of your organization that distinguish it from your competitors, and why the State should consider selecting your organization over other medical care vendors.

Response

Here's what makes the Blues the best choice for the State's health care program:

- We have the largest PPO network in Michigan.
- We have established cost-effective agreements with health care providers throughout the state.
- The State of Michigan Service Center is dedicated to State of Michigan employees, retirees and their dependents.
- The State of Michigan Service Center received national recognition via Customer Operations Performance Center (COPC) certification in 2001.
- The Blue ID card is the most widely recognized ID card for health care services.
- Unlike other insurers, BCBSM has coverage available for everybody, regardless of age or health.
- We process claims fast and accurately. In 2001, we processed over 113 million claims for all lines of business.
- We're financially sound. Our financial reserves make us one of the strongest Blues Plans in the country.

2. <u>Customer Service</u>

A. Describe your hours of operation, including times available:

a) Member inquiries – "live" customer service representatives
b) Member inquiries - voice messages
c) Member inquiries – emergencies
d) Account administration – assigned client/service managers
e) Provider inquiries.

Response

a) Customer service lines are open Monday through Friday from 8:30 a.m. to noon. The line is open again from 1 p.m. until 4:45 p.m. Members can also receive face-to-face service at one of our 15 walk-in customer service offices, which are conveniently located throughout the state.

b) ASPECT, our telephone system, is designed to give members the utmost in service. From noon to 1 p.m. members can leave messages. During "live" hours, if all available representatives are servicing a caller, members will also be given the option of leaving a message. If a member calls on holidays or after hours, a recording will advise that the department is closed and the date and hours of operation. ASPECT allows the member to leave a message and a representative will return the call within 24 hours during the week and within 48 hours for weekends. For holidays, calls will be returned within 24 hours of the next business day.

c) 24-hour access is available to providers to verify eligibility in the case of emergencies.

d) The service center manager is available Monday through Friday, 8 a.m. to 5 p.m.

e) CAREN*Plus*, our automated provider telephone system, is available 24 hours a day.

B. Do you currently provide automated interactive telephone communication service? If yes, describe the menu available to callers and indicate if a touch-tone phone is required or if a voice-response feature is available. If available for our review, please provide the phone number, and sample id/login. If no, briefly describe plans for future addition.

Response

The Blue Cross Blue Shield of Michigan State of Michigan Service Center has an interactive telephone communication system. This system requires a touch-tone phone in order to access. If the customer does not have a touch-tone phone, they will be connected to a representative.

"Thank you for calling the State of Michigan Service Center. If you're calling from a touch-tone telephone, press one now. All others please hold for assistance. Please listen carefully. Our prompts have changed. For forms, brochures, and identification cards, press 9. To speak with a customer service representative, press 0 or remain on the line for assistance."