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. 9

to

CONTRACT NO. 071B0200075

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(517) 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
MPSERS Master Health Care Plan Administration			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 2 yr. options	December 31, 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	☐	☐		December 31, 2016
VALUE/COST OF CHANGE NOTICE:		ESTIMATED REVISED AGGREGATE CONTRACT VALUE:		
$0.00		$4,341,151,000.00		

Effective May 15, 2015, the contract changes per the attached Addendum and the Business Associates Agreement (BAA) are hereby incorporated into this contract.

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

Schedule B – Performance Guarantees/Service Level Agreements (SLAs)

The following replaces section 1.022 (M) in its entirety:

M. Service Level Agreements (SLAs) – Medicare

Requirements:
Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. Contractor must also provide process documentation detailing out the Contractor's internal processes used to gather and measure the data used to verify the Contractor's performance. This process documentation must be provided to the Plan Sponsor no later than the end of the first quarter of the Contract period and anytime thereafter when a significant change is made to the process.

Every SLA must have a report provided that is deemed adequate by the Plan Sponsor to verify the SLA has been met; SLAs without a corresponding report will be deemed unmet and subject to the penalty. Samples of reports that will be used for SLA compliance are required in advance to be deemed adequate. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§ 2.190).

Within 45 Days after the end of each calendar quarter, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA for the Plan Sponsor, and provide payment for any applicable penalties to the Plan Sponsor. Any metric that is reported must be accompanied by supporting documentation. Annual SLA reports are due 90 days after the close of the plan year.

The following SLAs are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are for all Services provided under this Contract for the Plan Sponsor and are divided in two categories: Medicare and non-Medicare. Penalties will be assessed separately for Medicare and non-Medicare services and the Contractor must report on each separately. Separate penalties will be assessed for the month in which performance was assessed. No individual SLA shall be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

SLA #1
Eligibility Uploads
Guarantee
One-hundred percent (100.00%) of all accurate records that pass Contractor's validation edits must be uploaded according to the Plan Sponsor's schedule within one Business Day of receipt (as defined in 1.022G). The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis. The SLA report must show weekly activity defined as the number of records uploaded, number of records not accepted, and the timeframe for presenting the discrepancy reports to the Plan Sponsor. Any records that do not pass the contractor's validation test must be reported to the Plan Sponsor within two Business Days after the file has been uploaded in the format specified by ORS.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #2
ID Cards
Guarantee
ID Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. ID Cards must have an accuracy rate of 100.00%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis. Performance must be substantiated by documentation providing proof of receipt date and mailing date. Accuracy must be measured by sampling ID card production to ensure 100.00% accuracy of information.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #3
Customer Service Call – Average Speed of Answer
Guarantee

SLA #3
Contractor shall maintain an average speed of answer of 120 seconds. The ASA standard will be applied to the speed at which the initial call is answered by a CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #4
Telephone Servicing Factor
Guarantee
80.00% of calls must be in queue (left IVR) for service less than 30 seconds. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #5
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 5.00%. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #6
Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to 95.00% or more of written inquiries within 14 Days of receipt and 98.00% of all Member inquiries must be resolved within 28 Days and 100.00% of written inquiries must be resolved within 60 Days. Written inquiries will include those forwarded to the Contractor by the Plan Sponsor. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #7
Timeliness of Data Transmission to Plan Sponsor’s Data Vendor and Pharmacy Benefits Manager
Guarantee

SLA #7
Pursuant to Section 1.042, Contractor must agree to deliver Claim data files to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager in agreed-upon format. Delivery of data files, with all required fields correctly populated, must be completed within 15 Days after the close of each month. If the 15th falls on Saturday or Sunday, the data file can be delivered on Monday without penalty.
Penalty
The penalty for failure to meet the SLA for monthly reports is $300,000 for each quarter that the SLA is not met, for either the Plan Sponsor's Data Vendor or Pharmacy Benefits Manager.

SLA #8
Timely Production of Complete Management Reports
Guarantee
Contractor must provide complete monthly and quarterly reports within 45 Days of the end of the month and quarter, and annual reports within 90 days of Plan year end. The Contractor must measure and report its performance on this SLA on a quarterly or annual basis, depending on report.
Penalty
The penalty for failure to meet the SLA for monthly and quarterly reports is $300,000 for each quarter that the SLA is not met. The penalty for failure to meet the SLA for annual reports is $1,200,000.

SLA #9
Financial Error Rate
Guarantee

SLA #9
The financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00%. Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $325,000 per quarter not met.

SLA #10
Non-financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a non-financial error divided by the total number of claims in the sample) must not exceed 3.00% Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $325,000 per quarter not met.

SLA #11
Claims Processing Time
Guarantee
95.00% of clean Claims must be processed within 30 calendar Days. 100.00% of all Claims must be processed within 60 calendar Days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty

SLA #11
The penalty for failure to meet this SLA is $55,000 for each month that the SLA is not met.

SLA #12
Care Transition to Home 30-Day Readmissions
Guarantee
Contractor guarantees to achieve one of the following for the annual rate of all cause inpatient readmissions within 30 days for members enrolled in the Care Transition to Home Program, excluding planned readmissions, trauma and maternity: 1. remain at or below the established threshold; 2. achieve a 2% improvement from the previous year's rate if performance is more than 2% above (worse than) the target; or 3. improve performance back toward the established threshold if performance is less than 2% above the target. Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs. Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.
Penalty
The penalty for failure to meet this SLA is $0 per year the SLA is not met.

SLA #13
Disease Management Hospital Admissions
Guarantee

Contractor guarantees to achieve one of the following for the annual combined rate of acute hospital inpatient admissions per 1000 members enrolled in the Disease Management Program with CHF, COPD, CAD, and Diabetes adjusted for the combined trend of the population without CHF, COPD, CAD, and Diabetes, excluding admissions for trauma and maternity:

1. remain at or below the established threshold;
2. achieve a 5% reduction from the previous year's rate if performance is more than 5% above (worse than) the target; or
3. improve performance back toward the established threshold if performance is less than 5% above (worse than) the target.

Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs.

Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.

Penalty

The penalty for failure to meet this SLA is $0 per year the SLA is not met.

SLA #14
Disease Management Emergency Room Visits
Guarantee
Contractor guarantees to achieve one of the following for the annual combined number of Emergency Room visits/1000 members enrolled in the Disease Management Program with CHF, COPD, CAD, and Diabetes adjusted for the trend of the combined population with CHF, COPD, CAD, and Diabetes, excluding visits for trauma and maternity: 1. remain at or below the established threshold; 2. achieve a 2% improvement from the previous year's rate if performance is more than 2% above (worse than) the target; or 3. improve performance back toward the established threshold if performance is less than 2% above (worse than) the target. Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs. Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.
Penalty
The penalty for failure to meet this SLA is $0 per year the SLA is not met.

SLA #15

Clinical Quality Improvement

Guarantee

Contractor must measure and report performance on an annual basis on the following HEDIS measures following HEDIS methodology and reporting schedule.

- **DIABETES**: Comprehensive Diabetes Care (CDC) The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
    - Hemoglobin A1c (HbA1c) testing
    - HbA1c poor control (>9.0%)
    - HbA1c control (<8.0%)
    - Eye exam (retinal) performed
    - Medical attention for nephropathy
    - BP control (<140/90 mm Hg)
- **HEART FAILURE:** Controlling High Blood Pressure (CBP) The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:
    - Members 18–59 years of age whose BP was <140/90 mm Hg
    - Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
    - Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
- **COPD:** Pharmacotherapy Management of COPD Exacerbation (PCE) The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:
        - Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
        - Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

BCBSM will calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and NCQA Quality Compass® National Average for the comparable population (i.e., Medicare PPO or Commercial PPO).

SLA is considered “Met” if performance for every reported measure is at or above national average OR demonstrates statistically significant improvement from the previous year’s rate if below the national average.

SLA is considered “Not Met” if performance for a reported measure does not meet the aforementioned criteria for “Met”.

Penalty

The penalty for failure to meet this SLA is $0 per year the SLA is not met.

SLA #16
Quality Improvement Projects
Guarantee
By October 31st of each Plan Year, the Contractor must develop several process improvement projects based on Contractor's quarterly annual performance evaluations reviewed during the previous quarters' management meetings. The Contractor and the Plan Sponsor will mutually agree upon the number of process improvement projects The Plan Sponsor will be the final decider on the total number; however, the number will not exceed three (3). These process improvement projects must be approved by Plan Sponsor by December 31st. Contractor will complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is $1,200,000 if the Contractor does not develop and have approved projects for the next Plan Year. The Contract will pay $2,400,000 if the Contractor does not complete the approved projects.

SLA #17

Contractor Performance/Satisfaction

Guarantee

Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1 to 5. The Contractor will be measured using the Plan Sponsor's annual survey to assess the Contractor's Performance within the following categories:

1. Senior Account Manager Performance
2. Communications
3. Data Reporting
4. Clinical Management
5. Customer Service
6. Administrative Support

The Contractor's total Performance score will be determined by weighting equally the overall satisfaction scores of each of the six categories.

Penalty

The penalty for failure to meet this SLA is $1,200,000 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional $500,000.

SLA #18
Member Satisfaction Surveys
Guarantee
One random sample Member survey must be completed annually specific to the Plan Sponsor's population at no additional cost to the Plan Sponsor. The survey must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for prior approval of questions and scoring methodology prior to deployment. The respondent pool must be statistically valid based on the Plan Sponsor's total population. Survey results must be available to the Plan Sponsor by the end of Q3 within the Plan Year. There must be separate member satisfaction surveys for both Medicare and Non-Medicare populations. Results must be reported separately.
Penalty
The penalty for failure to meet this SLA is $1,200,000 per year not met.

SLA #19
Financial Accuracy Rate
Guarantee
Financial Accuracy on claims processing (as defined as the sum of the absolute value of financial errors on claims processed divided by the total dollar value of claims paid) must not fall below 99.00%. Contractor must measure its performance on this SLA based on a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is $1,300,000 per year not met, plus $325,000 for each 0.5% below the standard.

Schedule B – Performance Guarantees/Service Level Agreements (SLAs)

The following replaces section 1.022 (M) in its entirety:

M. Service Level Agreements (SLAs) – Non-Medicare

Requirements:

Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. Contractor must also provide process documentation detailing out the Contractor's internal processes used to gather and measure the data used to verify the Contractor's performance. This process documentation must be provided to the Plan Sponsor no later than the end of the first quarter of the contract period and anytime thereafter when a significant change is made to the process.

Every SLA must have a report provided that is deemed adequate by the Plan Sponsor to verify the SLA has been met; SLAs without a corresponding report will be deemed unmet and subject to the penalty. Samples of reports that must be used for SLA compliance are required in advance to be deemed adequate. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§ 2.190).

Within 45 Days after the end of each calendar quarter, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA for the Plan Sponsor, and provide payment for any applicable penalties to the Plan Sponsor. Any metric that is reported must be accompanied by supporting documentation. Annual SLA reports are due 90 days after the close of the plan year.

The following SLAs are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are for all Services provided under this Contract for the Plan Sponsor and are divided in two categories: Medicare and non-Medicare. Penalties will be assessed separately for Medicare and non-Medicare services and the Contractor must report on each separately. Separate penalties for the month in which performance was assessed. No individual SLA shall be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

SLA #1
Eligibility Uploads
Guarantee
One-hundred percent (100.00%) of all accurate records that pass Contractor's validation edits must be uploaded according to the Plan Sponsor's schedule within one Business Day of receipt (as defined in 1.022G). The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis. The SLA report must show weekly activity defined as the number of records uploaded, number of records not accepted, and the timeframe for presenting the discrepancy reports to the Plan Sponsor. Any records that do not pass the Contractor's validation test must be reported to the Plan Sponsor within two Business Days after the file has been uploaded in the format specified by ORS.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #2
ID Cards
Guarantee
ID Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. ID Cards must have an accuracy rate of 100.00%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis. Performance must be substantiated by documentation providing proof of receipt date and mailing date. Accuracy must be measured by sampling ID card product ion to ensure 100.00% accuracy of information.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #3
Customer Service Call –Speed of Answer
Guarantee

SLA #3
Contractor shall maintain an average speed of answer or 120 seconds. The ASA standard will be applied to the speed at which the initial call is answered by a CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #4
Telephone Servicing Factor
Guarantee
80.00% of calls must be in queue for service (left IVR) less than 30 seconds. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #5
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 5.00%. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #6
Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to 95.00% or more of written inquiries within 14 Days of receipt and 98.00% of all Member inquiries must be resolved within 28 Days and 100% of written inquiries must be resolved within 60 Days. Written inquiries will include those forwarded to the Contractor by the Plan Sponsor. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #7
Timeliness of Data Transmission to Plan Sponsor’s Data Vendor and Pharmacy Benefits Manager
Guarantee

SLA #7
Pursuant to § 1.042, Contractor must agree to deliver Claim data files to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager in agreed-upon format. Delivery of data files, with all required fields correctly populated, must be completed within 15 Days after the close of each month. If the 15th falls on Saturday or Sunday, the data file can be delivered on Monday without penalty.
Penalty
The penalty for failure to meet the SLA for monthly reports is $50,000 for each quarter that the SLA is not met, for either Plan Sponsor's Data Vendor or Pharmacy Benefits Manager.

SLA #8
Timely Production of Complete Management Reports
Guarantee
Contractor must provide complete monthly and quarterly reports within 45 Days of the end of the month and quarter, and annual reports within 90 days of Plan year end. The Contractor must measure and report its performance on this SLA on a quarterly or annual basis, depending on report.
Penalty
The penalty for failure to meet the SLA for monthly and quarterly reports is $50,000 for each quarter that the SLA is not met. The penalty for failure to meet the SLA for annual reports is$50,000.

SLA #9
Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00%. Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $45,000 per quarter not met.

SLA #10
Non-financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a non-financial error divided by the total number of claims in the sample) must not exceed 3.00% Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $45,000 per quarter not met

SLA #11
Claims Processing Time
Guarantee
95.00% of all claims must be processed within 30 calendar Days. 100.00% of all claims must be processed within 60 calendar Days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is $10,000 for each month that the SLA is not met.

SLA #12
Care Transition to Home 30-Day Readmissions
Guarantee
Contractor guarantees to achieve one of the following for the annual rate of all cause inpatient readmissions within 30 days for members enrolled in the Care Transition to Home Program, excluding planned readmissions, trauma and maternity: 1. remain at or below the established threshold; 2. achieve a 2% improvement from the previous year's rate if performance is more than 2% above (worse than) the target; or 3. improve performance back toward the established threshold if performance is less than 2% above the target. Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs. Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.
Penalty
The penalty for failure to meet this SLA is $120,000 per year the SLA is not met.

SLA #13
Disease Management Hospital Admissions
Guarantee

Contractor guarantees to achieve one of the following for the annual combined rate of acute hospital inpatient admissions per 1000 members enrolled in the Disease Management Program with CHF, COPD, CAD, Asthma, and Diabetes adjusted for the combined trend of the population without CHF, COPD, CAD, Asthma and Diabetes, excluding admissions for trauma and maternity:

1. remain at or below the established threshold;
2. achieve a 5% reduction from the previous year's rate if performance is more than 5% above (worse than) the target; or
3. improve performance back toward the established threshold if performance is less than 5% above (worse than) the target.

Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs.

Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.

Penalty

The penalty for failure to meet this SLA is $120,000 per year the SLA is not met.

SLA #14
Disease Management Emergency Room Visits
Guarantee
Contractor guarantees to achieve one of the following for the annual combined number of Emergency Room visits/1000 members enrolled in the Disease Management Program with CHF, COPD, CAD, Asthma, and Diabetes adjusted for the trend of the combined population with CHF, COPD, CAD, Asthma and Diabetes, excluding visits for trauma and maternity: 1. remain at or below the established threshold; 2. achieve a 2% improvement from the previous year's rate if performance is more than 2% above (worse than) the target; or 3. improve performance back toward the established threshold if performance is less than 2% above (worse than) the target. Contractor must report its performance on this SLA on an annual basis. The SLA will be considered "Met" if any one of the three aforementioned performance scenarios occurs. Measurement methodology and thresholds will be provided by contractor and must be mutually agreed upon prior to the conclusion of the first quarter of the contract year.
Penalty
The penalty for failure to meet this SLA is $120,000 per year the SLA is not met.

SLA #15

Clinical Quality Improvement

Guarantee

Contractor must measure and report performance on an annual basis on the following HEDIS measures following HEDIS methodology and reporting schedule.

- **DIABETES**: Comprehensive Diabetes Care (CDC) The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
    - Hemoglobin A1c (HbA1c) testing
    - HbA1c poor control (>9.0%)
    - HbA1c control (<8.0%)
    - Eye exam (retinal) performed
    - Medical attention for nephropathy
    - BP control (<140/90 mm Hg)
- **HEART FAILURE:** Controlling High Blood Pressure (CBP) The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:
    - Members 18–59 years of age whose BP was <140/90 mm Hg
    - Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
    - Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
- **ASTHMA:** Use of Appropriate Medications for People With Asthma (ASM) The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

BCBSM will calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and NCQA Quality Compass® National Average for the comparable population (i.e., Medicare PPO or Commercial PPO).

SLA is considered “Met” if performance for every reported measure is at or above national average OR demonstrates statistically significant improvement from the previous year’s rate if below the national average.

SLA is considered “Not Met” if performance for a reported measure does not meet the aforementioned criteria for “Met”.

Penalty

The penalty for failure to meet this SLA is $360,000 per year the SLA is not met.

Each specific metric in the SLA will be subject to an equal percentage of the total penalty for this SLA if not met. For example, if there were 4 applicable measures, each measure would be assessed 25% of the penalty if not met.

SLA #16

SLA #16
Quality Improvement Projects
Guarantee
By October 31st of each Plan Year, the Contractor must develop several process improvement projects based on Contractor's annual performance evaluations reviewed during the previous quarters' management meetings. The Contractor and the Plan Sponsor will mutually agree upon the number of process improvement projects The Plan Sponsor will be the final decider on the total number; however, the number will not exceed three (3).These quality improvement projects must be approved by Plan Sponsor by December 31st. Contractor must complete the process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is $200,000 if the Contractor does not develop and have approved projects for the next Plan Year. The Contract will pay $400,000 if the Contractor does not complete the approved projects.

SLA #17
Contractor Performance/Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1 to 5. The Contractor will be measured using the Plan Sponsor's annual survey to assess the Contractor's Performance within the following categories: 1. Senior Account Manager Performance 2. Communications 3. Data Reporting 4. Clinical Management 5. Customer Service 6. Administrative Support The Contractor's total Performance score will be determined by weighting equally the overall satisfaction scores of each of the six categories.
Penalty
The penalty for failure to meet this SLA is $200,000 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional$100,000 penalty.

SLA #18
Member Satisfaction Surveys
Guarantee
One random sample Member survey must be completed annually specific to the Plan Sponsor's population at no additional cost to the Plan Sponsor. The survey must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for prior approval of questions and scoring methodology prior to deployment. The respondent pool must be statistically valid based on the Plan Sponsor's total population. Survey results must be available to the Plan Sponsor by the end of Q3 within the Plan Year. There must be separate member satisfaction surveys for both Medicare and Non-Medicare populations. Results must be reported separately.
Penalty
The penalty for failure to meet this SLA is $200,000.

SLA #19
Financial Accuracy Rate
Guarantee
Financial Accuracy on claims processing (as defined as the sum of the absolute value of financial errors on claims processed divided by the total dollar value of claims paid) must not fall below 99.00%. Contractor must measure its performance on this SLA based on a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is $300,000 per year not met, plus $75,000 for each 0.5% below the standard.

HIPAA BUSINESS ASSOCIATE ADDENDUM

The parties to this Business Associate Addendum (Addendum) are the State of Michigan, acting by and through the Department of Technology Management and Budget, on behalf of the Office of Retirement Services (State) and Blue Cross Blue Shield of Michigan (Contractor). This Addendum supplements and is made a part of the existing contract(s) or agreement(s) between the parties including the following Contract(s): 071B0200075 and 071B4300037 (Contract).

For purposes of this Addendum, the State is (check one):

(X) Covered Entity (CE)

( ) Business Associate (Associate)

and the Contractor is (check one):

( ) Covered Entity (CE)

(X) Business Associate (Associate)

RECITALS

A. Under the terms of the Contract, CE wishes to disclose certain information to Associate, some of which may constitute Protected Health Information. In consideration of the receipt of such information, Associate agrees to protect the privacy and security of the information as set forth in this Addendum.

B. CE and Associate intend to protect the privacy and provide for the security of Protected Health Information disclosed to Associate pursuant to the Contract in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and regulations promulgated by the U.S. Department of Health and Human Services (HIPAA Rules) and other applicable laws, as amended.

C. The HIPAA Rules require CE to enter into an agreement containing specific requirements with Associate before CE may disclose Protected Health Information to Associate.

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum have the same meaning as those terms under HIPAA and the HIPAA Rules.

b. "Agent" has the same meaning given to the term under the federal common law of agency.

c. "Agreement" means the Contract and this Addendum, as read together.

d. "Breach" means the acquisition, access, Use or Disclosure of Protected Health Information in a manner not permitted under the Privacy Rule that compromises the security or privacy of such information, as defined in 45 CFR § 164.402.

e. "Contract" means the underlying written agreement or purchase order between the parties for the goods or services to which this Addendum is added. Contract also includes all amendments and addendums to the original contract, both effective before and effective after the date of this Addendum.

f. "Designated Record Set" has the same meaning as the term under 45 CFR §164.501.

g. "Disclosure" has the same meaning as the term under 45 CFR §160.103,.

h. "Electronic Protected Health Information" or "Electronic PHI" has the same meaning as the term under 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Associate on behalf of CE.

i. "HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

j. "HITECH Act" means The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, specifically Division A: Title XIII Subtitle D—Privacy, and its corresponding regulations as enacted under the authority of the Act.

k. "Individual" has the same meaning as the term under 45 CFR §160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR §165.502(g).

l. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

m. "Protected Health Information," "Protected Information," or "PHI" has the meaning given to the term under the Privacy Rule, 45 CFR §160.103.

n. "Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of Protected Health Information or interference with system operations in an information system.

o. "Security Rule" means the Standards for Security of Electronic Protected Health Information at 45 CFR parts §160 and §164, Subparts A and C.

p. "Subcontractor" means a person or entity that creates, receives, maintains, or transmits Protected Health Information on behalf of Associate and who is now considered a Business Associate, as the latter term is defined in 45 CFR §160.103.

q. "Unsecured Protected Health Information" or "Unsecured PHI" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by DHHS as defined in the Breach Rule, 45 CFR § 164.402.

r. "Use" has the same meaning as the term under 45 CFR §164.103.

2. Obligations and Activities of Associate.

a. Permitted Uses and Disclosures. Associate may Use and Disclose Protected Health Information only as necessary to perform services owed CE under the Contract and meet its obligations under this Addendum, provided that such Use or Disclosure would not violate Subpart E of 45 CFR 164. All other Uses or Disclosures by Associate not authorized by this Addendum, or by specific written instruction of CE, are prohibited. Except as otherwise limited by this Addendum, Associate may Use and Disclose Protected Health Information as follows:

i. Associate may Use Protected Health Information for the proper management and administration of the Associate or to carry out the legal responsibilities of the Associate.

ii. Associate may Disclose Protected Health Information for the proper management and administration of the Associate, provided that Disclosures are Required by Law; or Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used, or further Disclosed, only as Required by Law, or for the purpose for which it was Disclosed to the person, and the person notifies the Associate of any instances of which it is aware that the confidentiality of the information has been breached.

iii. Except as otherwise limited in this Agreement, Associate may Use Protected Health Information to provide Data Aggregation services to CE for the Health Care Operations of CE, as permitted by 45 CFR §164.504(e)(2)(i)(B). Associate agrees that said services shall not be provided in a manner that would result in Disclosure of Protected Health Information in a manner inconsistent with the HIPAA Rules. Further, Associate agrees that any such wrongful Disclosure of Protected Health Information may constitute a Breach and, after performing the required risk analysis under the HIPAA Rules, shall be reported to CE in accordance with this Addendum.

iv. Associate may Use Protected Health Information to report violations of law to appropriate federal and state authorities, consistent with 45 CFR §164.502(j)(1).

b. Appropriate Safeguards. Associate must implement and maintain appropriate administrative, physical, and technical safeguards, and comply with Subpart C of 45 CFR 164 regarding Electronic PHI, to prevent the Use or Disclosure of Protected Health Information other than as provided in this Addendum. These safeguards shall comport with HIPAA Rules and include at minimum:

i. Achieving and maintaining compliance with the HIPAA Security Rule, as necessary in conducting operations on behalf of CE under this Addendum.

ii. Maintaining a comprehensive written information privacy and security program that reasonably and appropriately protects the confidentiality, integrity, and availability of Protected Health Information.

c. Security Incidents. Associate must notify and report to CE in the manner described herein any Security Incident, whether actual or suspected, and any Use or Disclosure of Protected Information in violation of this Addendum of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR §164.410, and any Security Incident of which it becomes aware, and take the following actions:

i. Notice to CE. Associate must notify CE, via e-mail and telephone, within three (3) business days of the discovery of any Use or Disclosure of Protected Health Information in violation of this Addendum, or any Security Incident of which it becomes aware. Associate must follow its notification to CE with a report that meets the requirements outlined immediately below.

ii. Investigate; Report to CE. Associate must promptly investigate any Security Incident. Within ten (10) business days of the discovery, Associate must submit a preliminary report to CE identifying, to the extent known at the time, any information relevant to ascertaining the nature and scope of the Security Incident. Within fifteen (15) business days of the discovery of the Security Incident and unless otherwise directed by CE in writing, Associate must provide a complete report of the investigation to CE. Such report shall identify, to the extent possible: (a) each Individual whose Protected Health Information has been, or is reasonably believed by Associate to have been accessed, acquired, Used or Disclosed; (b) the type of Protected Health Information accessed, Used or Disclosed (e.g., name, social security number, date of birth) and whether such information was Unsecured; (c) who made the access, Use, or Disclosure; and (d) an assessment of all known factors relevant to a determination of whether a Breach occurred under applicable provisions of the HIPAA Rules or any other applicable federal or state regulations. If Associate determines that a Breach of Unsecured PHI did occur, the report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain any improper Use or Disclosure. If CE requests information in addition to that listed in the report, Associate shall make reasonable efforts to provide CE with such information. Associate agrees that CE reserves the right to review and recommend changes to any corrective action plan and make a final determination as to whether a Breach of PHI occurred and whether any notifications may be required under applicable state or federal regulations, including specifically 45 CFR §§164.404-408. In the event of a Breach of Unsecured PHI, as determined by CE, Associate agrees, consistent with 45 CFR §164.404(c) to provide CE with information and documentation in its control necessary to meet the requirements of said sections, and in a manner and format to be reasonably specified by CE.

iii. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a Security Incident or a Use or Disclosure of Protected Health Information in violation of the requirements of this Addendum. Associate must take: (a) prompt corrective action to cure any such violation and (b) any other action pertaining to such unauthorized Use or Disclosure required by applicable federal and state laws and regulations.

d. Responsibility for Notifications. If the cause of a Breach of Protected Health Information is attributable to Associate or its Agents or Subcontractors, Associate is responsible for all required reporting and notification(s) of the Breach, as specified in and in accordance with 45 CFR §§164.404-408. CE's authorized representative shall provide input on the time, manner, and content of any such notification. In the event of such Breach, and without limiting Associate's obligations of indemnification as further described in this Addendum, Associate must indemnify, defend, and hold harmless CE for any and all claims or losses, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from CE in connection with the occurrence.

e. Associate's Agents and Subcontractors. If Associate uses one or more Subcontractors or Agents to provide services under the Agreement, and such Agents or Subcontractors receive or have access to Protected Health Information, each Subcontractor or Agent must sign an agreement with Associate containing substantially the same provisions as this Addendum and in conformance with 45 CFR §164.504(e)(2), and to assume toward Associate all of the obligations and responsibilities that the Associate, by this Addendum, assumes toward CE. Associate agrees to provide said Agents or Subcontractors Protected Health Information in accordance with the HIPAA Rules and other applicablefederal and state law and must: (i) implement and maintain sanctions against Subcontractors and Agents that violate such restrictions and conditions; and (ii) mitigate, to the extent practicable, the effects of any such violation.

f. Access to Protected Health Information. Associate agrees to make Protected Health Information regarding an Individual maintained by Associate or its Agents or Subcontractors in a Designated Record Set available to CE or to such Individual for inspection and copying in order to meet CE's obligations under 45 CFR §164.524. Associate must permit such access within ten (10) days of a request. An Individual's request for access must be submitted on standard request forms available from Associate. If CE receives a request for access, CE, in addition to addressing the request on its behalf, will forward the request in writing to Associate in a timely manner. If Associate or its Agents or Subcontractors maintain Electronic Health Records for CE, then Associate must provide, where applicable, electronic access to the Electronic Health Records.

g. Amendment of Protected Health Information. Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set as directed by CE pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy CE's obligations under 45 CFR 164.526. If an Individual requests an amendment of Protected Health Information directly from Associate or its Agents or Subcontractors, Associate must notify CE in writing within ten (10) days of the request, and then, in that case, only CE may either grant or deny the request.

h. Accounting Rights. Associate agrees to maintain, and within ten (10) days of a request from CE or an Individual for an accounting of Disclosures of Protected Health Information, make

available the information in accordance with 45 CFR §164.528. An Individual's request for an accounting of disclosures must be submitted on standard request forms available from Associate. If CE receives a request for an accounting, CE, in addition to addressing the request on its own behalf, will forward the request in writing to Associate in a timely manner.

i. Access to Records and Internal Practices. Unless otherwise protected or prohibited from discovery or Disclosure by law, Associate must make its internal practices, books, and records, including policies and procedures (collectively "Compliance Information"), relating to the Use or Disclosure of PHI and the protection of same, available to the Secretary of DHHS (hereinafter, "Secretary") for purposes of the Secretary determining CE's compliance with the HIPAA Rules. Associate shall have a reasonable time within which to comply with requests for such access, consistent with this Addendum. In no case shall access be required in less than five (5) business days after Associate's receipt of such request, unless otherwise designated by the Secretary.

j. Minimum Necessary. Associate (and its Agents or Subcontractors) shall only request, Use and Disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, Use or Disclosure, in accordance with the Minimum Necessary requirements of the Privacy Rule, including, but not limited to 45 CFR §§ 164.502(b) and 164.514(d).

k. Compliance.

i. To the extent that Associate carries out one or more of CE's obligations under the HIPAA Rules, Associate must comply with all requirements that would be applicable to CE.

ii. CE shall consult with Associate before CE agrees to an Individual's request to restrict the Use or Disclosure of the Individual's PHI that may affect Associate. Associate will respond to all requests submitted directly by Individuals to restrict the use or disclosure of their PHI. CE will promptly notify Associate in writing of any request for restriction on the use or disclosure of PHI. Any restriction requests must be submitted on Associate's request forms.

l. Retention of Protected Health Information. Notwithstanding Section 5(d) of this Addendum, Associate and its Subcontractors or Agents shall retain all Protected Health Information throughout the term of the Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) years from the date of creation or the date when it last was in effect, whichever is later, or as Required by Law. This obligation shall survive the termination of the Contract.

m. Destruction of Protected Health Information. Associate must implement policies and procedures for the final disposition of Protected Health Information, including Electronic PHI, and/or the hardware and equipment on which it is stored, including but not limited to, removal before re-Use, in accordance with the Security Rule, and other applicable laws relating to the final disposition of PHI.

n. Audits, Inspection, and Enforcement. Within ten (10) days of a written request by CE, Associate and its Agents or Subcontractors must allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the Use or Disclosure

of Protected Health Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE or Associate shall execute a nondisclosure agreement, if requested by Associate or CE. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under this Addendum. If Associate is the subject of an audit, compliance review, or complaint investigation by DHHS that is related to the performance of its obligations pursuant to this Addendum, Associate must notify CE and provide CE with a copy of any Protected Health Information that Associate provides to DHHS concurrently with providing such information to DHHS. Associate is responsible for all civil penalties assessed due to an audit or investigation of Associate by DHHS.

o. Audit Findings. Associate must implement any appropriate Safeguards, as identified by CE in an audit conducted under paragraph 2(o).

p. Safeguards During Transmission. Associate must utilize safeguards that reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of Protected Health Information transmitted to CE pursuant to this Addendum, in accordance with the standards and requirements of the HIPAA Rules and other applicable federal or state regulations, until such Protected Health Information is received by CE, and in accordance with any specifications set forth in Attachment A.

q. Due Diligence. Associate must exercise due diligence and take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HIPAA Rules, and other applicable laws or regulations pertaining to PHI, and that its Agents, Subcontractors and vendors are in compliance with their obligations as required by this Addendum.

r. Sanctions and/or Penalties. Associate understands that a failure to comply with the provisions of HIPAA, the HIPAA Rules or any other state or federal regulation that is applicable to Associate may result in the imposition of sanctions and/or penalties on Associate under HIPPA, the HIPAA Rules, or any other applicable laws or regulations pertaining to PHI.

s. Loss of Data. In the event of a Breach of Protected Health Information, Associate must, at CE's sole discretion, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the Protected Health Information for the period required to comply with applicable law, or, in the absence of any legally required monitoring services, for no less than twenty-four (24) months following the date of notification to such individuals. Associate must also reimburse the State for the cost of any audit of Associate's handling and remediation of the Breach. This section shall survive termination of the Agreement.

3. Obligations of CE.

a. Safeguards During Transmission. CE must utilize safeguards that reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of Protected Health Information transmitted to Associate pursuant to this Addendum, in accordance with the standards and requirements of the HIPAA Rules and other applicable federal or state regulations, until such Protected Health Information is received by Associate, and in accordance with any specifications set forth in Attachment A.

b. Notice of Limitations and Changes. CE must notify Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR §164.520, or any restriction to the Use or Disclosure of PHI that CE has agreed to in accordance with 45 CFR §164.522, to the extent that such limitation may affect Associate's Use or Disclosure of PHI. CE must also notify Associate of any changes in, or revocation of, permission by Individual to Use or Disclose PHI of which it becomes aware, to the extent that such changes may affect Associate's Use or Disclosure of PHI.

4. Term. This Addendum shall continue in effect as to each Contract to which it applies until such Contract is terminated or is replaced with a new contract between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs. However, certain obligations will continue as specified in this Addendum.

5. Termination.

a. Material Breach. Except as otherwise provided in the Contract, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of the Agreement and provide grounds for CE to terminate the Agreement for cause, subject to section 5(b):

i. Default. If Associate refuses or fails to timely perform any of the provisions of this Addendum, CE may notify Associate in writing of the non-performance, and if not corrected within thirty (30) days, CE may immediately terminate the Agreement. Associate agrees to continue performance of the Agreement to the extent it is not terminated.

ii. Duties. Notwithstanding termination of the Agreement, and subject to any reasonable directions from the CE, Associate agrees to take timely, reasonable and necessary action to protect and preserve property in the possession of the Associate in which CE has an interest.

iii. Erroneous Termination for Default. If after such termination it is determined, for any reason, that Associate was not in default, or that Associate's action/inaction was excusable, such termination shall be treated as a termination for convenience, and the rights and obligations of the parties shall be the same as if the Contract had been terminated for convenience, as described in this Addendum or in the Contract.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the

provisions of this Addendum or another arrangement and does not terminate the Agreement pursuant to Section 5(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE's efforts to cure such breach or end such violation are unsuccessful, CE may terminate the Agreement.

c. Reserved.

d. Effect of Termination.

i. At the direction of CE, and except as provided in section 5(d)(ii), upon termination of the Agreement for any reason, Associate must return or destroy all Protected Health Information that Associate or its Agents or Subcontractors still maintain in any form, and shall retain no copies of such information. If CE directs Associate to destroy the Protected Information, Associate must certify in writing to CE that such information has been destroyed. If CE directs associate to return such information, Associate must do so promptly in any format reasonably specified by CE.

ii. If Associate believes that returning or destroying the Protected Information is not feasible, including but not limited to, a finding that record retention requirements provided by law make return or destruction infeasible, Associate must promptly provide CE written notice of the conditions making return or destruction infeasible. Upon mutual agreement of CE and Associate that return or destruction of Protected Information is infeasible, Associate must continue to extend the protections of this Addendum to such information, and must limit further Use of such Protected Health Information to those purposes that make the return or destruction of such Protected Health Information infeasible.

6. Reserved.

7. No Waiver of Immunity. No term or condition of this Addendum shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of applicable laws, including the Michigan Governmental Immunity Act, MCL 691.1401, *et seq.*, the Court of Claims Act, MCL 600.6401, *et seq.*, the Federal Tort Claims Act, 28 U.S.C. 2671, *et seq.*, or the common law, as applicable, as now in effect or hereafter amended.

8. Reserved.

9. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Addendum, HIPAA, the HIPAA Rules, or other applicable laws pertaining to Protected Health Information will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of Protected Health Information.

10. Reserved.

11. Amendment.

a. Amendment to Comply with Law. The parties agree to take such action as is necessary to amend this Addendum from time to time as may be necessary for CE and Associate to comply with and implement the standards and requirements of HIPAA, the HIPAA Rules, and other applicable laws relating to the security or privacy of PHI. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Rulesor other applicable laws. Either party may terminate the Agreement upon thirty (30) days written notice if (i) the other does not promptly enter into negotiations to amend this Agreement when requested by the requesting party under this Section or (ii) the non-requesting party does not enter into an amendment to this Agreement when requested providing assurances regarding the safeguarding of PHI that the requesting party, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA Rules, and other applicable laws.

b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

12. Assistance in Litigation or Administrative Proceedings. Associate must make itself, and any Subcontractors, employees or Agents assisting it in the performance of its obligations under this Addendum available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against a party, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA, the HIPAA Rules, or other laws relating to security and privacy of Protected Health Information, except where the other party or its Subcontractor, employee or Agent is a named adverse party.

13. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Effect on Contract. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Contract shall remain in force and effect. This Addendum is incorporated into the Contract as if set forth in full therein. The parties expressly acknowledge and agree that sufficient mutual consideration exists to make this Addendum legally binding in accordance with its terms. Associate and CE expressly waives any claim or defense that this Addendum is not part of the Agreement between the parties under the Contract.

15. Interpretation and Order of Precedence. This Addendum is incorporated into and becomes part of each Contract identified herein. Together, this Addendum and each separate Contract constitute the Agreement of the parties with respect to their Business Associate relationship under HIPAA and the HIPAA Rules. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Rules, and applicable state laws. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Rules, and applicable state laws. This Addendum supercedes and replaces any previous separately executed HIPAA addendum between the parties. In the event of any conflict between the mandatory provisions

of the HIPAA Rules and the provisions of this Addendum, the HIPAA Rules shall control. Where the provisions of this Addendum differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Addendum shall control.

16. Effective Date. This Addendum is effective upon receipt of the last approval necessary and the affixing of the last signature required.

17. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate's obligations under Section 5(d) (Effect of Termination) and record retention laws and Section 13 (No Third Party Beneficiaries) shall survive termination of this Agreement and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate.

18. Representatives and Notice.

a. Representatives. For the purpose of this Addendum, the individuals identified in the Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby designated as the parties' respective representatives for purposes of this Addendum. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. Except as otherwise provided in this Addendum, all required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

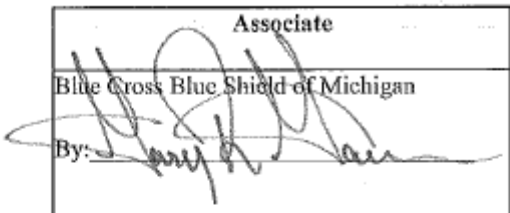
Name: _____
Title: _____
Department and Division: _____
Address: _____
_____
_____

Business Associate Representative:

Name: _____
Title: _____
Department and Division: _____
Address: _____
_____
_____

Any notice given to a party under this Addendum shall be deemed effective, if addressed to such party, upon: (i) delivery, if hand delivered; or (ii) the third (3rd) business day after being sent by certified or registered mail.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the January 1, 2015 Effective Date.

Associate	Covered Entity
Blue Cross Blue Shield of Michigan By: 	State of Michigan By:_____
Print Name: Gary B. Gauss	Print Name:_____
Title: VP, Key Hedge Group Business	Title:_____

ATTACHMENT A

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum dated _____, between _____ and _____ (Addendum) and is effective as of _____ (the Attachment Effective Date). This Attachment applies to the specific contracts listed below covered by the Addendum. This Attachment may be amended from time to time as provided in Section 11(b) of the Addendum.

1. Specific Contract Covered. This Attachment applies to the following specific contract covered by the Addendum: _____

2. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may Use Protected Health Information as follows:

_____

_____

_____

3. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may Disclose Protected Health Information as follows:

_____

_____

_____

4. Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Health Information in the course of assisting Associate in the performance of its obligations under the Contract and the Addendum:

_____

_____

_____

5. Receipt. Associate's receipt of Protected Health Information pursuant to the Contract and Addendum shall be deemed to occur as follows, and Associate's obligations under the Addendum shall commence with respect to such Protected Health Information upon such receipt:

_____

_____

_____

6. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the Use and Disclosure of Protected Health Information:

_____

_____

_____

7. Additional Terms. *[This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security of privacy specifications, de-identification or re-identification of data and other additional terms.]*

Associate	**Covered Entity**
[INSERT NAME] By:_____	[INSERT NAME] By:_____
Print Name: _____	Print Name: _____
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. 8

to

CONTRACT NO. 071B0200075

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(517) 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
MPSERS Master Health Care Plan Administration			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 2 yr. options	December 31, 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	☒	☐	2 Years	December 31, 2016
VALUE/COST OF CHANGE NOTICE:		ESTIMATED REVISED AGGREGATE CONTRACT VALUE:		
$1,186,000,000.00		$4,341,151,000.00		

Effective January 1, 2015, this Contract is exercising the second two option years and is increased by $1,186,000,000.00. The revised Contract expiration date is December 31, 2016.

Contract changes per the attached Addendum are hereby incorporated into this Contract.

All other terms, conditions, specifications and pricing remain the same. Per vendor and agency agreement, DTMB Procurement approval, and State Administrative Board approval on October 28, 2014.

This Addendum No 8 to DTMB Contract No. 071B0200075 ("the Contract") is effective on January 1, 2015 and is made between Blue Cross Blue Shield of Michigan ("CONTRACTOR") with offices at 600 Lafayette East, Detroit, Michigan 48226-2998 and Michigan Public School Employee Retirement System ("MPSERS") with offices at 7150 Harris Drive, Dimondale, MI 48821. Per Section 2.002 of the Contract, the parties hereby agree to exercise the second 2-year option term in the Contract and the extended term is now January 1, 2015 through December 31, 2016.

Recitals

Whereas, CONTRACTOR is a non-profit mutual insurance company organized under the laws of the State of Michigan;

Whereas, CONTRACTOR has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer group Medicare Advantage ("MA") plans;

Whereas, the Michigan Public School Employees Retirement System ("Plan Sponsor") is the plan sponsor and Blue Cross Blue Shield of Michigan is the plan administrator of the Plan Sponsor's commercial and Medicare Advantage health plans;

Whereas, the parties desire to continue the Plan Sponsor's self-funded arrangement for both Medicare Advantage and Non-Medicare Advantage health care coverage and enter into a performance based arrangement;

WHEREAS, the Parties wish to modify and supplement the provisions of the Contract;

NOW, THEREFORE, in consideration of the mutual promises set forth below, the Parties hereto agree as follows:

1. The Plan Sponsor agrees to pay the Contractor according to Schedule A.

2. "Costs" are defined as the sum of the administrative fee set forth in Schedule A plus Benefit Expenses for incurred claims minus revenue received from CMS, with all amounts determined as of September of the year following the applicable year, excluding any Risk-Adjusted Data Valuation (RADV) audit amount.

3. "Benefit Expense" means fee-for-service payments, capitations, quality bonuses and incentives, patient centered medical home payments for care coordination, risk sharing and hospital settlements, payments to BCBSM third party vendors that provide clinical services directly to members, and payments that provide a direct operational benefit to facilities for rendering medical and related services to members.

4. The Contractor and the Plan Sponsor agree to a performance incentive model, where the Plan Sponsor's liability for Costs will be capped, except as set forth below, at:

a. $112.84 Per Member Per Month, effective January 1, 2015 through December 31, 2015
b. $116.22 Per Member Per Month, effective January 1, 2016 through December 31, 2016

The Contractor will be liable for Costs above the annual cap up to the Contractor's total respective annual administrative fee as set forth in Schedule A. Thereafter, any additional Costs will be paid by the Plan Sponsor.

5. The first $100 million of savings resulting from Costs below the cap in Section 4 will be shared equally between the Plan Sponsor and the Contractor (50%/50%). The Plan Sponsor will retain 100% of savings in excess of $100 million.

6. Any CMS overpayments identified in a CMS RADV audit of the 2015 and 2016 plan years will be shared equally between the Plan Sponsor and the Contractor (50%/50%).

7. The Contractor and Plan Sponsor agree to mutually determine an actuarial adjustment to Section 4 if there is a material change in benefit plan design or the Plan Sponsor's MA membership covered by BCBSM.

8. The Contractor and the Plan Sponsor agree to renegotiate Section 4 if there is a change that would shift costs from the Medical Plan contractor to the Pharmacy Benefit Manager contractor, the Dental Plan contractor, and/or the Vision Plan contractor.

9. The Contractor agrees to process claims so that the coinsurance is taken before the deductible for the Medicare plan and the Non-Medicare plan. If the Contractor cannot comply with this requirement, the Contractor agrees to reimburse the Plan Sponsor the resulting financial impact.

Schedule A – Effective January 1, 2015 through December 31, 2016

Per Month Administration Fee- 2015 and 2016

Non- Medicare PPO	**Per Contract per Month**	**Dependent Unit Fee per Month**
Administrative Fee	2015-$28.85 2016-$29.72	2015-$41.20 2016-42.44
Optional – Disease Management	2015-$1.72 2016-$1.77	N/A
Optional – Nurse Line	2015-$0.13 2016-$0.13	N/A
Optional – Wellness Program	2015-$0.91 2016-$0.94	N/A
Optional – Quit the Nic	2015-$0.07 2016-$0.07	N/A
Total	2015-$31.68 2016-$32.63	2015-$41.20 2016-$42.44

Per Month Administration Fee- 2015 and 2016

Medicare Advantage	**Per Member Per Month**
Administrative Fee	$60.50
Optional – Disease Management	Included in Basic
Optional – Nurse Line	Included in Basic
Optional – Wellness Programs	Included in Basic
Total	$60.50

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. 7

to

CONTRACT NO. 071B0200075

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(517) 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:			
MPSERS Master Health Care Plan Administration			
INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 2 yr. options	December 31, 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	☐	☐	N/A	December 31, 2014
VALUE/COST OF CHANGE NOTICE:			ESTIMATED REVISED AGGREGATE CONTRACT VALUE:	
$0.00			$3,155,151,000.00	

Contract changes per the ADDENDUM attached must be implemented. All other terms, conditions, specifications and pricing remain unchanged. Per vendor and agency agreement and DTMB Procurement approval.

SLA #10
Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00%. Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per quarter not met, of the total quarterly Administrative Fee paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #11
Non-financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a non-financial error divided by the total number of claims in the sample) must not exceed 3.00% Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per quarter not met, of the total quarterly Administrative Fee paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #12
Claims Processing Time
Guarantee
95.00% of all Claims must be processed within 10 Calendar Days. 100.00% of all Claims must be processed within 15 Calendar Days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.50% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

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 18, 2013

CHANGE NOTICE NO. 6
to
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(517) 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

MPSERS Master Health Care Plan Administration

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 2 yr. options	December 31, 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	☒	☐	One Year	December 31, 2014

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$594,000,000.00	$3,155,151,000.00

Effective immediately, the second option year is being utilized to December 31, 2014 and is increased by $594,000,000.00. Contract changes per the ADDENDUM attached must be implemented.

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

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

This addendum to DTMB Contract No. 071B0200075 ("the Contract") is effective on January 1, 2014 and is made between Blue Cross Blue Shield of Michigan ("CONTRACTOR") with offices at 600 Lafayette East, Detroit, Michigan 48226-2998 and Michigan Public School Employee Retirement System ("MPSERS") with offices at 7150 Harris Drive, Dimondale, MI 48821

Recitals

Whereas, CONTRACTOR is a non-profit health care corporation organized under the laws of the State of Michigan;

Whereas, CONTRACTOR has contracted with CMS to offer group Medicare Advantage ("MA") plans;

Whereas, the Michigan Public School Employees Retirement System ("Plan Sponsor") is the plan sponsor and Blue Cross Blue Shield of Michigan is the plan administrator of the Plan Sponsor's commercial and Medicare Advantage health plans;

WHEREAS, the Parties wish to modify and supplement the provisions of the Contract;

NOW, THEREFORE, in consideration of the mutual promises set forth below, the Parties hereto agree as follows:

1. The Plan Sponsor agrees to pay the Contractor according to Schedule A.

2. The Contractor agrees to reimburse the Plan Sponsor for the financial impact of having to reimburse all providers as in-network for Medicare DME benefits for the 2013 plan year.

3. Plan design modifications that reduce member access to providers and/or increase costs to the Plan Sponsor or members are not to be made without the Plan Sponsor's approval.

4. With regard to DME/P&O/Medical Supplies, when members who were using DMEnsion national network providers in 2012 and the providers became a non-network with the Contractor's network change effective Jan. 1, 2013, the Contractor must pay the Plan Sponsor the difference between the DMEnsion national network reimbursement fee and the non-network reimbursement fee for claims processed in 2013 and must waive the member out-of-network cost share on these claims processed in 2013. The Contractor agrees to process claims so that the coinsurance is taken before the deductible for the Medicare plan and the Non-Medicare plan. If the Contractor cannot comply with this requirement by January 1, 2014, the Contractor agrees to reimburse the Plan Sponsor the resulting financial impact.

5. The Contractor will provide the Plan Sponsor with all eligibility information about the Plan Sponsor's members received from affiliate sources such that the Plan Sponsor remains the enrollment system of record.

6. Section 1.022(M) of the Contract is hereby deleted in its entirety and is replaced with Schedule B.

7. Section 1.031(A)(2) is modify to the following language:

   Other Key Staff: These contracted positions are also considered Key Personnel for purposes of this Contract, are expected to be onsite to the Plan Sponsor, and must work toward achieving the goals of the Plan Sponsor for the Plan and its members. Plan Sponsor must be involved in the selection of those occupying these contracted positions and any matters related to ensuring retention:

   1) Two Administrators with strong communication skills and the understanding of Contract and vendor management, eligibility issue management, and complex benefit administration for Medicare and non-Medicare plans. They must have the ability to analyze complex administrative issues to problem resolution. Must have experience with purchaser health plan administration, preferably in a retiree population. Bachelor's degree required; master's preferred.

2) One Data Analyst with strong communication skills and sophisticated modeling techniques including proficiency with Access, pivot tables, and SQL queries for both administrative and claims data. Must have ability to analyze complex data reports and offer solutions to issues. Bachelor's degree required.

3) One Administrative Assistant with superior customer service and administrative skills, including scheduling meetings, responding to correspondence and creating power point presentations. Bachelor's degree preferred.

The budget for these positions expected to provide sufficient funds to ensure retention of qualified staff members, for example including consideration for an annual merit-based increase. If any of these positions are vacant at any point in the year, Contractor will report to the Plan Sponsor by January 31 of the following year the budgeted amount and the actual amount spent for these positions. If there is a difference, the amount of budget not spent for each plan year will be returned to the Plan Sponsor within 60 days.

8. The language in Attachment A is added to this Contract.

Schedule A – Effective January 1, 2014 through December 31, 2014

Per Month Administration Fee- 2014

Non-Medicare PPO	Per Contract	Dependent Unit Fee
Basic Services	$28.00	$40.00
Optional – Disease Management	$1.72	N/A
Optional – Nurse Line	$.13	N/A
Opitonal – Wellness Programs	$.91	N/A
Optional – Quit the Nic	$.07	N/A
Total	$30.83	$40.00

Per Month Administration Fee- 2014

Medicare Advantage	Per Member
Basic Services Fee	$60.50
Optional – Disease Management	Included in Basic
Optional- Nurse Line	Included in Basic
Optional – Wellness Programs	Included in Basic
Total	$60.50

Schedule B – Performance Guarantees/Service Level Agreements (SLAs)

The following replaces section 1.022 (M) in its entirety:

M. Service Level Agreements (SLAs) – Medicare

Requirements:

Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. Every SLA must have a report provided that is deemed adequate by the Plan Sponsor to verify the SLA has been met; SLAs without a corresponding report will be deemed unmet and subject to the penalty. Samples of reports that will be used for SLA compliance are required in advance to be deemed adequate. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§ 2.190).

Within 45 Days after the end of each calendar quarter, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA for the Plan Sponsor, and provide payment for any applicable penalties to the Plan Sponsor. Any metric that is reported must be accompanied by supporting documentation. Annual SLA reports are due 90 days after the close of the plan year.

The following SLAs are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are for all Services provided under this Contract for the Plan Sponsor and are divided in two categories: Medicare and non-Medicare. Penalties will be assessed separately for Medicare and non-Medicare services and the Contractor must report on each separately. Separate penalties will be assessed as a percentage of applicable monthly, quarterly, or annual Administration Fees as paid by the Plan Sponsor to the Contractor for the month in which performance was assessed.

SLA #1
Eligibility Uploads
Guarantee
One-hundred percent (100.00%) of all accurate records that pass Contractor's validation edits must be uploaded according to the Plan Sponsor's schedule within one Business Day of receipt (as defined in 1.022G). The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis. The SLA report must show weekly activity defined as the number of records uploaded, number of records not accepted, and the timeframe for presenting the discrepancy reports to the Plan Sponsor. Any records that do not pass the contractor's validation test must be reported to the Plan Sponsor within two Business Days after the file has been uploaded in the format specified by ORS.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total month's Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #2
ID Cards
Guarantee
ID Cards for all new Contract Holders must be mailed within 10 Days of Contractor receiving eligibility record. ID Cards must have an accuracy rate of 100.00%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis. Performance must be substantiated by documentation providing proof of receipt date and mailing date. Accuracy must be measured by sampling ID card product ion to ensure 100.00% accuracy of information.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #3
Customer Service Call – Average Speed of Answer
Guarantee
On a monthly basis, 100.00% of all calls must be answered within an average of 30 seconds or less. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administration Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #4
Telephone Servicing Factor
Guarantee
85.00% of calls must be in queue (left IVR) for service less than 30 seconds. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administration Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #5
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 3.00%. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #6
Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to 95.00% or more of written inquiries within 14 Days of receipt and 98.00% of all Member inquiries must be resolved within 28 Days and 100.00% of written inquiries must be resolved within 60 Days. Written inquiries will include those forwarded to the Contractor by the Plan Sponsor. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #7
Appeals Reporting Requirements
Guarantee
The Contractor must administer the Appeals Policies that are compliant with the CMS requirements. Reporting will include the timeframe of Appeal processing (30 Days for pre-service; 60 Days for post-service). Reporting for appeals to include Member count, nature of Appeal, timeliness of handling, and outcome (Member resolution). Second level Appeals and beyond, pursuant to CMS requirements, are to be included and reported as defined above. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #8
Timeliness of Data Transmission to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager
Guarantee
Pursuant to Section 1.042, Contractor must agree to deliver Claim data files to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager in agreed-upon format. Delivery of data files, with all required fields correctly populated, must be completed within 15 Days after the close of each month.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.00% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met, for either the Plan Sponsor's Data Vendor or Pharmacy Benefits Manager.

SLA #9
Timely Production of Complete Management Reports
Guarantee
Contractor must provide complete monthly and quarterly reports within 45 Days of the end of the month and quarter, and annual reports within 90 days of Plan year end. The Contractor must measure and report its performance on this SLA on a quarterly or annual basis, depending on report.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.00% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met. The penalty for failure to meet the SLA for annual reports is 2.00% of the total annual Administrative Fee paid to the Contractor by Plan Sponsor.

SLA #10
Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00%. Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #11
Non-financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00% Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #12
Claims Processing Time
Guarantee
95.00% of all Claims must be processed within 10 Business Days. 100.00% of all Claims must be processed within 15 Days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.50% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #13
Case Management
Guarantee
Contractor must review 100.00% of all cases referred for Case Management and either accept or reject each case within five Business Days of receipt. Case Management activity should reflect reaching out to high cost claimants. Contractor must measure its performance on this SLA on a quarterly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 2.00%, per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #14
Case Management-Care Plans
Guarantee
Contractor must provide all Case Management cases a documented care plan within 15 Business Days of acceptance of the case to the program. Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 2.00%, per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #15
Disease Management-Outreach
Guarantee
Contractor must be in contact via telephone or mail with 100.00% of all Members deemed eligible for a Disease Management program. Contact is defined by a minimum number of four attempts by telephone or by mail. Contractor to define prior to each Plan Year of the Contract the eligible population and the conditions covered. Contractor must measure its performance on this SLA on a quarterly basis and report it on quarterly basis.
Penalty.
The penalty for failure to meet this SLA is 0.50% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #16
Disease Management—Member Satisfaction
Guarantee
Prior to the commencement of each Plan Year, Plan Sponsor and Contractor must agree on the satisfaction survey instrument and scoring methodology of the survey to be sent to eligible Members participating in the Disease Management programs. Contractor must achieve a minimum of a 90.00% rating of “satisfied”. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor.

SLA #17
Disease Management- Return on Investment
Guarantee
Savings resultant from the Disease Management programs(s) must be commensurate with the annual fees for the programs(s) and must be quantifiable, using prior claims experience and the year-over-year cost increase levels of the non-enrolled population. Contractor and Plan Sponsor must agree to the methodology and a formula to gauge this SLA and Contractor is requested to propose such a formula for Plan Sponsor review and approval. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor.

SLA #18
Clinical Quality Improvement
Guarantee
As approved by Plan Sponsor and Contractor in the annual work plan, Plan Sponsor and Contractor must agree to a series of process and utilization measures for each Disease Management program selected by the Plan Sponsor no later than January 31st of the current contract year. Initial year baselines will be established using the experience of the Plan year prior by no later than 1Q of the new plan year. Subsequent performance baselines will be established each year and will be based on the previous year's statistics. Levels of improvement standards will be mutually agreed upon by Plan Sponsor and Contractor. Contractor must measure and report its performance on this SLA on an annual basis. Failure to establish baselines based on prior year's performance by 1Q of the current plan year will be considered a not met.
Penalty
The penalty for failure to meet this SLA is 1.00% of Contractor's annual Administration Fee for each measure where either improvement was not obtained or high performance maintained.

SLA #19
Quality Improvement Projects
Guarantee
By October 31st of each Plan Year, the Contractor must develop three process improvement projects based on Contractor's quarterly performance evaluations reviewed during the previous quarters' management meetings. These process improvement projects must be approved by Plan Sponsor by December 31st. Contractor will complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is 1.00% of the Contractor's annual Administration Fee for each project that has not been developed and approved for the next Plan Year and 2.00% of the Contractor's annual Administration Fee for each project not completed for the current Plan Year.

SLA #20
Contractor Performance/Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1 to 5. The Contractor must use the Plan Sponsor's annual survey to assess the Contractor's Performance within the following categories: 1. Senior Account Manager Performance 2. Communications 3. Data Reporting 4. Clinical Management 5. Customer Service 6. Administrative Support The Contractor's total Performance score will be determined by weighting equally the overall satisfaction scores of each of the six categories.
Penalty
The penalty for failure to meet this SLA is 2.00% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor. An overall score less than 4.00 will result in the assessment of 2.00% of Contractor's annual Administration Fee. Failure to score at least 3.50 will result in an additional 1.00% penalty of Contractor's annual Administration Fee.

SLA #21
Member Satisfaction Surveys
Guarantee
One random sample Member survey must be completed annually specific to the Plan Sponsor's population at no additional cost to the Plan Sponsor. The survey must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for prior approval of questions and scoring methodology prior to deployment. The respondent pool must be statistically valid based on the Plan Sponsor's total population. Survey results must be available to the Plan Sponsor by Q3 within the Plan Year. There must be separate member satisfaction surveys for both Medicare and Non-Medicare populations. Results must be reported separately.
Penalty
The penalty for failure to meet this SLA is 2.00% of the total Contractor's annual Administration Fees paid to the Contractor by the Plan Sponsor.

Schedule B – Performance Guarantees/Service Level Agreements (SLAs)

The following replaces section 1.022 (M) in its entirety:

M. Service Level Agreements (SLAs) – Non-Medicare

Requirements:

Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. Every SLA must have a report provided that is deemed adequate by the Plan Sponsor to verify the SLA has been met; SLAs without a corresponding report will be deemed unmet and subject to the penalty. Samples of reports that must be used for SLA compliance are required in advance to be deemed adequate. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by State employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§ 2.190).

Within 45 Days after the end of each calendar quarter, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA for the Plan Sponsor, and provide payment for any applicable penalties to the Plan Sponsor. Any metric that is reported must be accompanied by supporting documentation. Annual SLA reports are due 90 days after the close of the plan year.

The following SLAs are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are for all Services provided under this Contract for the Plan Sponsor and are divided in two categories: Medicare and non-Medicare. Penalties will be assessed separately for Medicare and non-Medicare services and the Contractor must report on each separately. Separate penalties will be assessed as a percentage of applicable monthly, quarterly, or annual Administration Fees as paid by the Plan Sponsor to the Contractor for the month in which performance was assessed.

SLA #1
Eligibility Uploads
Guarantee
One-hundred percent (100.00%) of all accurate records that pass Contractor's validation edits must be uploaded according to the Plan Sponsor's schedule within one Business Day of receipt (as defined in 1.022G). The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis. The SLA report must show weekly activity defined as the number of records uploaded, number of records not accepted, and the timeframe for presenting the discrepancy reports to the Plan Sponsor. Any records that do not pass the Contractor's validation test must be reported to the Plan Sponsor within two Business Days after the file has been uploaded in the format specified by ORS.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total month's Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #2
ID Cards
Guarantee
ID Cards for all new Contract Holders must be mailed within 10 Days of Contractor receiving eligibility record. ID Cards must have an accuracy rate of 100.00%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis. Performance must be substantiated by documentation providing proof of receipt date and mailing date. Accuracy must be measured by sampling ID card product ion to ensure 100.00% accuracy of information.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #3
Customer Service Call – Average Speed of Answer
Guarantee
On a monthly basis 100.00% of all calls must be answered within an average of 30 seconds or less. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administration Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #4
Telephone Servicing Factor
Guarantee
85.00% of calls must be in queue for service (left IVR) less than 30 seconds. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #5
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 3.00%. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #6
Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to 95.00% or more of written inquiries within 14 Days of receipt and 98.00% of all Member inquiries must be resolved within 28 Days and 100% of written inquiries must be resolved within 60 Days. Written inquiries will include those forwarded to the Contractor by the Plan Sponsor. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #7
Appeals Reporting Requirements
Guarantee
The Contractor must administer the Appeal Policies that are compliant with Plan Sponsor's requirements. Reporting will include the timeframe of Appeal processing (30 Days for pre-service; 60 Days for post-service). Reporting of Appeals must include Member count, nature of Appeal, and timeliness of handling, and outcome (Member resolution). The second level of an Appeal, conducted internal at the Contractor, must be a separate report and include all of the components listed above. The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #8
Timeliness of Data Transmission to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager
Guarantee
Pursuant to § 1.042, Contractor must agree to deliver Claim data files to Plan Sponsor's Data Vendor and Pharmacy Benefits Manager in agreed-upon format. Delivery of data files, with all required fields correctly populated, must be completed within 15 Days after the close of each month.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.00% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met, for either Plan Sponsor's Data Vendor or Pharmacy Benefits Manager.

SLA #9
Timely Production of Complete Management Reports
Guarantee
Contractor must provide complete monthly and quarterly reports within 45 Days of the end of the month and quarter, and annual reports within 90 days of Plan year end. The Contractor must measure and report its performance on this SLA on a quarterly or annual basis, depending on report.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.00% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met. The penalty for failure to meet the SLA for annual reports is 2.00% of the total annual Administrative Fee paid to the Contractor by Plan Sponsor.

SLA #10
Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00%. Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #11
Non-financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis with a randomly generated claim sample size sufficient to produce a 95% confidence interval with a margin of error of not greater than +/-3%. The resultant error rate (as defined as the number of claims in the sample containing a financial error divided by the total number of claims in the sample) must not exceed 3.00% Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.00% per month not met, of the total monthly Administrative Fee paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #12
Claims Processing Time
Guarantee
95.00% of all claims must be processed within 10 Business Days. 100.00% of all claims must be processed within 15 Business Days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.50% per month not met, of the total monthly Administrative Fees paid to the Contractor by the Plan Sponsor for each month that the SLA is not met.

SLA #13
Case Management
Guarantee
Contractor must review 100.00% of all cases referred for Case Management and either accept or reject each case within five Business Days of receipt. Case Management activity should reflect reaching out to high cost claimants. Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 2.00%, per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #14
Case Management-Care Plans
Guarantee
Contractor must provide all Case Management cases a documented care plan within 15 Business Days of acceptance of the case to the program. Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 2.00%, per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #15
Disease Management-Outreach
Guarantee
Contractor must be in contact via telephone or mail with 100.00% of all Members deemed eligible for a Disease Management program. Contact is defined by a minimum number of 4 attempts by telephone and/or mail. Contractor to define prior to each Plan Year of the Contract the eligible population and the conditions covered. These must be agreed to by Plan Sponsor. Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 0.50% per quarter not met, of the total quarterly Administrative Fees paid to the Contractor by the Plan Sponsor for each quarter that the SLA is not met.

SLA #16
Disease Management—Member Satisfaction
Guarantee
Prior to the commencement of each Plan Year, Plan Sponsor and Contractor must agree on the satisfaction survey instrument and scoring methodology of the survey to be sent to eligible Members participating in the Disease Management programs. Contractor must achieve a minimum of a 90.00% rating of "satisfied". Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor.

SLA #17
Disease Management- Return on Investment
Guarantee
Savings resultant from the Disease Management programs(s) must be commensurate with the annual fees for the programs(s) and must be quantifiable, using prior claims experience and the year-over-year cost increase levels of the non-enrolled population. Contractor and Plan Sponsor must agree to the methodology and a formula to gauge this SLA and Contractor is requested to propose such a formula for Plan Sponsor review and approval. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor.

SLA # 18
Clinical Quality Improvement
Guarantee
As approved by Plan Sponsor and Contractor in the annual work plan, Plan Sponsor and Contractor must agree to a series of process and utilization measures for each Disease Management program selected by the Plan Sponsor no later than January 31st of the current contract year. Initial year baselines will be established using the experience of the Plan year prior by no later than 1Q of the new plan year. Subsequent performance baselines must be established each year and must be based on the previous year's statistics. Levels of improvement standards must be mutually agreed upon by Plan Sponsor and Contractor. Contractor must measure and report its performance on this SLA on an annual basis. Failure to establish baselines based on prior year's performance by 1Q of the current plan year will be considered a not met.
Penalty
The penalty for failure to meet this SLA is 1.00% of Contractor's annual Administration Fee for each measure where either improvement was not obtained or high performance maintained.

SLA #19
Quality Improvement Projects
Guarantee
By October 31st of each Plan Year, the Contractor must develop three process improvement projects based on Contractor's quarterly performance evaluations reviewed during the previous quarters' management meetings. These quality improvement projects must be approved by Plan Sponsor by December 31st. Contractor must complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is 1.00% of the Contractor's annual Administration Fee for each project that has not been developed and approved for the next Plan Year and 2.00% of the Contractor's annual Administration Fee for each project not completed for the current Plan Year.

SLA #20
Contractor Performance/Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1 to 5. The Contractor must use the Plan Sponsor's annual survey to assess the Contractor's Performance within the following categories: 1. Senior Account Manager Performance 2. Communications 3. Data Reporting 4. Clinical Management 5. Customer Service 6. Administrative Support The Contractor's total Performance score will be determined by weighting equally the overall satisfaction scores of each of the six categories.
Penalty
The penalty for failure to meet this SLA is 2.00% of the total annual Administrative Fees paid to the Contractor by the Plan Sponsor. An overall score less than 4.00 will result in the assessment of 2.00% of Contractor's annual Administration Fee. Failure to score at least 3.50 will result in an additional 1.00% penalty of Contractor's annual Administration Fee.

SLA #21
Member Satisfaction Surveys
Guarantee
One random sample Member survey must be completed annually specific to the Plan Sponsor's population at no additional cost to the Plan Sponsor. The survey must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for prior approval of questions and scoring methodology prior to deployment. The respondent pool must be statistically valid based on the Plan Sponsor's total population. Survey results must be available to the Plan Sponsor by Q3 within the Plan Year. There must be separate member satisfaction surveys for both Medicare and Non-Medicare populations. Results must be reported separately.
Penalty
The penalty for failure to meet this SLA is 2.00% of the total Contractor's annual Administration Fees paid to the Contractor by the Plan Sponsor.

Attachment A
Medicare Compliance Terms - Updated January 2013

A. Medicare Part C Requirements. Plan Sponsor acknowledges and agrees that unless CMS has provided a specific employer or union group waiver, Medicare Part C requirements for enrollment, disenrollment, benefits and other applicable provisions apply.

B. Eligibility and Eligibility Certification. Contractor will apply the End Stage Renal Disease waiver for Plan Sponsor so Enrollees with ESRD may enroll in the Medicare Advantage Group plan as permitted by and subject to the requirements established by CMS and the Medicare Secondary Payer rules.

C. Group Disenrollment Requirements. In accordance with CMS guidance, Contractor will accept valid disenrollment requests for Enrollees without obtaining a written disenrollment request when Plan Sponsor and/or its subcontractor use an electronic membership file process and where Plan Sponsor provides all information required for Contractor to submit a complete record to CMS. The disenrollment effective date must be prospective. Receipt date will be the date a complete record of the disenrollment request or decision is received by Contractor.

D. Data Use Restriction. Information collected on behalf of and for the purposes of administering the Medicare Advantage Group Plan is subject to CMS data use restrictions. Such Medicare Advantage data shall only be used by Contractor and by Plan Sponsor for administration of the Medicare Advantage Group Plan.

E. RADV Risk Mitigation Practices. Plan Sponsor agrees that Contractor will conduct periodic mitigation activities to address Risk Adjustment Data Validation (RADV) Audit risk. These efforts may result in a determination that Hierarchical Condition Category codes (HCC) submitted for risk adjustment to CMS must be withdrawn as part of the CMS reconciliation process. Additionally, these activities may result in identification of additional HCCs eligible for risk adjustment. Plan Sponsor acknowledges and agrees that any change in CMS risk adjusted revenue resulting from these risk mitigation activities will be passed through to Plan Sponsor as set forth in the applicable Pass Through requirements.

F. Record Keeping. All records related to the administration of Group's Medicare Advantage plan shall be maintained for at least ten (10) years after the final date of the Agreement period, or completion of a CMS audit, whichever date is later. Plan Sponsor shall permit HHS, the Comptroller General, or their designees to audit, evaluate, or inspect any books, contracts, and other records that pertain to the administration of the Group's Medicare Advantage plan. Plan Sponsor shall provide such information to Contractor as shall be necessary to comply with reporting requirements established by CMS.

G. Obligations under Medicare. Plan Sponsor agrees to abide by and comply with the obligations imposed on it by the applicable Medicare Laws and Regulations. As used in this Agreement, the term "Medicare Laws and Regulations" shall mean and include: (i) the Medicare Modernization Act; (ii) the Social Security Act, as amended, (iii) Part C of Title XVIII of the Social Security Act and all rules and regulations related to Part C that are from time to time adopted by CMS; (iv) any laws and regulations enacted, adopted, promulgated, applied, followed or imposed by any governmental authority or court with respect to Medicare; and (v) any and all administrative guidelines (including the Medicare Marketing Guidelines), bulletins, manuals, instructions, requirements, policies, standards, or directives from time to time adopted or issued by CMS or HHS relating to any of the foregoing, as any of the preceding Medicare Laws and Regulations from time to time may be amended, modified, revised or replaced, or interpreted by any governmental authority or court.

H. Out-of-Area Services -- Medicare Advantage

Contractor has relationships with other Blue Cross and/or Blue Shield Licensees (“Host Blues”) referred to generally as the “Medicare Advantage Program.” When Enrollees access certain healthcare services outside the geographic area and when such out of area services are available under the Enrollee’s coverage or otherwise approved by Contractor, the claim for those services may be processed through the Medicare Advantage Program and presented to Contractor for payment in accordance with the rules of the Medicare Advantage Program policies then in effect. The Medicare Advantage Program available to Enrollees under this agreement is described generally below. This does not apply to the DME/P&O/Medical Supplies,

Enrollee Liability Calculation

The cost of the service, on which Enrollee out of pocket liability (deductible/copayment/coinsurance) is based, will generally be the Medicare allowable amount for covered services.

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. 5
to
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	TELEPHONE	CONTRACTOR #, MAIL CODE
Detroit, MI 48226	(313) 255-9000 or 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Administration Services for MPSERS Post-Employment Health Insurance (hospital and medical services only) - DTMB/ORS**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, 2 Year Options	December 31, 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:

EXTEND CONTRACT EXPIRATION DATE	EXERCISE CONTRACT OPTION YEAR(S)	EXTENSION BEYOND CONTRACT OPTION YEARS	LENGTH OF OPTION/EXTENSION	EXPIRATION DATE AFTER CHANGE
☒ No ☐ Yes	☐	☐		December 31, 2013

VALUE/COST OF CHANGE NOTICE:	ESTIMATED AGGREGATE CONTRACT VALUE REMAINS:
$0.00	$2,561,151,000.00

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 agreement and DTMB Procurement approval.

Retiree Drug Subsidy Agreement

This agreement ("Agreement") is effective as of _____ (the "Effective Date") and is made between Blue Cross Blue Shield of Michigan ("BCBSM") and Office of Retirement Services ("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. [Ref. Appendix A]

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. [Ref. Appendix A]

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. [Ref. Appendix A]

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. [Ref. Appendix A]

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, [Ref. Appendix A] 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) [Ref. Appendix A] 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 to an unrelated third party without the prior written consent of the other party.

C. Subcontracting. The parties acknowledge and agree that BCBSM may use subcontractors to perform some or all of the services described in Section III and Section VI.

D. Entire Agreement. This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

E. Governing Law. The laws of the State of Michigan shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties hereunder, without giving effect to principles of conflicts of law.

F. No Third Party Beneficiary. Nothing in this Agreement is intended to create, or shall be deemed or construed to create, any rights or remedies in any third party including, without limitation, Plan Sponsor's active and retired employees (and their dependents).

G. Notice. Any notice required or desired to be given relating to this Agreement shall be in writing and shall be either hand delivered, or sent by U.S. mail, postage prepaid and return-receipt requested (receipt shall be deemed to be 5 days after postmark by the U.S. Postal Service), or overnight courier addressed as follows:

BCBSM: Vincent Gray Blue Cross Blue Shield of Michigan 500 Renaissance Center MC 517A Detroit, MI 48243	(Information of Plan Sponsor)

Notices given hereunder shall be deemed given upon documented receipt. The addresses to which notices are to be sent may be changed by written notice given in accordance with this section.

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: _____

Appendix A

42 CFR 423.882 - DEFINITIONS.

§ 423.882

Definitions.

For the purposes of this subpart, the following definitions apply:

Actually paid means that the costs must be actually incurred by the qualified retiree prescription drug plan and must be net of any direct or indirect remuneration (including discounts, 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 offered to some or all purchasers) from any manufacturer or pharmacy that would serve to decrease the costs incurred under the qualified retiree prescription drug plan.

Administrative costs means costs incurred by a qualified retiree prescription drug plan that are not drug costs incurred to purchase or reimburse the purchase of Part D drugs.

Allowable retiree costs means the subset of gross covered retiree plan-related prescription drug costs actually paid by the sponsor of the qualified retiree prescription drug plan or by (or on behalf of) a qualifying covered retiree under the plan.

Benefit option means a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

Employment-based retiree health coverage means coverage of health care costs under a group health plan based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. The term includes coverage provided by voluntary insurance coverage, or coverage as a result of a statutory or contractual obligation.

Gross covered retiree plan-related prescription drug costs, or *gross retiree costs*, means those Part D drug costs incurred under a qualified retiree prescription drug plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:

(1) The share of prices paid by the qualified retiree prescription drug plan that is received as reimbursement by the pharmacy or by an intermediary contracting organization, and reimbursement paid to indemnify a qualifying covered retiree when the reimbursement is associated with a qualifying covered retiree obtaining Part D drugs under the qualified retiree prescription drug plan.

(2) All amounts paid under the qualified retiree prescription drug plan by or on behalf of a qualifying covered retiree (such as the deductible, coinsurance, or cost sharing) in order to obtain Part D drugs that are covered under the qualified retiree prescription drug plan.

Group health plans include plans as defined in section 607(1) of ERISA, 29 U.S.C. § 1167(1). They also include the following plans:

(1) A Federal or State governmental plan, which is a plan providing medical care that is established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision of a State (including a county or local government), or by any agency or instrumentality or any of the foregoing, including a health benefits plan offered under chapter 89 of Title 5, United States Code (the Federal Employee Health Benefit Plan (FEHBP)).

(2) A collectively bargained plan, which is a plan providing medical care that is established or maintained under or by one or more collective bargaining agreements.

(3) A church plan, which is a plan providing medical care that is established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches that is exempt from tax under section 501 of the Internal Revenue Code of 1986 (26 U.S.C. 501).

(4) An account-based medical plan such as a Health Reimbursement Arrangement (HRA) as defined in Internal Revenue Service Notice 2002-45, 2002-28 I.R.B. 93, a health Flexible Spending Arrangement (FSA) as defined in Internal Revenue Code (Code) section 106(c)(2), a health savings account (HSA) as defined in Code section 223, or an Archer MSA as defined in Code section 220, to the extent they are subject to ERISA as employee welfare benefit plans providing medical care (or would be subject to ERISA but for the exclusion in ERISA section 4(b), 29 U.S.C.§ . § 1003(b), for governmental plans or church plans).

Part D drug is defined in § 423.100 of this part.

Part D eligible individual is defined in § 423.4 of this part.

Qualified retiree prescription drug plan means employment-based retiree health coverage that meets the requirements set forth in § 423.884 of this chapter for a Part D eligible individual who is a retired participant or the spouse or dependent of a retired participant under the coverage.

Qualifying covered retiree means a Part D eligible individual who is: a participant or the spouse or dependent of a participant; covered under employment-based retiree health coverage that qualifies as a qualified retiree prescription drug plan; and not enrolled in a Part D plan. For this purpose, the determination of whether an individual is covered under employment-based retiree health coverage is made by the sponsor in accordance with the rules of its plan. For purposes of this subpart, however, an individual is presumed not to be covered under employment-based

retiree health coverage if, under the Medicare Secondary Payer rules in § 411.104 of this chapter and related CMS guidance, the person is considered to be receiving coverage by reason of current employment status. The presumption applies whether or not the Medicare Secondary Payer rules actually apply to the sponsor. For this purpose, a sponsor also may treat a person receiving coverage under its qualified retiree prescription drug plan as the dependent of a qualifying covered retiree in accordance with the rules of its plan, regardless of whether that person constitutes the qualifying covered retiree's dependent for Federal or State tax purposes.
Retiree drug subsidy amount, or subsidy payment, means the subsidy amount paid to sponsors of qualified retiree prescription drug coverage under § 423.886(a).
Standard prescription drug coverage is defined in § 423.100 of this part.
Sponsor is a plan sponsor as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(16)(B), except that, in the case of a plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of financing, the term means the employer.
Sponsor agreement means an agreement by the sponsor to comply with the provisions of this subpart.

42 CFR 423.4 - DEFINITIONS.

§ 423.4 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial equivalence means a state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with section 1860D–11(c) of the Act and with CMS actuarial guidelines.

Brand name drug means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(c)), including an application referred to in section 505(b)(2) of the Federal Food, Drug and Cosmetic Act (21 USC 355(b)(2)).

Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursement contract under section 1876(h) of the Act.

Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Part D benefit, below

the level of the arrangement between a Part D plan sponsor (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Eligible fallback entity or fallback entity is defined at §423.855.

Fallback prescription drug plan is defined at §423.855.

First tier entity means any party that enters into a written arrangement, acceptable to CMS, with a Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under Part D.

Fiscally sound operation means an operation which at least maintains a positive net worth (total assets exceed total liabilities).

Formulary means the entire list of Part D drugs covered by a Part D plan.

Full-benefit dual eligible individual has the meaning given the term at §423.772, except where otherwise provided.

Generic drug means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

Group health plan is defined at §423.882.

Insurance risk means, for a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitutions, nor does it include elements potentially in the control of the pharmacy (for example, labor costs or productivity).

MA stands for Medicare Advantage, which refers to the program authorized under Part C of title XVIII of the Act.

MA plan has the meaning given the term in §422.2 of this chapter.

MA-PD plan means an MA plan that provides qualified prescription drug coverage.

Medicare prescription drug account means the account created within the Federal Supplementary Medical Insurance Trust Fund for purposes of Medicare Part D.

Monthly beneficiary premium means the amount calculated under §423.286 for Part D plans other than fallback prescription drug plans, and §423.867(a) for fallback prescription drug plans.

PACE Plan means a plan offered by a PACE organization.

PACE organization is defined in §460.6 of this chapter.

Part D eligible individual means an individual who meets the requirements at §423.30(a).

Part D plan (or Medicare Part D plan) means a prescription drug plan, an MA-PD plan, a PACE Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

Part D plan sponsor or Part D sponsor refers to a PDP sponsor, MA organization offering a MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

PDP region means a prescription drug plan region as determined by CMS under §423.112.

PDP sponsor means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part that apply to entities that offer prescription drug plans. This includes fallback entities.

Pharmacist means any individual who holds a current valid license to practice pharmacy in a State or territory of the United States or the District of Columbia.

Prescription drug plan or PDP means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in §423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K of this part. This includes fallback prescription drug plans.

Related entity means any entity that is related to the Part D sponsor by common ownership or control and

(1) Performs some of the Part D plan sponsor's management functions under contract or delegation;

(2) Furnishes services to Medicare enrollees under an oral or written agreement; or

(3) Leases real property or sells materials to the Part D plan sponsor at a cost of more than $2,500 during a contract period.

Service area (Service area does not include facilities in which individuals are incarcerated.) means for—

(1) A prescription drug plan, an area established in §423.112(a) within which access standards under §423.120(a) are met;

(2) An MA–PD plan, an area that meets the definition of MA service area as described in §422.2 of this chapter, and within which access standards under §423.120(a) are met;

(3) A fallback prescription drug plan, the service area described in §423.859(b);

(4) A PACE plan offering qualified prescription drug coverage, the service area described in §460.22 of this chapter; and

(5) A cost plan offering qualified prescription drug coverage, the service area defined in §417.1 of this chapter.

Subsidy-eligible individual means a full subsidy eligible individual (as defined at §423.772) or other subsidy eligible individual (as defined at §423.772).

Tiered cost-sharing means a process of grouping Part D drugs into different cost sharing levels within a Part D sponsor's formulary.

42 CFR 423.880 - BASIS AND SCOPE.

§ 423.880
Basis and scope.
(a) Basis. This subpart is based on section 1860D–22 of the Act, as amended by section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
(b) Scope. This section implements the statutory requirement that a subsidy payment be made to sponsors of qualified retiree prescription drug plans.

42 CFR 423.884 - REQUIREMENTS FOR QUALIFIED RETIREE PRESCRIPTION DRUG PLANS.

§ 423.884
Requirements for qualified retiree prescription drug plans.

(c) Application— (1) Submitting an application. The sponsor (or its designee) must submit an application for the subsidy to CMS that is signed by an authorized representative of the sponsor. The application must be provided in a form and manner specified by CMS.

(3) Terms and conditions. To receive a subsidy payment, the sponsor (through the signed sponsor agreement or as otherwise specified by CMS) must specifically accept and agree to:
(iii) Acknowledge that the information in the application is being provided to obtain Federal funds; and

42 CFR 423.890 - APPEALS.

§ 423.890
Appeals.

(d) Reopening— (1) Ability to reopen. CMS may reopen and revise an initial or reconsidered determination upon its own motion or upon the request of a sponsor:

(i) Within 1 year of the date of the notice of determination for any reason.
(ii) Within 4 years for good cause.
(iii) At any time when the underlying decision was obtained through fraud or similar fault.

42 CFR 423.888 - PAYMENT METHODS, INCLUDING PROVISION OF NECESSARY INFORMATION.

§ 423.888
Payment methods, including provision of necessary information.

(d) Maintenance of records. (1) The sponsor of the qualified retiree prescription drug plan (or a designee), as applicable, must maintain, and furnish to CMS or the OIG upon request, the records enumerated in paragraph (d)(3) of this section. The records must be maintained for 6 years after the expiration of the plan year in which the costs were incurred for the purposes of audits and other oversight activities conducted by CMS to assure the accuracy of the actuarial attestation and the accuracy of payments.

3) The records that must be retained are:
(i) Reports and working documents of the actuaries who wrote the attestation submitted in accordance with § 423.884(a).
(ii) All documentation of costs incurred and other relevant information utilized for calculating the amount of the subsidy payment made in accordance with § 423.886, including the underlying claims data.
(iii) Any other records specified by CMS.

Supplied for reference only, for all compliance concerns up to date CRFs must be examined in current government publications"

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 **September 13, 2012**
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 4
to
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Blue Cross Blue Shield of Michigan	Patricia Soyemi	psoyemi@bcbsm.com
600 Lafayette East	**TELEPHONE**	**CONTRACTOR #, MAIL CODE**
Detroit, MI 48226	(313) 255-9000 or 448-6943	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR	DTMB	Kerrie Vanden Bosch	(517) 636-6104	vandenboschk@michigan.gov
BUYER	DTMB	Lance Kingsbury	(517) 241-3768	kingsburyl@michigan.gov

CONTRACT SUMMARY:

DESCRIPTION: **Administration Services for MPSERS Post-Employment Health Insurance (hospital and medical services only) - DTMB/ORS**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2010	December 31, 2012	2, two year	December 31, 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:

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	Dec. 31, 2013

VALUE/COST OF CHANGE NOTICE:	ESTIMATED REVISED AGGREGATE CONTRACT VALUE:
$661,151,000.00	$2,561,151,000.00

Effective September 13, 2012, this contract is hereby EXTENDED to December 31, 2013 and is INCREASED by $661,151,000.00. For Plan Year 2013, Contractor agrees to charge to Plan Sponsor per Member per month (PMPM) administrative charges that are the same as the 2012 PMPM rates, as outlined in Attachment A-Price Quotation. Contractor agrees to pay Plan Sponsor $1.5million Loyalty Discount. This sum is to be paid by Contractor in a lump sum to Plan Sponsor. The Loyalty Discount payment to Plan Sponsor must be made by Contractor by a mutually agreed up on date within Plan Year 2013. All other terms, conditions, pricing and specifications remain the same. Per Contractor and agency agreement and the approval of both DTMB Procurement and the State Administrative Board on September 13, 2012.

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 **December 3, 2010**
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 3
TO
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **Blue Cross Blue Shield of Michigan** **600 Lafayette East** **Detroit, MI 48226** **psoyemi@bcbsm.com**	TELEPHONE Patricia Soyemi **313-225-9000 or 448-6943** BUYER/CA (517) 241-3768 **Lance Kingsbury**
Contract Compliance Inspector: Kerrie Vanden Bosch (517) 636-6104 vandenboschk@michigan.gov **Administration Services for MPSERS Post-Employment Health Insurance (hospital and medical services only) - DTMB/ORS**	
CONTRACT PERIOD: **3 yrs + 2 two-year options** From: **January 1, 2010** To: **December 31, 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 ALL LOCAL UNITS OF GOVERNMENT.

NATURE OF CHANGE(S):
The attached Medicare Advantage Addendum, including Schedules A, B, C and D, is hereby incorporated into this Contract. Except as otherwise noted in Schedule D, this terms of this Addendum only apply to the Medicare Advantage PPO Plan for Plan Sponsor's eligible Members. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON: ORS request and DTMB/Procurement & Real Estate Services Administration approval.

ESTIMATED CONRACT VALUE REMAINS: $1,900,000,000.00

FOR THE CONTRACTOR:	**FOR THE STATE:**
Blue Cross Blue Shield of Michigan Firm Name	Signature **Sergio Paneque, Senior Deputy Director** Name/Title
Authorized Agent Signature	**Procurement & Real Estate Services Administration** Division
Authorized Agent (Print or Type)	Date
Date	

MPSERS Medicare Advantage PPO
Addendum to Contract No. 071B0200075

This addendum no. 3 to DTMB Contract No. 071B0200075 ("the Contract") is effective on January 1, 2011 and is made between Blue Cross Blue Shield of Michigan ("BCBSM") with offices at 600 Lafayette East, Detroit, Michigan 48226-2998 and Michigan Public School Employee Retirement System ("MPSERS") with offices at 7150 Harris Drive, Dimondale, MI 48821

Recitals

Whereas, BCBSM is a non-profit health care corporation organized under the laws of the State of Michigan;

Whereas, BCBSM has contracted with CMS to offer group Medicare Advantage ("MA") plans;

Whereas; the Michigan Public School Employees Retirement System ("Plan Sponsor") is the plan sponsor and Blue Cross Blue Shield of Michigan is the plan administrator of the Blue Cross Medicare Advantage Plan of Plan Sponsor's health plan

Whereas, Plan Sponsor desires to amend the Plan Sponsor's health care contract with BCBSM to offer the BCBSM Medicare Advantage PPO Plan to Plan Sponsor's eligible Members

Now therefore, the parties agree as follows:

1. Definitions

A. "BCBS Plan" means a company that has been licensed by BCBSA.

B. "BCBSA" means the Blue Cross and Blue Shield Association.

C. "BCBSM" means Blue Cross Blue Shield of Michigan.

D. "CMS" means the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

E. "Claim" means a request for payment for a health care service provided to an Enrollee, with an incurred date for the service during the term of this Addendum.

F. "Coverages" means the benefits offered under BCBSM's Medicare Advantage Plan for the Plan Sponsor as set forth in **Schedule B.**

G. "Effective Date" means January 1, 2011.

H. "Enrollee" means a Member that Plan Sponsor has enrolled in BCBSM's Medicare Advantage Group PPO Plan, subject to CMS' approval.

I. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, *et seq.*, and regulations promulgated thereunder.

J. "Medicare Part C" means the Medicare Advantage program administered according to 42 CFR 422, *et seq.*, as amended, and CMS regulatory guidance issued in the form of manuals, letters, notices, or other means of written communication with respect to Medicare Advantage Plans.

K. "Plan Sponsor" means MPSERS.

L. "Renewal Date" means the date one year after the Effective Date, and the same date of every subsequent year. The Renewal Date is conditioned upon continuation of BCBSM's Medicare contract with CMS.

2. Plan Sponsor Responsibilities

A. Eligibility and Enrollment.

1. Plan Sponsor must notify BCBSM of any Member that will be enrolled in BCBSM's Medicare Advantage Group PPO Plan utilizing electronic procedures and formats for the transfer of enrollment and Eligibility data in a format to be mutually agreed upon. Plan Sponsor acknowledges that BCBSM may require a paper application if all necessary information is not contained in the electronic file. BCBSM agrees to minimize the use of paper applications to the greatest extent possible. BCBSM is responsible for collection of paper applications if needed.

2. For enrollment effective January 1, 2011, BCBSM agrees to advise eligible Members that Plan Sponsor intends to enroll them into the BCBSM MA PPO plan through an automatic enrollment process unless the Member affirmatively opts out of such enrollment. BCBSM agrees that all such Members will be provided enrollment information at least 21 days prior to the effective date of the beneficiary's enrollment in the MA Plan, along with a copy of the summary of benefits offered under the selected plan, an explanation of how to get more plan information, and an explanation of how to contact Medicare for information on other Medicare health plans that might be available to the Member. The Plan Sponsor's enrollment information submitted to BCBSM must comply with CMS requirements. All Member communication materials are subject to the terms and requirements of the Contract, section 1.022 E (2), provided that such terms and requirements do not conflict with CMS requirements. If there is a disagreement concerning the interpretations of CMS requirements regarding Member communication materials by either party, both parties agree to negotiate in good faith to reach a mutually acceptable resolution. Plan Sponsor acknowledges that CMS mandates that BCBSM send Member communications by certain dates and that BCBSM will be constrained to send CMS model language if an agreement cannot be reached. BCBSM will make reasonable requests to CMS on behalf of Plan Sponsor for requested changes to Member communication materials within the timeframes allowed by CMS.

3. For enrollment after January 1, 2011, BCBSM must accept requests for enrollment that:
   (i) are for a Member that is eligible for enrollment per the eligibility requirements of the Plan Sponsor;
   (ii) are submitted in accordance with CMS requirements;
   (iii) are submitted on CMS approved enrollment applications, if Pan Sponsor utilizes a paper application;
   (iv) clearly denote the Member's agreement to abide by BCBSM's Medicare Advantage Group PPO Plan's requirement and rules;
   (v) certify the Member's receipt of CMS required disclosure information; and
   (vi) include the Member's authorization to allow BCBSM to disclose and exchange necessary information with the U.S. Department of Health and Human Services and its designees.

4. Plan Sponsor must maintain a record of each Member's election in a format that can be easily, accurately and quickly reproduced upon request by BCBSM and/or CMS as necessary.

5. Plan Sponsor acknowledges that final enrollment in BCBSM's Medicare Advantage Group PPO Plan is contingent upon a Member: (1) being entitled to Medicare Part A and enrolled in Part B; (2) not being enrolled in any other Medicare Advantage plan; and (3) and being approved by CMS.

6. Plan Sponsor is responsible for transmitting Eligibility and enrollment information for Members. Eligibility information for Members will be transferred to BCBSM from Plan Sponsor by electronic medium including all necessary information with respect to current enrollees prior to December 1, 2010. Payment of Administration Fee is predicated on the enrollment records of the Plan Sponsor.

   Requirements:
   BCSBM must meet the following requirements:
   (1) BCBSM must comply with all applicable requirements of HIPAA.
   (2) BCBSM must maintain Member information.

(3) BCBSM must verify Member Eligibility for coverage, at a minimum, on an annual basis. This includes verifying the availability of other primary coverage.
(4) BCBSM must accept electronic data transfer on a weekly basis from Plan Sponsor, in a HIPAA compliant 834 file provided through a data exchange gateway. BCBSM must work with Plan Sponsor for approval of the implementation of this data transfer. Discrepancy reports must be supplied within two business days, in a format to be mutually agreed to by Plan Sponsor and BCBSM.
(5) BCBSM is responsible for any changes to its systems or processes required to support the receipt and processing of Plan Sponsor's enrollment files.
(6) Enrollment files must be processed and Member Eligibility and/or enrollment update completed within four business days of notification from the Plan Sponsor or its designee, and assuming CMS approval has been granted relative to Medicare Advantage Members, with confirmation of changes submitted to Plan Sponsor.
(7) BCBSM must have validation edits in place to ensure, for each data load, that all fields are properly populated and readable.
(8) BCBSM must accept verbal notification from Plan Sponsor regarding Member Eligibility and initiate the enrollment process immediately upon verbal notification.
(9) BCBSM must provide to the Plan Sponsor, by means of a secured Internet portal, access to the system used to maintain Eligibility.
(10) BCBSM must provide to Providers, by means of a secured Internet portal, access to Eligibility.
(11) BCBSM must have appropriate staff of information technology professionals to provide timely programming when needed to implement system changes and produce reports.
(12) BCBSM must use a secure system for all administrative communications concerning Members, including transport of electronic files containing confidential information.
(13) Communication involving any identifiable Member information must be protected using passwords and a File Transfer Protocol for retrieval.
(14) BCBSM must be able to provide summary enrollment statistics, along with other enrollment data, upon the Plan Sponsor's request, in a mutually agreed upon format.

B. Plan Sponsor Certification of Eligibility and Enrollment Information. Plan Sponsor certifies to the best of its knowledge and understanding to BCBSM that all Eligibility data transfers submitted to BCBSM are accurate, complete and truthful. Plan Sponsor acknowledges that BCBSM is relying upon Plan Sponsor's accuracy of its Eligibility data transfers because BCBSM must certify the accuracy of such enrollment information to CMS.

C. Payments by Plan Sponsor.

1. Plan Sponsor acknowledges that each month BCBSM receives CMS capitated payments for Members enrolled in BCBSM's Medicare Advantage PPO Plan. Any payments received by BCBSM on behalf of Plan Sponsor's Members are subject to the Contract's requirements for full Pass-Through Pricing and Transparency. BCBSM must apply all CMS revenue to the Plan Sponsor on a monthly payment interval.

2. Plan Sponsor agrees that BCBSM's Administration Fee as set forth on Schedule A shall first be paid from such CMS capitated payments. The cost of any Claims shall next be paid from such CMS capitated payments. If BCBSM's Administration Fee and the cost of Claims exceed the CMS capitated payment, Plan Sponsor shall pay BCBSM any such amount pursuant to the invoicing terms of the Contract, section 2.044. BCBSM shall reconcile any terminations (including retroactive terminations made by CMS) at least once each year. BCBMS must provide Pass-Through Pricing to Plan Sponsor. BCBSM must not charge Plan Sponsor or any Member any amount above that which is paid to the Provider under the terms of the contract between BCBSM and the Provider.

3. The Administration Fees set forth in Schedule A includes revenue and membership reconciliation efforts, Social Service Coordinators dual eligible enrollment efforts, and BCBSM's vendor's enhanced revenue management program.

4. If the Contract terminates, Plan Sponsor shall pay BCBSM for the cost of any Enrollee Claims during the run-out period. Plan Sponsor acknowledges that Claims may be submitted by Providers (up to 12 months) after the service date (run-out period) and

BCBSM will not receive any new CMS capitated payments during such run-out period. Any payments received by BCBSM as the result of CMS payment reconciliations on behalf of Plan Sponsor's Members are subject to the Contract's requirements for full Pass-Through Pricing and Transparency. BCBSM will continue to do run-out activities per the attached Schedule C. BCBSM must continue to submit Claims files to MPSERS and their data management vendor during the 12 month run-out period.

D. Member Communications. Plan Sponsor agrees that BCBSM will communicate with any Enrollee as required by CMS or BCBSM, including but not by way of limitation, summary of benefits, annual notice of change, evidence of coverage, surveys and other BCBSM standard documents as required by CMS. If BCBSM agrees to any Plan Sponsor request to modify BCBSM standard documents, e.g., coordination of benefit verifications, BCBSM will provide a quote to Plan Sponsor of BCBSM's actual costs, including BCBSM's labor and time for any such modifications, and receive written approval from Plan Sponsor for the additional costs prior to implementing the modifications. Any/all Member communications are subject to the terms and requirements of the Contract, section 1.022 E (2) provided that such terms and requirements do not conflict with CMS requirements. If there is a disagreement concerning the interpretations of CMS requirements by either party, both parties agree to negotiate in good faith to reach a mutually acceptable resolution. Plan Sponsor acknowledges that CMS mandates that BCBSM send Member communications by certain dates and that BCBSM will be constrained to send CMS model language if an agreement cannot be reached. BCBSM will make reasonable requests to CMS on behalf of Plan Sponsor for requested changes within the timeframes allowed by CMS.

E. Retroactive Disenrollment. If CMS determines that an Enrollee was not eligible for BCBSM's Medicare Advantage Group PPO Plan and requires that BCBSM retroactively disenroll such Enrollee, BCBSM shall process Member Claims as if original Medicare were in place and Member shall pay the appropriate cost share per the Plan Design in effect during that time period and Plan Sponsor will pay applicable Claims costs.

F. Enrollee Options Upon Disenrollment. If an Enrollee disenrolls from this Plan, Plan Sponsor shall offer such Enrollee an option to enroll in any other health care plan offered by Plan Sponsor, if any and if such Enrollee is eligible to participate in such health care plan, as required by Statute or defined by the Plan.

3. Medicare Advantage PPO Plan Terms and Conditions

A. Enrollment Verification Process and Eligibility. BCBSM or its subcontractor shall submit to CMS the Eligibility data transfers that it receives from Plan Sponsor for verification and final enrollment in BCBSM Medicare Advantage PPO Plan. CMS shall review such enrollment data and determine if an Member will be enrolled in the BCBSM Medicare Advantage PPO Plan.

The BCBSM Medicare Advantage PPO Plan shall not deny, limit, or condition the coverage or furnishing of benefits to Members eligible to enroll on the basis of any factor that is related to health status, including, but not limited to a medical condition, including mental as well as physical illness; Claims experience; receipt of health care; medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence; or a disability.

B. Claims Processing. Processing and payment of Claims is subject to the terms and requirements set forth in section 1.022 B of the Contract provided that such terms and requirements do not conflict with CMS requirements.

C. Intentionally omitted.

D. Required Disclosures. At the time of enrollment and at least annually thereafter and in compliance with the timeframes as set forth by CMS, BCBSM shall disclose the following to Enrollees:

1. Service area. BCBSM's service area and any enrollment continuation area and any out-of-area coverage provided under the plan.

2. Benefits. An evidence of coverage document and summary of benefits offered under BCBSM Medicare Advantage PPO Plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and for purposes of comparison are --

   i. The benefits offered under original Medicare, and
   ii. The availability of the Medicare hospice option and any approved hospices in the service area, including those that BCBSM owns, controls, or has a financial interest in, if any.

3. Access to Providers. BCBSM 's Medicare Advantage Group PPO Plan, with respect to a particular category of health care Providers, has payment rates that are not less than the rates that apply under original Medicare for the Provider in question or it has contracts or agreements with a sufficient number and range of Providers to furnish the Covered Services.

4. Emergency coverage. BCBSM's Medicare Advantage PPO Plan covers emergencies in accordance with 42 CFR 422.113 and discloses to Enrollees the appropriate use of emergency services; Prior Authorization is not required for services; the process and procedures for obtaining emergency services; and the use of the 911 telephone system or its local equivalent.

5; Supplemental benefits for BCBSM's Medicare Advantage PPO Plan. Any mandatory or optional supplemental benefits and the premium for those benefits.

6. Prior Authorization and review rules. BCBSM shall disclose any Prior Authorization rules and other review requirements that must be met in order to ensure payment for the services and instructions to Enrollees that, in cases where non-contracting providers submit a bill directly to the Enrollee, the Enrollee should not pay the bill, but submit it to BCBSM for processing and determination of Enrollee liability, if any.

7. Grievance and appeals procedures. BCBSM shall provide to Enrollees all grievance and appeals rights and procedures that include:

   (a) Timeframe for requests for service. When a party has made a request for a service, BCBSM must notify the Enrollee of its determination as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days after the date BCBSM receives the request for a standard BCBSM determination. BCBSM may extend the timeframe by up to 14 calendar days if the Enrollee requests the extension or if the BCBSM justifies a need for additional information and how the delay is in the interest of the Enrollee (for example, the receipt of additional medical evidence from non-contracted providers may change a BCBSM decision to deny). When BCBSM extends the timeframe, it must notify the Enrollee in writing of the reasons for the delay, and inform the Enrollee of the right to file an expedited grievance if he or she disagrees with BCBSM's decision to grant an extension.

   (b) Timeframe for requests for payment. BCBSM shall process requests for payment according to the "prompt payment" provisions set forth in 42 CFR 422.520.

   (c) Written notice for denials. If BCBSM decides to deny service or payment in whole or in part, or if an Enrollee disagrees with BCBSM's decision to discontinue or reduce the level of care for an ongoing course of treatment, BCBSM must give the Enrollee written notice of the determination.

   (d) Written notice for denials. If an Enrollee requests BCBSM to provide an explanation of a Practitioner's denial of an item or service, in whole or in part, BCBSM must give the Enrollee a written notice.

   (e) Form and content of notice. The notice of any denial under paragraph (d) of this section must --

(i) Use approved notice language in a readable and understandable form;

(ii) State the specific reasons for the denial;

(iii) Inform the Enrollee of his or her right to reconsideration;

(iv) (a) For service denials, describe both the standard and expedited reconsideration processes, including the Enrollee's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and

(b) For payment denials, describe the standard reconsideration process and the rest of the appeal process; and

(v) Comply with any other notice requirements specified by CMS.

(f) Effect of failure to provide timely notice. If BCBSM fails to provide the Enrollee with timely notice of BCBSM's determination as specified in this section, this failure itself constitutes an adverse BCBSM determination and may be appealed.

8. Quality assurance program. A description of the quality assurance program required under 42 CFR 422.152.

9. Disenrollment rights and responsibilities. BCBSM shall provide to Enrollees all disenrollment rights and responsibilities.

E. Disclosures upon request. Upon the request of an Member eligible to elect BCBSM's Medicare Advantage PPO Plan, BCBSM shall provide to the Member the following information:

1. Benefits under original Medicare, including covered services, Enrollee cost-sharing, such as deductibles, coinsurance, and copayment amounts and any Enrollee liability for balance billing.

2. BCBSM's procedures to control utilization of services and expenditures.

3. The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as grievances according to 42 CFR 422.564 and appeals according to 42 CFR 422.578.

4. A summary description of the method of compensation for physicians.

5. BCBSM's financial condition, including the most recently audited information regarding, at least, a description of the financial condition of BCBSM.

6. If BCBSM exercises the option in 42 CFR 422.101(b)(3) related to an MA plan, then it must make the local coverage determination that applies to Members of that plan readily available to Providers, including through a web site on the Internet.

F. Changes in BCBSM Medicare Advantage PPO Plan Rules. If changes are made to the rules for BCBSM's Medicare Advantage PPO Plan, BCBSM shall:

1. For changes that take effect on January 1, notify all Enrollees at least 15 days before the beginning of the Annual Coordinated Election Period defined in section 1851(e)(3)(B) of the Act.

2. For all other changes, notify all Enrollees at least 30 days before the intended effective date of the changes.

G. Disenrollment

1. *Optional disenrollment.* BCBSM may disenroll Members from the Medicare Advantage Group PPO Plan in any of the following circumstances:

(i) The Group fails to pay amounts due as set forth in Schedule A, according to payments terms in Schedule A of this addendum and the Contract.

(ii) The Member has engaged in disruptive behavior as set forth in 42 CFR 422.74.

(iii) The Member provides fraudulent information on his or her election form or permits abuse of his or her enrollment card.

2. *Required disenrollment.* BCBSM shall disenroll Members under the following circumstances:

(i) The Member is no longer eligible for MPSERS coverage.

(ii) The Member loses entitlement to Part A or Part B benefits.

(iii) Death of the Member.

(iv) The State terminates the Contract with BCBSM.

(v) CMS terminates its contract with BCBSM.

3. *Notice.* Before disenrollment, BCBSM shall provide the Member with notice of disenrollment in accordance with CMS Enrollment Guidance.

H. Enrollee Protections

1. BCBSM has adopted and maintains arrangements and networks that are satisfactory to CMS to protect Enrollees from incurring liability (for example, as a result of BCBSM's insolvency or other financial difficulties) for payment of any fees that are BCBSM's legal obligation.

2. BCBSM shall indemnify an Enrollee for payment of any fees that are BCBSM's legal obligation for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with BCBSM, to provide services to Enrollees.

3. BCBSM shall provide for continuation of Enrollee health care benefits for the duration of the contract period for which CMS payments have been made; and for Enrollees who are hospitalized on the date BCBSM's contract with CMS terminates, or, in the event of the BCBSM's insolvency, through discharge.

I. Reports

BCBSM will provide a quarterly report that shows the savings that were generated by Plan Sponsor enrolling in BCBSM's Medicare Advantage PPO Group Plan as compared to the 2010 Plan Sponsor Medicare Supplemental program. The savings will be calculated as follows:

Program Savings = Medicare Supplemental Experience/Cost minus Medicare Advantage Experience/Cost.

Medicare Supplemental Experience/Cost = Plan Sponsor 2010 Medicare Supplemental claims cost per Member multiplied by a trend factor (agreed upon by the parties in advance) multiplied by the number of Members in Medicare Advantage Plan plus Supplemental Administration Fee.

Medicare Advantage Experience/Cost = Plan Year Medicare Advantage Claims minus CMS Revenue payments to BCBSM (including projections of retroactive revenue payments resulting from Revenue Management activities) minus Medicare Advantage COB/Audit Recoveries minus Dual Eligible Revenue payments to BCBSM plus BCBSM's Medicare Advantage Administration Fee.

1st quarter plan year reports with actual experience and costs will not be available to Plan Sponsor until the 3rd quarter of the plan year due to CMS reporting to BCBSM, medical and care management program reporting, and audit recovery processes. BCBSM will assist Plan Sponsor by providing quarterly estimates and projections until the actual experience and cost reports are available in the 3rd quarter of 2011. Plan Sponsor acknowledges that the 2011 experience and costs will not include any Part D prescription drug experience or costs.

BCBSM will provide written notification to Plan Sponsor upon receipt from CMS of the data required to complete this report. The report will be delivered to Plan Sponsor no later than 10 business days after receipt of the data from CMS, which will be no later than September 15 of the plan year. Penalties for SLAs related to reports (SLA# 10) will not apply to this report.

4. Providers

A. Provider Access Standards. BCBSM's Medicare Advantage Group PPO Plan is a Preferred Provider Organization for Service Plan 800 Series Plans that complies with federal government access requirements for such plans.

B. Enrollee Responsibility. In order to receive health care benefits of the Plan, it is the Enrollee's responsibility to show Providers BCBSM's Medicare Advantage PPO Plan identification card before treatment is rendered and select those Providers who are willing to treat them and accept payment from BCBSM's Medicare Advantage Plan as a contracted network provider.

C. BCBSM Assistance. BCBSM will, upon Enrollee request, attempt to help the Enrollee find physician or hospital Providers willing to treat Medicare Plus Blue Enrollees in reasonable proximity to the Enrollee's place of usual residence.

D. Available Disenrollment Options. If BCBSM cannot locate a Provider willing to treat an Enrollee within a reasonable proximity to the Enrollee, BCBSM will provide the Enrollee with information on available disenrollment options.

5. General Provisions

A. Condition Precedent. This Addendum is expressly contingent upon the renewal of BCBSM's contract with CMS. BCBSM's Medicare Advantage Group PPO Plan is an authorized "800 Series Plan" and its benefits are at least as good as Medicare Part A and Part B benefits.

B. Service Mark Licensee Status. BCBSM is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks. BCBSM is not an agent of BCBSA and, by entering into this MA Addendum, Plan Sponsor agrees that it made this MA Addendum based solely on its relationship with BCBSM, that BCBSA is not a party to, nor has any obligations under this MA Addendum, and that no obligations of BCBSA are created or implied by this language.

C. Amendments. Unless otherwise set forth in this MA Addendum, this MA Addendum may be amended only in accordance with Section 2.024 of the Contract , except this MA Addendum shall be automatically amended to incorporate any change in federal law or CMS regulation or guideline that is applicable to BCBSM's Medicare Advantage Group PPO Plan.

D. Interest. No interest charge accrues to Plan Sponsor or is payable by BCBSM to Plan Sponsor arising out of or related to any CMS capitation amounts BCBSM receives. CMS capitation payments must be reported to Plan Sponsor within seven business days of receipt by BCBSM.

E. Saving Projections. BCBSM does not guarantee or represent that Plan Sponsor will have any financial savings generated, created or produced in any manner as a result of Plan Sponsor contracting with and enrolling in BCBSM's Medicare Advantage Group PPO Plan. Plan Sponsor acknowledges that its decision to change from its Medicare supplemental

plan that existed prior to January 1, 2011 to BCBSM's Medicare Advantage Plan Sponsor PPO Plan is not based on any BCBSM financial guarantees.

F. Order of Precedence. In the event of a conflict between the terms of this Addendum, in regards to the Medicare Advantage Group PPO Plan, and the terms of the Contract, the terms of this Addendum will control.

SCHEDULE A

MPSERS
Medicare Advantage
Contract Effective Date: January 01, 2011
Medical

	PMPM
Base Admin Fee	$37.00
Revenue Management	$11.22
Margin	$2.56
Medical Management	$5.21
Network Management	$0.96
HDI DRG audits	$1.72
Verification of Coverage	$0.18
2011 Admin Fee	$58.85

Estimated Monthly Members: 130,000

Schedule B

MPSERS BENEFITS 11-22-10	In-Network Cost share information	Out of Network Cost share information
2011 MPSERS PPO	Med/Surg Deductible: $300 Med/Surg Out of pocket max: $900 DME DMEnsions cost share is separate from Med/Surg cost share. (See below for DME DMEnsions details)	
	All in-network coinsurance, copayments and deductibles apply to the out of pocket (OOP) maximum.	All out of network coinsurance, copayments and deductible apply to the out of pocket (OOP) maximum.
Product Guidelines	Pre-Certification / Pre-Authorization is required for **specified** High Tech Radiology services, LTAC, SNF, and Inpatient Rehabilitation JVHL/Quest/Munson Lab Network and provider reimbursement applies POLL (Physician Office Lab List) services apply to in-network providers Emergency Care – Apply facility cost share of $50 maximum. There is no cost share for physician services rendered in the ER Original Medicare cost share that occurs for members enrolled in Hospice is not a covered benefit	No pre-certification or pre-authorization is required (for CSRs only, do not include in member communications) Lab networks do not apply POLL does not apply Emergency Care – Apply facility cost share of $50 maximum. There is no cost share for physician services rendered in the ER Original Medicare cost share that occurs for members enrolled in Hospice is not a covered benefit
World Wide Coverage	Not limited to emergency and urgent care. Med/Surg deductible and out of pocket maximum applies. Cost share will be based on the type of service.	
Episode of Care	A coinsurance if applicable will be taken on each line of service.	
Inpatient Facility Services		
Inpatient Hospital Care – (Includes Rehabilitative Services Mental Health and Substance Abuse) Unlimited days	10% coinsurance after deductible	10% coinsurance after deductible
Home Health Care – (Non DME)	No member cost share	No member cost share
Skilled Nursing Facility 100 days per benefit period	10% coinsurance after deductible	10% coinsurance after deductible
Hospice Care (See Additional Benefits for Hospice Respite Care)	Covered by Original Medicare	Covered by Original Medicare
Blood — including storage and administration. Coverage of whole blood and packed red cells begins with the first pint.	10% coinsurance after deductible	10% coinsurance after deductible
Outpatient Facility Services (includes ASC, ESRD, Hospital, Rehabilitative and Psychiatric Services)		
ASC Facility	10% coinsurance after deductible	10% coinsurance after deductible
Clinic CORF	10% coinsurance after deductible	10% coinsurance after deductible
Clinic ESRD	10% coinsurance after deductible	10% coinsurance after deductible
Clinic OPT	10% coinsurance after deductible	10% coinsurance after deductible
Emergency Room Care	$50 Maximum copayment -waived if admitted within 3 days	$50 Maximum copayment -waived if admitted within 3 days
Federally Qualified Health Clinic	10% coinsurance after deductible	10% coinsurance after deductible
Hospital Based Outpatient	10% coinsurance after deductible	10% coinsurance after deductible

Services		
Religious Nonmedical Health Care Institutions	10% coinsurance after deductible	10% coinsurance after deductible
Rural Health Clinic	10% coinsurance after deductible	10% coinsurance after deductible
Physician / Practitioner Services		
Allergy and Clinical Immunology	10% coinsurance after deductible	10% coinsurance after deductible
Anesthesia Services (general anesthesia, moderate sedation & qualifying circumstances for anesthesia)	10% coinsurance after deductible	10% coinsurance after deductible
Biofeedback	10% coinsurance after deductible	10% coinsurance after deductible
Cardiac Catherization	10% coinsurance after deductible	10% coinsurance after deductible
Cardiography	10% coinsurance after deductible	10% coinsurance after deductible
Cardiovascular – Therapeutic	10% coinsurance after deductible	10% coinsurance after deductible
Central Nervous System Assessments/Tests	10% coinsurance after deductible	10% coinsurance after deductible
Chemotherapy Administration	10% coinsurance after deductible	10% coinsurance after deductible
Chemotherapy Drugs	10% coinsurance after deductible	10% coinsurance after deductible
Chiropractic Services		
Manipulative Therapy	10% coinsurance after deductible	10% coinsurance after deductible
Diagnostic Test, X-rays		
High Tech: CT, MRI, Nuclear Medicine, Pet Scan	10% coinsurance after deductible	10% coinsurance after deductible
Low Tech	10% coinsurance after deductible	10% coinsurance after deductible
Therapeutic	10% coinsurance after deductible	10% coinsurance after deductible
Dialysis	10% coinsurance after deductible	10% coinsurance after deductible
Endocrinology	10% coinsurance after deductible	10% coinsurance after deductible
Gastroenterology	10% coinsurance after deductible	10% coinsurance after deductible
Health and Behavior Assessments/Interventions	10% coinsurance after deductible	10% coinsurance after deductible
Hydration, Therapeutic, Prophylactic and Diagnostic Injections/Infusions	10% coinsurance after deductible	10% coinsurance after deductible
Immunization Administration of Vaccines/Toxoids	10% coinsurance after deductible	10% coinsurance after deductible
Injectables	10% coinsurance after deductible	10% coinsurance after deductible
Laboratory Services – Clinical	No member cost share	No member cost share
Laboratory Services – Pathology	10% coinsurance after deductible	10% coinsurance after deductible
Medical Care (Evaluation and Management Services)		
Inpatient, Office, Outpatient (Including home visits and mental health and substance abuse)	10% coinsurance after deductible	10% coinsurance after deductible
Emergency Evaluation and Management Services	No member cost share	No member cost share
Urgent Care performed in CMS location 20	10% coinsurance after deductible	10% coinsurance after deductible
Neurology and Neuromuscular Procedures	10% coinsurance after deductible	10% coinsurance after deductible
Noninvasive Physiologic studies and procedures	10% coinsurance after deductible	10% coinsurance after deductible
Non-Invasive Vascular Diagnostic Studies	10% coinsurance after deductible	10% coinsurance after deductible

Ophthalmology - Specialized Services	10% coinsurance after deductible	10% coinsurance after deductible
Osteopathic Manipulative Therapy	10% coinsurance after deductible	10% coinsurance after deductible
Photodynamic Therapy	10% coinsurance after deductible	10% coinsurance after deductible
Physical Medicine and Rehabilitation	10% coinsurance after deductible	10% coinsurance after deductible
Podiatry Services	10% coinsurance after deductible	10% coinsurance after deductible
Psychiatric Services		
Therapy visit	10% coinsurance after deductible	10% coinsurance after deductible
Non – Therapy services	10% coinsurance after deductible	10% coinsurance after deductible
Pulmonary Medicine	10% coinsurance after deductible	10% coinsurance after deductible
Vent Management - Inpatient Hospital	10% coinsurance after deductible	10% coinsurance after deductible
Vent Management - Other Facility	10% coinsurance after deductible	10% coinsurance after deductible
Special Dermatological Procedures	10% coinsurance after deductible	10% coinsurance after deductible
Special Otorhinolaryngologic (ENT) Services	10% coinsurance after deductible	10% coinsurance after deductible
Speech Therapy	10% coinsurance after deductible	10% coinsurance after deductible
Surgical Services	10% coinsurance after deductible	10% coinsurance after deductible
Vaccines/Toxoids	10% coinsurance after deductible	10% coinsurance after deductible
Preventive Services (as defined by Medicare)		
Flu Shot including administration	No member cost share	No member cost share
Pneumococcal including administration	No member cost share	No member cost share
Hepatitis B (HBV) including administration	No member cost share	No member cost share
HIV Screening	No member cost share	No member cost share
Abdominal Aortic Aneurysms (AAA)	No member cost share	No member cost share
Bone Mass Measurement	No member cost share	No member cost share
Cardiovascular Disease Screening	No member cost share	No member cost share
Colorectal Cancer Screening		
Flexible Sigmoidoscopy	No member cost share	No member cost share
Screening Colonoscopy	No member cost share	No member cost share
Barium Enema	No member cost share	No member cost share
Fecal Occult Blood Test	No member cost share	No member cost share
Diabetes Screening Tests	No member cost share	No member cost share
Diabetes Self-Management Training (DSMT)	No member cost share	No member cost share
Glaucoma Screening	No member cost share	No member cost share
Welcome to Medicare Exam		
Initial Preventive Examination (IPPE)	No member cost share	No member cost share
EKG for IPPE	No member cost share	No member cost share
EKG Tracing, Interpretation and Report for IPPE	No member cost share	No member cost share
Kidney Disease Education Services	No member cost share	No member cost share
Medical Nutrition Therapy Services	No member cost share	No member cost share
Personalized Prevention Plan Services (PPPS)	No member cost share	No member cost share
Prostate Cancer Screening		
Digital Rectal Exam	No member cost share	No member cost share

PSA Test	No member cost share	No member cost share
Screening Mammography	No member cost share	No member cost share
Screening Pap Tests	No member cost share	No member cost share
Smoking and Tobacco-Use Cessation Counseling	No member cost share	No member cost share
Other Services		
Ambulance Services	10% coinsurance after deductible	10% coinsurance after deductible
Durable Medical Equipment-(Non DMEnsions) Benefits limited to Part B jurisdictional services only	10% coinsurance after deductible	10% coinsurance after deductible
Group Enhanced Benefits - Refer below to see if group enhanced benefits apply to this group		
Home Infusion Therapy		
Nursing Visits	10% coinsurance after deductible	10% coinsurance after deductible
DME equipment, supplies and coordination	10% coinsurance after deductible	10% coinsurance after deductible
Total Body Skin Exam	Not a benefit	Not a benefit
Routine Physicals	Not a benefit	Not a benefit
Acupuncture	Not a benefit	Not a benefit
Chiropractic Approved Radiological	10% coinsurance after deductible	10% coinsurance after deductible
Chiropractic Approved E&M	Not a benefit	Not a benefit
Chiropractic Physical Therapy	Not a benefit	Not a benefit
Clinical Psychologist Consultation Services	Not a benefit	Not a benefit
Contraceptive Devices	Not a benefit	Not a benefit
Determination of a Refractive State	10% coinsurance after deductible	10% coinsurance after deductible
Gradient Compression Stockings	Not a benefit	Not a benefit
Hearing Services-routine exams	10% coinsurance after deductible	10% coinsurance after deductible
Hearing Aids Monaural or Binaural	10% coinsurance after deductible	10% coinsurance after deductible
Hospice Respite Care	No member cost share	No member cost share

Human Organ Transplant (There is a $1 Million lifetime maximum for non-Medicare covered organs, per organ)	10% coinsurance after deductible	10% coinsurance after deductible
Lasik Surgery (Facility or Professional)	Not a benefit	Not a benefit
Private Duty Nursing	10% coinsurance after deductible	10% coinsurance after deductible
RK Surgery	Not a benefit	Not a benefit
Routine Hepatitis C screening	Not a benefit	Not a benefit
Sterilization	10% coinsurance after deductible	10% coinsurance after deductible
TMJ Device	10% coinsurance after deductible	10% coinsurance after deductible
Travel, Meals, Lodging associated with HOTP benefits	No member cost share	No member cost share
Weight Loss Surgery	Not a benefit	Not a benefit
Weight Reduction Benefit	Not a benefit	Not a benefit
Wig, Wig Stand, Adhesive	Not a benefit	Not a benefit
Voluntary Abortion	Not a benefit	Not a benefit
Annual GYN Exam	10% coinsurance after deductible	10% coinsurance after deductible

DME (Dmensions Services)

No member deductible for in or out of network services Out of network services are subject to a $1,000 out of network out of pocket maximum. **This out of pocket maximum does not apply to the med/surg out of pocket maximum.**		
DME	No member cost share	20% coinsurance
Diabetes Testing Supplies	No member cost share	No member cost share

Schedule C – Medicare Advantage Program Run-out Functions Post-terminations, BCBSM must provide only those services set forth below

Member and Provider Servicing Answer all MPSERS Medicare Advantage member or responsible party phone calls and resolve issues/questions regarding claims or eligibility issues that occurred prior to 12/31 of the year the contract ends. As appropriate, respond to member/responsible party in writing Respond to all written inquiries from MPSERS Medicare Advantage members or responsible parties and resolve issues/questions regarding claims or eligibility issues that ocurred prior to 12/31 of year contract ends Answer all provider phone calls and resolve issues/questions regarding claims or eligibility issues for MPSERS Medicare Advantage members that occurred prior to 12/31 of year contract ends. As apprpriate, respond to provider in writing Respond to all written inquiries from providers and resolve issues/questions regarding claims or eligibility issuesf for MPSERS Medicare Advantage members that ocurred prior to 12/31 of year contract ends	12/31 of year contract ends
Member and Provider Grievance and Appeals Acknowledge, research, and appropriately respond to all MPSERS Medicare Advantage member or responsible party grievances or appeals regarding events or claims that occurred prior to 12/31 of the year contract ends For all adverse appeal decisions, prepare CMS required documentation and forward to CMS's IRE - Maximus/CHDR for determination Effectuate all appeals decisions made by Maximus/CHDR Acknowledge, research, and appropriately respond to all provider appeals regarding claims for MPSERS Medicare Advantage members that occurred prior to 12/31 of the year the contract ends. As appropriate, respond to provider in writing For all adverse appeal decisions, prepare CMS required documentation and forward to CMS's IRE - First Coast for determination As appropriate, prepare and submit appeal of First Coast decision for ALJ review Effectuate all appeals decisions made by First Coast/ALJ	12/31 of year contract ends
Med/Surg Claim Processing including all adjustments Receive, validate eligibility, edit, and appropriately adjudicate all professional and facility claims for services provided to MPSERS Medicare Advantage prior to 12/31 of the year the contract ends Process any appropriate adjustments to previously adjudicated claims for services provided to MPSERS Medicare Advantage members prior to 12/31 of the year the contract ends Provide MPSERS with data via the weekly wire reflecting paid/adjusted claims activity and required funding	12 months after the contract ends

DME Claim Processing including all adjustments Receive, validate eligibility, edit, and appropriately adjudicate all DME claims for equipment and/or services provided to MPSERS Medicare Advantage prior to 12/31 of the year the contract ends Process any appropriate adjustments to previously adjudicated claims for DME equipment and/or services provided to MPSERS Medicare Advantage members prior to 12/31 of the year the contract ends Provide MPSERS with data via the weekly wire reflecting paid/adjusted claims activity and required funding	12 months after the contract ends
CMS CTM Member & Provider Complaints Appropriately acknowledge and address any CTM complaints received from MPSERS Medicare Advantage members. This included all complaints received by BCBSM fro MPSERS new PBM - Catalyst - that were received in January but routed to BCBSM instead of Caralyst by CMS because Catalyst was non-responsive. CMS asked us to reach out to the members and provide the members with support and education to ease the transition which we did Appropriately acknowledge and address any CTM complaints received from providers regarding MPSERS Medicare Advantage members. Respond to CMS via the CTM and document all actions taken	12/31 of year contract ends
Enrollment & Payment Reconciliation Receive, analyze/validate, and book all CMS and Part C enrollment and payment adjustments for MPSERS Medicare Advantage members for enrollment period from 1/1/06 through 12/31 of the year the contract ends Provide MPSERS with a 2009 Retrospective Revenue Management Payment report when the actual payment is received	12 months after contract ends
Revenue Management - DOS for last Contract year - submission on 1/31 of following year Complete retrospective review of all appropriate medical charts for all MPSERS Medicare Advantage members with 'suspect id's" Prepare RAPS files of all appropriate and submitable diagnoses for MPSERS Medicare Advantage members for submission to CMS Submit RAPS files to CMS's contractor by deadline of 1/31/10	12/31 of year contract ends no further chart reviews or other revenue management work will be conducted after this date
Cost and Use Reporting Complete monthly and year end standard cost and utilization reports Submit report to MPSERS	12/31 of year contract ends

Basic support of CMS audits related to MPSERS Medicare Advantage business Respond to CMS or their designated contractor for any audit Hold entrance conference Provide all requested data/files Participate in requested interviews with CMS Hold exit conference	12/31 of year contract ends
Basic retrospective recoveries and COB Include all MPSERS professional, facility, and DME claims in BCBSM's Medicare Advantage COB & Recovery Department standard data mining, investigation, and analysis processes Process COB as routine part of claims adjudication process for all MPSERS Medicare Advantage professional, facility, and DME claims incurred prior to 12/31 of the year the contract ends As appropriate, pursue recoveries for any MPSERS Medicare Advantage professional, facility, and DME claims incurred prior to 12/31 of the year the contract ends as part of BCBSM's standard recovery process	12/31 of year contract ends
General Data/Reporting support Provide MPSERS with monthly and final year end standard cost and utilization file updated to include the claims runout of Medicare Advantage claims for services incurred during last year of contract Provide monthly and final claims and membership file to Thompson Reuters on behalf of MPSERS for their analysis	12 months after the contract ends
Retrospective Fraud, Waste and Abuse Include all MPSERS Medicare Advantage professional, facility, and DME claims in BCBSM's Medicare Advantage Corporate Financial Investigations standard data mining, investigation, and analysis processes Pursue recoveries for any MPSERS Medicare Advantage professional, facility, and DME claims incurred prior to 12/31 of the year the contract ends as part of BCBSM's standard recovery process	12/31 of year contract ends

Note: If MPSERS desires support in any of these areas beyond the "duration of support" date that is listed for each, BCBSM will agree to provide that support on a time and materials basis. BCBSM's hourly rate will be $75 while the rate to engage the external expert is $400 per hour.

Schedule D – Performance Guarantees/Service Level Agreements (SLAs)

The following replaces section 1.022 (M) in its entirety:

1.022 (M) Performance Guarantees/Service Level Agreements (SLAs)
Requirements:

Contractor must ensure that the SLAs are quantifiable, subject to the Plan Sponsor approval. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by Plan Sponsor employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§2.190).

Within 45 Days after the end of each calendar quarter, Contractor must provide Plan Sponsor with a report assessing the Contractor's performance under each SLA and provide payment for any applicable penalties to the Plan Sponsor.

The SLAs in this section are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are divided in two categories: Medicare and non-Medicare. Penalties will be assessed separately for Medicare and non-Medicare services and the Contractor must report on each separately. The maximum penalty that will be applied to the Contractor in any one year, regardless of the sum of the individual penalties in that year, for both Medicare and non-Medicare services combined, will not exceed 35% of the annual Administration Fee. Separate penalties will be assessed as a percentage of applicable monthly, quarterly, or annual Administration Fees as set forth in each SLA. Monthly Administration Fees is defined as the total Administration Fees paid by the Plan Sponsor to the Contractor for the month in which performance was assessed. Quarterly Administration Fees is defined as the total Administration Fees paid by the Plan Sponsor to the Contractor for the quarter in which performance was assessed. Annual Administration Fees is defined as the total Administration Fees paid by the Plan Sponsor to the Contractor for the year in which performance was assessed.

Administration Fees for Medicare Advantage Services is defined as the base Administration Fee.

The following SLAs are specific to Medicare Advantage Services:

SLA# 1
ID Cards
Guarantee
For new Contract Holders, 100% of ID Cards must be mailed by Contractor within 7 days of Contractor receiving eligibility record. ID Cards must have an accuracy rate of 99.0% or higher.
Penalty
The penalty for failure to meet the ID Card Timeliness SLA is 1.0% of the quarterly Administration fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard. The penalty for failure to meet the ID Card Accuracy SLA is 1.0% of the quarterly Administration Fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard.

SLA# 2
Timeliness of Member Enrollment Materials
Guarantee
99% of all Member enrollment materials must be mailed within three days of request. 100% of all Member enrollment materials must be mailed within 14 days of request.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee.

SLA# 3
Account Management - Satisfaction
Guarantee

SLA# 3
Plan Sponsor must complete an annual satisfaction survey using a mutually-agreed upon survey tool, to be completed in January respective to the preceding year. A 5-point scale will be utilized. Contractor's account management team must score at least 4.00. A score under 3.50 will result in an additional penalty.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to score at least 3.50 will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 4
Satisfaction Surveys
Guarantee
One random sample member survey must be completed annually on a Plan Sponsor specific basis. A minimum satisfaction rate of 85% responses of satisfied is required. Failure to reach a satisfaction rate of at least 80% will result in an additional penalty.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to reach a satisfaction rate of at least 80% will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 5
Customer Service Call – Average Speed of Answer
Guarantee
On a monthly basis, the calls must be answered an average of 30 seconds or less. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through February 28, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning March 1, 2011, the penalty for failure to meet this SLA is 1.5% of Contractor's total Administration fee for the quarter, plus 0.05% of its fee for each additional 5 seconds above the standard.

SLA # 6
Customer Service Response Time – Blockage Rate (Busy Signal)
Guarantee
The monthly blockage rate must not exceed 0.0%. Blockage is defined as a caller receiving a busy signal. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the Contractor's quarterly Administration Fee, plus 0.5% of the quarterly Administration Fee for each additional 0.1% above the standard.

SLA # 7
First Call Resolution
Guarantee
85% of calls must be resolved on the first call. Members following up on same issue within seven calendar days cannot be considered resolved. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty

SLA # 7
The penalty for failure to meet this SLA is waived through February 28, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning March 1, 2011, the penalty for failure to meet this SLA is 1.0% of Contractor's Administration Fee for the quarter, plus 0.5% of its fee for each additional 5.0% below the standard.

SLA #8
Customer Service Response Time to Written Inquiries
Guarantee
Contractor must resolve 95% of all Member inquiries within 14 Days of receipt; 98% of all Member inquiries must be resolved within 28 Days; and 100% of all Member inquiries must be resolved within 60 Days. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through February 28, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning March 1, 2011, the penalty for failure to meet this SLA is 1.0% of Contractor's administrative fee for the quarter.

SLA #9
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 3% (determined by the number of calls abandoned by the total number of calls). A call will be considered abandoned if the Member hangs up at any time after initiating a transfer out of the IVR. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through February 28, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning March 1, 2011, the penalty for failure to meet this SLA is 2% of Contractor's Administration fee for the quarter, plus 0.5% of its fee for each additional 1.0% above the standard. .

SLA #10
Timely Production of Management Reports
Guarantee
Pursuant to Section 1.042, Contractor must provide monthly and quarterly reports within 30 Days of the end of the month, 45 Days of the end of the quarter, and annual reports within 90 Days of the end of the Plan Year. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is waived through February 28, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning March 1, 2011, the penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee. The penalty for failure to meet the SLA for quarterly reports is 3.0% of Contractor's quarterly Administration Fee. The penalty for failure to meet the SLA for annual reports is 5.0% of Contractor's annual Administration Fee.

SLA #11
Timeliness of Data Transmission to Plan Sponsor's Data Vendor
Guarantee
Contractor must agree to deliver data files to Plan Sponsor's Data Vendor in agreed-upon format. Delivery of data files—with all required fields correctly populated—must be completed within 15 Days after the close of each month.

SLA #11

Penalty

The penalty for failure to meet this SLA is waived through March 14, 2011. Outstanding data files due under this SLA must be received by March 15, 2011. Failure to submit all outstanding data files by March 15, 2011 will result in retroactive penalties (to January 1, 2011).

The penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee.

SLA #12

Financial Accuracy Rate

Guarantee

Financial accuracy on claims processing (as defined as the sum of the absolute value of financial errors on claims processed divided by the total dollar volume of claims paid) must not fall below 99%.

Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.

Penalty

The penalty for failure to meet this SLA is 5.0% of Contractor's quarterly Administration Fee, plus an additional 1.0% of quarterly fee for each 0.5% below the standard.

SLA #13

Financial Error Rate

Guarantee

The financial error (as defined as the number of claims containing a financial error divided by the total number of claims) must not exceed 3%.

Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.

Penalty

The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee, plus 1.0% of the quarterly fee for each additional 1.0% below the standard.

SLA #14

Non-financial Error Rate

Guarantee

The non-financial error rate (as defined as the number of claims with a non-financial error divided by the total number of claims) must not exceed 3%.

Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.

Penalty

The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee, plus 0.5% of the quarterly fee for each additional 1.0% below the standard.

SLA #15
Average Claims Turnaround
Guarantee
The average time between when Claims have been received and processed must not exceed 10 calendar days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet t the Claims Turn-Around SLA is 1.5% of Contractor's Administration Fee for the quarter, plus 1.5% of the quarterly fee for each additional 3 days above the standard.

SLA #16
Case Management
Guarantee
Contractor must review 100% of all cases referred for Case Management and either accept or reject each case within 2 business days of receipt. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #17
Case Management-Care Plans
Guarantee
Contractor must provide all Case Management cases a documented care plan within 7 business days of acceptance of the case to the program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #18
Disease Management-Outreach
Guarantee
Contractor must be in contact with 100% of all Members deemed eligible for a Disease Management program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 8.34% of Contractor's annual Disease Management program fee. Failure to achieve at least 95% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee. Failure to achieve at least 90% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee.

SLA #19
Disease Management-Clinical Improvement
Guarantee

SLA #19
Unless otherwise approved by Plan Sponsor and Contractor annual work plan, Plan Sponsor and Contractor must agree to a series of process and utilization measures for each Disease Management program selected by the Plan Sponsor. Initial year baselines will be established using the experience of the Plan year prior to Contractor assuming responsibility for administering the Plan. Subsequent performance baselines will be established each year and will be based on the previous year's statistics. Levels of improvement standards will be mutually agreed upon by Plan Sponsor and Contractor. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet the standards as described in this SLA is 25.0% of Contractor's annual Disease Management program fee, with each measure assigned a proportionate share of the penalty.

SLA #20
Disease Management—Member Satisfaction
Guarantee
Plan Sponsor and Contractor must agree on the satisfaction survey to be sent to eligible Members in the Disease Management programs. Contractor must achieve a minimum of a 90% rating of "satisfied". Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 25.0% of Contractor's annual Disease Management program fee.

SLA #21
Disease Management—Return on Investment
Guarantee
Savings resultant from the Disease Management program(s) must be commensurate with the annual fees for the program(s) and must be quantifiable, using prior claims experience and the year-over-year cost increase levels of the non-enrolled population. Contractor and Plan Sponsor must agree to the methodology and a formula to gauge this SLA and Contractor is requested to propose such a formula for Plan Sponsor review and approval.
Penalty
The penalty for failure to meet this SLA, in accordance with the mutually agreed to methodology and formulas, is 25.0% of Contractor's annual Disease Management program fee.

SLA #22
Clinical Quality Improvement
Guarantee
Relevant Healthcare Effectiveness Data and Information Set (HEDIS) measures or other recognized quality indicators (as approved by Plan Sponsor) will be used to establish baselines. Contractor must measure and report its performance on this SLA on an annual basis. Contractor must also show improvement from the previous year in the following quality-of-care measures (or as otherwise directed by Plan Sponsor in annual Work Plan): Percent of diabetic Members with an annual retinal eye exam Percent of female Members receiving cervical cancer screening tests Percent of Members who have suffered a heart attack who receive beta-blockers Percent of Members receiving LDL Cholesterol screening tests Percent of female Members over the age of 40 receiving mammography screening Percent of hospital readmissions
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's annual Administration Fee for each measure for improvement that was not attained.

SLA #23
Quality Improvement Projects

SLA #23
Guarantee
During the third quarter of each Plan Year, the Contractor must develop three process improvement projects based on Plan performance evaluations reviewed during the previous quarters' management meetings. There projects will be reviewed and approved by the Plan Sponsor for implementation during the next Plan Year. Contractor will complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is 1.0% of the Contractor's annual Administration Fee for each project that has not been developed and approved for the next Plan Year and 2.0% of the Contractor's annual Administration Fee for each project not completed for the current Plan Year.

The following SLAs are specific to non-Medicare Advantage Services:

SLA# 1
ID Cards
Guarantee
For new Contract Holders, 100% of ID Cards must be mailed by Contractor within 7 days of Contractor receiving eligibility record. ID Cards must have an accuracy rate of 99.0% or higher.
Penalty
The penalty for failure to meet the ID Card Timeliness SLA is 1.0% of the quarterly Administration fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard. The penalty for failure to meet the ID Card Accuracy SLA is 1.0% of the quarterly Administration Fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard.

SLA# 2
Timeliness of Member Enrollment Materials
Guarantee
99% of all Member enrollment materials must be mailed within three days of request. 100% of all Member enrollment materials must be mailed within 14 days of request.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee.

SLA# 3
Account Management - Satisfaction
Guarantee
Plan Sponsor must complete an annual satisfaction survey using a mutually-agreed upon survey tool, to be completed in January respective to the preceding year. A 5-point scale will be utilized. Contractor's account management team must score at least 4.00. A score under 3.50 will result in an additional penalty.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to score at least 3.50 will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 4
Satisfaction Surveys
Guarantee
One random sample member survey must be completed annually on a Plan Sponsor specific basis. A minimum satisfaction rate of 85% responses of satisfied is required. Failure to reach a satisfaction rate of at least 80% will result in an additional penalty.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to reach a satisfaction rate of at least 80% will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 5
Customer Service Call – Average Speed of Answer
Guarantee
On a monthly basis, the calls must be answered an average of 30 seconds or less. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through January 31, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning February 1, 2011, the penalty for failure to meet this SLA is 1.5% of Contractor's total Administration fee for the quarter, plus 0.05% of its fee for each additional 5 seconds above the standard.

SLA # 6
Customer Service Response Time – Blockage Rate (Busy Signal)
Guarantee
The monthly blockage rate must not exceed 0.0%. Blockage is defined as a caller receiving a busy signal. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of the Contractor's quarterly Administration Fee, plus 0.5% of the quarterly Administration Fee for each additional 0.1% above the standard.

SLA # 7
First Call Resolution
Guarantee
85% of calls must be resolved on the first call. Members following up on same issue within seven calendar days cannot be considered resolved. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through January 31, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning February 1, 2011, the penalty for failure to meet this SLA is 1.0% of Contractor's Administration Fee for the quarter, plus 0.5% of its fee for each additional 5.0% below the standard.

SLA # 7

SLA #8
Customer Service Response Time to Written Inquiries
Guarantee
Contractor must resolve 95% of all Member inquiries within 14 Days of receipt; 98% of all Member inquiries must be resolved within 28 Days; and 100% of all Member inquiries must be resolved within 60 Days. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through January 31, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning February 1, 2011, the penalty for failure to meet this SLA is 1.0% of Contractor's administrative fee for the quarter.

SLA #9
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 3% (determined by the number of calls abandoned by the total number of calls). A call will be considered abandoned if the Member hangs up at any time after initiating a transfer out of the IVR. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is waived through January 31, 2011. The Contractor will provide monthly measurements to MPSERS during this time period and will make good faith effort to maintain a high level of service during this time period. Beginning February 1, 2011, the penalty for failure to meet this SLA is 2% of Contractor's Administration fee for the quarter, plus 0.5% of its fee for each additional 1.0% above the standard. .

SLA #10
Timely Production of Management Reports
Guarantee
Pursuant to Section 1.042, Contractor must provide monthly and quarterly reports within 30 Days of the end of the month, 45 Days of the end of the quarter, and annual reports within 90 Days of the end of the Plan Year. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee. The penalty for failure to meet the SLA for quarterly reports is 3.0% of Contractor's quarterly Administration Fee. The penalty for failure to meet the SLA for annual reports is 5.0% of Contractor's annual Administration Fee.

SLA #11
Timeliness of Data Transmission to Plan Sponsor's Data Vendor
Guarantee
Contractor must agree to deliver data files to Plan Sponsor's Data Vendor in agreed-upon format. Delivery of data files—with all required fields correctly populated—must be completed within 15 Days after the close of each month.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee.

SLA #11

SLA #12
Financial Accuracy Rate
Guarantee
Financial accuracy on claims processing (as defined as the sum of the absolute value of financial errors on claims processed divided by the total dollar volume of claims paid) must not fall below 99%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 5.0% of Contractor's quarterly Administration Fee, plus an additional 1.0% of quarterly fee for each 0.5% below the standard.

SLA #13
Financial Error Rate
Guarantee
The financial error (as defined as the number of claims containing a financial error divided by the total number of claims) must not exceed 3%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee, plus 1.0% of the quarterly fee for each additional 1.0% below the standard.

SLA #14
Non-financial Error Rate
Guarantee
The non-financial error rate (as defined as the number of claims with a non-financial error divided by the total number of claims) must not exceed 3%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee, plus 0.5% of the quarterly fee for each additional 1.0% below the standard.

SLA #15
Average Claims Turnaround
Guarantee
The average time between when Claims have been received and processed must not exceed 10 calendar days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet t the Claims Turn-Around SLA is 1.5% of Contractor's Administration Fee for the quarter, plus 1.5% of the quarterly fee for each additional 3 days above the standard.

SLA #16
Case Management
Guarantee
Contractor must review 100% of all cases referred for Case Management and either accept or reject each case within 2 business days of receipt. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #17
Case Management-Care Plans
Guarantee
Contractor must provide all Case Management cases a documented care plan within 7 business days of acceptance of the case to the program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #18
Disease Management-Outreach
Guarantee
Contractor must be in contact with 100% of all Members deemed eligible for a Disease Management program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 8.34% of Contractor's annual Disease Management program fee. Failure to achieve at least 95% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee. Failure to achieve at least 90% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee.

SLA #19
Disease Management-Clinical Improvement
Guarantee
Unless otherwise approved by Plan Sponsor and Contractor annual work plan, Plan Sponsor and Contractor must agree to a series of process and utilization measures for each Disease Management program selected by the Plan Sponsor. Initial year baselines will be established using the experience of the Plan year prior to Contractor assuming responsibility for administering the Plan. Subsequent performance baselines will be established each year and will be based on the previous year's statistics. Levels of improvement standards will be mutually agreed upon by Plan Sponsor and Contractor. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty

SLA #19
The penalty for failure to meet the standards as described in this SLA is 25.0% of Contractor's annual Disease Management program fee, with each measure assigned a proportionate share of the penalty.

SLA #20
Disease Management—Member Satisfaction
Guarantee
Plan Sponsor and Contractor must agree on the satisfaction survey to be sent to eligible Members in the Disease Management programs. Contractor must achieve a minimum of a 90% rating of "satisfied". Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 25.0% of Contractor's annual Disease Management program fee.

SLA #21
Disease Management—Return on Investment
Guarantee
Savings resultant from the Disease Management program(s) must be commensurate with the annual fees for the program(s) and must be quantifiable, using prior claims experience and the year-over-year cost increase levels of the non-enrolled population. Contractor and Plan Sponsor must agree to the methodology and a formula to gauge this SLA and Contractor is requested to propose such a formula for Plan Sponsor review and approval.
Penalty
The penalty for failure to meet this SLA, in accordance with the mutually agreed to methodology and formulas, is 25.0% of Contractor's annual Disease Management program fee.

SLA #22
Clinical Quality Improvement
Guarantee
Relevant Healthcare Effectiveness Data and Information Set (HEDIS) measures or other recognized quality indicators (as approved by Plan Sponsor) will be used to establish baselines. Contractor must measure and report its performance on this SLA on an annual basis. Contractor must also show improvement from the previous year in the following quality-of-care measures (or as otherwise directed by Plan Sponsor in annual Work Plan): Percent of diabetic Members with an annual retinal eye exam Percent of female Members receiving cervical cancer screening tests Percent of Members who have suffered a heart attack who receive beta-blockers Percent of Members receiving LDL Cholesterol screening tests Percent of female Members over the age of 40 receiving mammography screening Percent of hospital readmissions
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's annual Administration Fee for each measure for improvement that was not attained.

SLA #23
Quality Improvement Projects
Guarantee
During the third quarter of each Plan Year, the Contractor must develop three process improvement projects based on Plan performance evaluations reviewed during the previous quarters' management meetings. There projects will be reviewed and approved by the Plan Sponsor for implementation during the next Plan Year. Contractor will complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty

SLA #23
The penalty for failure to meet this SLA is 1.0% of the Contractor's annual Administration Fee for each project that has not been developed and approved for the next Plan Year and 2.0% of the Contractor's annual Administration Fee for each project not completed for the current Plan Year.

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 4, 2010**
PROCUREMENT & REAL ESTATE SERVICES ADMINISTRATION
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 2
TO
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE Patricia Soyemi **313-225-9000 or 448-6943**
Blue Cross Blue Shield of Michigan **600 Lafayette East** **Detroit, MI 48226** **psoyemi@bcbsm.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**

Contract Compliance Inspector: Brian McLane (517) 322-1926 mclaneb@michigan.gov

Administration Services for MPSERS Post-Employment Health Insurance
(hospital and medical services only)
for Department of Technology, Management and Budget / Office of Retirement Services

CONTRACT PERIOD: **3 yrs + 2 two-year options**	From: **January 1, 2010**	To: **December 31, 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 ALL LOCAL UNITS OF GOVERNMENT.

NATURE OF CHANGE(S):

The attached pricing document (Attachment A) is hereby incorporated into this contract

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

AUTHORITY/REASON: DTMB/Procurement & Real Estate Services Administration approval.

ESTIMATED CONRACT VALUE REMAINS: $1,900,000,000.00

Attachment A
Price Quotation

The contract will be for a 3-year period with service commencing January 1, 2010 and ending December 31, 2012. Firm prices are to be quoted for each of the 3 years. The price quoted each year must be firm for the period January 1 of that year through December 31 of that year. Prices are to be quoted on a flat monthly fee for all services specified by this contract. Fees must be presented at a uniform Individual Fee and a separate Dependent Unit Fee.

Pricing should be provided for each product, Non-Medicare PPO Plan, Medicare Advantage Plan, Medicare Supplemental Plan. Basic services should be included as a whole and optional services should be specified separately.

Per Month Administration Fee 2010

Non-Medicare PPO	Individual Fee	Dependent Unit Fee
Basic Services	$28.00	$40.00
Optional – Disease Management	$1.72	N/A
Optional – Nurse Line	$.13	N/A
Optional – Wellness Programs	$.91	N/A
Optional – Quit the Nic	$.07	N/A
Total	$30.83	$40.00

Medicare Advantage **PPO**	Individual Fee	Dependent Unit Fee
Basic Services	$58.67	$58.67
Optional – Disease Management	Included in Basic	
Optional – Nurse Line	Included in Basic	
Optional – Wellness Programs	Included in Basic	
Optional – Please Specify		
Total	$58.67	$58.67

Medicare Supplemental	Individual Fee	Dependent Unit Fee
Basic Services	$**12.75**	$40.00
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Total	$**12.75**	$40.00

Attachment A
Price Quotation

Per Month Administration Fee 2011

Non-Medicare PPO	Individual Fee	Dependent Unit Fee
Basic Services	$28.00	$40.00
Optional – Disease Management	$1.72	N/A
Optional – Nurse Line	$.13	N/A
Optional – Wellness Programs	$.91	N/A
Optional – Quit the Nic	$.07	N/A
Total	$30.83	$40.00

Medicare Advantage **PPO**	Individual Fee	Dependent Unit Fee
Basic Services	$58.67	$58.67
Optional – Disease Management	Included in Basic	
Optional – Nurse Line	Included in Basic	
Optional – Wellness Programs	Included in Basic	
Optional – Please Specify		
Total	$58.67	$58.67

Medicare Supplemental	Individual Fee	Dependent Unit Fee
Basic Services	$**12.75**	$40.00
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Total	$**12.75**	$40.00

Attachment A
Price Quotation

Per Month Administration Fee 2012

Non-Medicare PPO	Individual Fee	Dependent Unit Fee
Basic Services	$28.00	$40.00
Optional – Disease Management	$1.72	N/A
Optional – Nurse Line	$.13	N/A
Optional – Wellness Programs	$.91	N/A
Optional – Please Specify	$.07	N/A
Total	$30.83	$40.00

Medicare Advantage	Individual Fee	Dependent Unit Fee
Basic Services	$58.67	$58.67
Optional – Disease Management	Included in Basic	
Optional – Nurse Line	Included in Basic	
Optional – Wellness Programs	Included in Basic	
Optional – Please Specify		
Total	$58.67	$58.67

Medicare Supplemental	Individual Fee	Dependent Unit Fee
Basic Services	$**12.75**	$40.00
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Optional – Please Specify		
Total	$**12.75**	$40.00

Pricing assumptions used in developing the Individual Fee and Dependent Unit Fee are as described in the State's answers to clarifications and questions in Addendum #1. For a family of 5 (a retiree, a spouse, and 3 children), the retiree is assessed at an individual fee, the spouse is assessed at an individual fee, the 3 children are assessed at one dependent unit rate. All children in a single family are covered in the Dependent Unit Rate.

Please see our guarantees that are described on the following pages.

Non Medicare PPO: Provider Discount Guarantee

ORS Discount Guarantee
Non-Medicare PPO Michigan Enrollee Population
For the Period January 1, 2010 to December 31, 2010
In and Out-of-Network Medical Claims Experience

BCBSM agrees to the following Discount (Estimated Aggregate Provider Savings) Guarantee based on the Claims and Estimated Aggregate Provider Savings Report for non-Medicare PPO Michigan enrollees:

A. Estimated Percent of Provider Savings Less than 48%

BCBSM will put at risk a portion of administrative fee collected over the January 1, 2010 to December 31, 2010 period. If the estimated percent of provider savings on Michigan hospital and physician claims

for MPSERS Members (excluding any Medicare claims) is less than 48.0 percent, then BCBSM will refund a portion of the at-risk administrative fee to the ORS. The amount of at-risk administrative fee refunded will be based on the following table:

Discount Range	Annual Amount of At Risk BCBSM Administrative Fee Refunded
Less than 42.0% - 43.9%	$1,500,000
Less than 44.0% - 45.9%	$1,000,000
Less than 46.0% - 47.9%	$500,000
48.0% or greater	None

B. Estimated Percent of Provider Savings Greater than 48.0%

If the estimated percent of provider savings on Michigan hospital and physician claims for MPSERS Members (excluding any Medicare claim) is greater than or equal to 48.0 percent, then BCBSM will refund no administrative fee to the ORS.

Note: The following claims are excluded from the calculations: Claims for which the MPSERS pays secondary to government programs; claims incurred outside of the United States; extra-contractual claim payments; claims in dispute; claims from non contracted providers.

BCBSM's Claims and Estimated Aggregate Provider Savings are based on claims reported by plans for claims incurred between January 1, 2010 and December 31, 2010, and paid through June 30, 2011. The reported average Percent of Estimated Provider Savings for the period may be less or more than the final, settled par plan liability to their providers because of timing issues, subsequent adjustments, amounts retained by par plans as additional administrative compensation, and other factors. The results will be calculated after June 30, 2011.

The discount guarantee is based on the present exposure count and distribution of MPSERS enrollment within Michigan. BCBSM reserves the right to recalculate the above target ranges (i.e. 48.0%) if the average non-Medicare Michigan employee count between January 1, 2010 and December 31, 2010 exceeds 30,000 or goes below 25,000 employees. This guarantee does not apply to non-contracted providers.

If this discount guarantee is accepted for the January 1, 2010 to December 31, 2010 plan year, we will re-evaluate the discounts and issue a new agreement for subsequent years to follow.

Non Medicare PPO: Care Management Programs in and outside the admin fee
Care Management programs included in the administrative fees shown on page 1

- Online Health Solution – included in Basic Services (Online Health Assessment; assess to Online Digital Portal; Online Digital Coaching Modules)
- Case Management – included in Basic Services
- Nurse Line – Optional service; **not** included in Basic Services fee
- Disease Management (Max Net Savings) & elective surgery counseling – Optional service; **not** included in Basic Services
- Wellness Programs - Telephonic Wellness Coaching – Optional service; **not** included in Basic Service
- Quit the Nic – Optional service; **not** included in Basic Service

Attachment A
Price Quotation

Our proposal contains the following enhancements beyond what we currently provide the ORS. These programs are **not** included in the administrative fees proposed and would come at an additional cost if desired:

- Disease Management and elective surgery counseling at a tailored level of outreach (Max Net Savings - targeting approximately 38% of members identified with a chronic condition and 15% identified for elective surgery counseling through predictive modeling)
- Telephonic Wellness Coaching – new component for highest risk members with a lifestyle score equivalent to 5+ risk factors (10% of those that took the HA)

These enhancements build on the comprehensive care management programs we already deliver to the ORS and are tailored to the unique characteristics of an older population. The ORS' non-Medicare populations' overall prevalence of chronic conditions rate of 25% is significantly higher, compared with our comparison group average of 10%. The enhancements offer a higher dose of disease management programs to address the needs of such a population.

This optimal savings maximizing level of outreach for Disease Management was developed for the ORS using our innovative solution analytic model. The model uses a set of assumptions about a group's population characteristics, outreach and intervention effectiveness, and care management operational cost structure to estimate the magnitude of benefits and costs of delivering a specific solution.

In our **Disease Management** program, members with chronic conditions are identified using claims data, data mining, predictive modeling, and stratified for telephonic outreach. Member coaching follows a whole person approach by coaches who are specially trained health care professionals. Our nurse coaches assess readiness to change, use motivational interviewing and counseling to help members build on their commitment to change behavior.

Our new **Online Health Solution** includes an Online Digital Portal, Online Health Assessment and Online Digital Coaching Modules. The Online Health Assessment is the primary tool used by BCBSM to provide the member with a critical look at their health status and allowing group customers to prioritize based on top risk factors and approach population health management strategically.

Based on the information provided in their Health Assessment, Members will be invited to join the online wellness program and provided with tailored messaging and a variety of tools including:

- lifestyle score
- comprehensive tailored plan for improving health & wellness (includes Digital Coaching Modules)
- personalized Health Dashboard filled with relevant content and news (newsletters and online libraries)

Since our innovative online health solution uses demographics and intelligent recruitment to tailor digital images and messaging, personalized content produced will be relevant to a more mature population, keeping Members engaged and focused on realizing their goals.

Telephonic Wellness Coaching complements the online health coaching interventions. The solution proposed to the ORS includes a "low dose" of telephonic wellness coaching tailored towards highest risk members with a lifestyle score equivalent to 5+ risk factors. Health coaching programs have shown to be an effective strategy in reducing risk factors that lead to chronic conditions. They have demonstrated the ability to enhance self-management of chronic conditions and address multiple behaviors and health risks. Toward that end, BCBSM developed this health coaching initiative that utilizes the results of the health assessment to identify members and proactively outreaches to them.

Through the **Nurse Line** all members have 24/7 access to registered nurse advocates that provide:

- single point of access to any program component

- follow up call on emergency recommendations
- symptom management coaching
- health and wellness information
- online tools guidance
- depression screening
- health education materials
- special programs information

Case Management addresses more complex needs. Referrals come form a variety of sources:

- Hospital (Pre-Notification and Pre-Authorization)
- External (Members, Family)
- Internal (Chronic Condition Management and 24/7 Nurse Line)
- Claims Based Predictive Model

The program offers scenario based targeted interventions including:

- Discharge planning
- ER Use Management
- Inpatient Hospital Use Management (multiple admissions)
- Pharmacy Management (multiple prescription drugs)
- Oncology Care Management

Enrolled Members are assigned a personal nurse case manager that develops an individual treatment plan. As Members receive medical services, the nurse case manager:

- educates the Member about the condition and disease process
- reviews health care needs and treatment options
- assists with coordination of health care services
- keeps in contact with the Member about progress between physician visits

Quit the Nic is a telephone-based program that addresses all forms of nicotine addiction including cigarettes, cigars and chewing or spit tobacco. It is a Member–driven program where Members call to enroll. During the first call, the nurse coach will discuss the Member's readiness to quit using tobacco and set an action plan. Members enrolled in the program will receive education information including:

- Set Yourself Free – pamphlet from the American Cancer Society
- Coping Pack – booklet containing coping responses and methods of dealing with the urge to use tobacco
- Calendar – a 60-day calendar for Member to track progress

The program includes a series of follow-up calls during which the nurse guides the Member through a series of topics to help the Member quit. During these counseling sessions the nurse will also discuss relapse prevention strategies.

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

July 8, 2010

CHANGE NOTICE NO. 1
TO
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE Patricia Soyemi **313-225-9000 or 448-6943**
Blue Cross Blue Shield of Michigan **600 Lafayette East** **Detroit, MI 48226** **psoyemi@bcbsm.com**	BUYER/CA (517) 241-3768 **Lance Kingsbury**

Contract Compliance Inspector: Brian McLane (517) 322-1926 mclaneb@michigan.gov

Administration Services for MPSERS Post-Employment Health Insurance
(hospital and medical services only)
for Department of Technology, Management and Budget / Office of Retirement Services

CONTRACT PERIOD: **3 yrs + 2 two-year options**	From: **January 1, 2010**	To: **December 31, 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.

NATURE OF CHANGE(S):

Effective immediately, the buyer, Contract Administrator in Section 2.021, and Notices in Section 2.025 are hereby changed to:

Lance Kingsbury
Phone: 517-241-3768
Email: kingsburyl@michigan.gov

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

Contract Section Heading 2.280 Extended Purchasing is added back into the Contract.

The following new section is hereby added to the Contract:

Section 2.281 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.

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: **$11,400,000.00**

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 **December 15, 2009**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

NOTICE
TO
CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **Blue Cross Blue Shield of Michigan** **600 Lafayette East** **Detroit, MI 48226** **psoyemi@bcbsm.com**	TELEPHONE Patricia Soyemi **(313) 225-9000 or 448-6943** BUYER/CA (517) 373-8622 **Malynda S. Little, CPPB**
Contract Compliance Inspector: Brian McLane (517) 322-1926 mclaneb@michigan.gov **Administration Services for Post-Employment Health Insurance (hospital and medical services only) for Michigan Public School Employees Retirement System (MPSERS) – Department of Management and Budget – Office of Retirement Services**	
CONTRACT PERIOD: **3 yrs. + 2 two-year options** From: **January 1, 2010** To: **December 31, 2012**	
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 based on RFP#071I9200205, this Contract Agreement and the vendor's quote dated 06/29/2009. ALL CONTRACT TERMS AND CONDITIONS ARE STATED WITHIN THIS AGREEMENT.

In the event of any conflicts between the specifications, and terms and conditions, as indicated by the State and those indicated by the vendor, those of the State take precedence. Orders for delivery may be issued directly by the Department of Management and Budget's (DMB) Office of Retirement Services (ORS), through the issuance of a Purchase Order Form.

Current Authorized Spend Limit: $1,900,000,000.00

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

CONTRACT NO. 071B0200075
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE Patricia Soyemi **(313) 225-9000 or 448-6943**
Blue Cross Blue Shield of Michigan **600 Lafayette East** **Detroit, MI 48226** **psoyemi@bcbsm.com**	BUYER/CA (517) 373-8622 **Malynda S. Little, CPPB**

Contract Compliance Inspector: Brian McLane (517) 322-1926 mclaneb@michigan.gov

Administration Services for Post-Employment Health Insurance (hospital and medical services only) for Michigan Public School Employees Retirement System (MPSERS) – Department of Management and Budget – Office of Retirement Services

CONTRACT PERIOD: **3 yrs. + 2 two-year options** From: **January 1, 2010** To: **December 31, 2012**

TERMS	SHIPMENT
N/A	**N/A**
F.O.B.	SHIPPED FROM
N/A	**N/A**

MINIMUM DELIVERY REQUIREMENTS
N/A

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are based on RFP#071I9200205, this Contract Agreement and the vendor's quote dated 06/29/2009. ALL CONTRACT TERMS AND CONDITIONS ARE STATED WITHIN THIS AGREEMENT.

In the event of any conflicts between the specifications, and terms and conditions, as indicated by the State and those indicated by the vendor, those of the State take precedence. Orders for delivery may be issued directly by the Department of Management and Budget's (DMB) Office of Retirement Services (ORS), through the issuance of a Purchase Order Form.

Current Authorized Spend Limit: $1,900,000,000.00

FOR THE CONTRACTOR:	**FOR THE STATE:**
Blue Cross Blue Shield of Michigan	
Firm Name	Signature
	Sergio Paneque, Director
Authorized Agent Signature	Name/Title
Kenneth R. Dallafor, Senior Vice President	**Business Services Administration**
Authorized Agent (Print or Type)	Division
Date	Date

Table of Contents

DEFINITIONS

24x7x365 means 24 hours a day, seven days a week, and 365 days a year (including the 366th day in a leap year).

Additional Service means any Services within the scope of the Contract, but not specifically provided under any Statement of Work.

Administration Fee means the agreed upon amount that will be paid to the Contractor by the Plan Sponsor for administration of the Plan.

A.M. Best Company means a credit rating organization serving the financial services industries, including the banking and insurance sectors.

A.M. Best Financial Strength Rating means an independent opinion, based on a comprehensive quantitative and qualitative evaluation, of a company's balance sheet strength, operating performance and business profile, as determined by A.M. Best Company.

Audit Period means the seven year period following Contractor's provision of any work under the Contract.

Average Speed of Answer (ASA) means the average time elapsed between when a caller elects to speak to a customer service representative and when the call is connected to a customer service representative.

Benefit Guide means the publication that the Member receives which is developed and issued by the Contractor.

Business Associate means a person assisting a Covered Entity in connection with its payment, treatment or health care operations, as more fully defined in 45 CFR §160.103.

Business Day (whether capitalized or not) must mean any day other than a Saturday, Sunday or State-recognized legal holiday from 8:00am EST through 5:00pm EST unless otherwise stated.

Blanket Purchase Order is an alternate term for Contract and is used in the Plan Sponsor's computer system.

Case Management means a Medical Management program that identifies potentially high cost cases and provides a nurse manager to the Member and his/her provider to identify cost effective treatment alternatives.

Center for Medicare and Medicaid Services (CMS) means the federal agency that administers and oversees the Medicare and Medicaid programs

Center of Excellence means a provider that is nationally recognized, through reported outcomes measures, for diagnosing and/or treating specific medical conditions (e.g. organ transplants, cardiac care) that the Contractor has credentialed as a premier provider for addressing that particular medical or surgical condition.

Claim means a submission for payment of a service.

Claims Processing means the procedures that the Contractor uses to review a Claim for Member eligibility, coverage determination, provider payment and Member obligation.

Coinsurance means that portion of the charge for Covered Services, calculated as a percentage of the charge, which is to be paid by Members pursuant to the Plan Sponsor's Plan Design.

Coinsurance Maximum means the maximum amount of coinsurance expenses that a Member is required to pay in a Plan Year.

Coordination of Benefits (COB) means claims administration when Members are covered by more than one hospital or medical plan.

Contract Holder means a Retirant, pension beneficiary, or COBRA participant who satisfies all of the eligibility criteria necessary to receive hospital/medical coverage through the Plan Sponsor.

Contractor means the organization selected to administer the non-Medicare PPO and/or the Medicare Advantage Plan and/or Medicare Supplemental Plan elements of the Plan.

Copayment means a fixed dollar portion of the charge for Covered Services which must be paid by Members pursuant to the Plan Design.

Covered Entity means a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. See Part II, 45 CFR 160.103.

Covered Products means the ancillary medical devices, supplies and prescription pharmaceuticals that are covered pursuant to the Plan Sponsor's Plan Design.

Covered Services means the medical services covered under the Plan Sponsor's Plan Design.

Customer Assistance or **Customer Service** means a web based and/or telephonic system by which Members can make inquiries about the Plan and the Contractor can answer or resolve them.

Days mean calendar days unless otherwise specified.

Deductible means a predetermined amount of money that a Member must pay before coverages are eligible for payment as stated in the Plan Sponsor's Plan Design.

Dental Plan means a plan that covers services provided in dentists' offices to sound natural teeth.

Deliverable means physical goods and/or services required or identified in a Statement of Work.

Dependent means an individual who satisfies, through a Contract Holder, all of the eligibility criteria necessary to receive hospital and medical coverages under the Plan Sponsor's Plan and is identified by the Plan Sponsor to the Contractor.

Dependent Unit Rate means an administrative fee for all Dependents, other than a spouse, as a combined unit.

Disease Management means a system of coordinated health care interventions and communications for populations with specific medical conditions, usually of a chronic nature.

Disruption Analysis means the identification of members who are obtaining their medical care from Providers that are not participating in the new Contactor's Provider Network and any proposed remediation to mitigate the disruption.

DMB means the Michigan Department of Management and Budget.

DME means Durable Medical Equipment.

DUR means Drug Utilization Review.

Eligible Claim means a submission for payment of a service that is covered by the Plan, pursuant to the Plan Design.

Eligibility means the status of an individual with respect to their coverage under the Plan.

Eligibility System means the database maintained by the Contractor that contains information on the effective dates of coverage for all Members that can be accessed by authorized individuals.

Enrollee Communications Meetings means meetings held jointly by the Plan Sponsor and the Contractor at locations throughout Michigan and at out-of-state locations to inform Members on Plan issues and to answer Member questions.

Evidence-based Practice means an approach to medical treatment that is consistent with current accepted clinical practice based on peer-reviewed research. Also referred to in the health care industry as Evidence-based Medicine or Evidence-based Healthcare.

Explanation of Benefits (EOB) means written statement sent to a Member, from the Contractor, after a claim has been reported, indicating the benefits and charges covered or not covered by the Plan.

FDA means the United States Food and Drug Administration.

Fee Schedule means the list of the charges established or agreed to by Network Providers and the Contractor for specific medical devices or services.

Formulary means the list of FDA-approved Covered Products developed by the Pharmacy and Therapeutics Committee of the Plan Sponsor's designated PBM, subject to the Plan Sponsor's Plan Design and coverage decisions.

Health Maintenance Organization (HMO) means a type of managed care organization (MCO) that provides a form of health care coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Identification Card means the card produced by the Contractor that documents the Member's coverage under the Plan

Individual Fee means an administrative fee for the Contract Holder and/or their spouse.

Incident means any interruption in any function performed for the benefit of the Plan Sponsor.

Key Personnel means any Personnel identified in **Section 1.031** as Key Personnel; also see Section 2.062.

Lifetime Maximum means the dollar limit the Plan is obligated to pay for any Member during the time the Member is eligible for coverage.

Medical Home means patient-centered care coordinated by primary care physicians requiring a high degree of personalized care coordination, access beyond the acute care episode, and identification of key medical and community resources to meet the patients' needs.

Medical Management means a program by which services prescribed by a Provider are subject to review by the Contractor to determine the Medical Necessity of the services and to ensure that the services are delivered in the most appropriate setting.

Medical Necessity means any health care service or procedure that a prudent practitioner would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (1) in accordance with generally accepted standards of care, (2) clinically appropriate in terms of type, frequency, extent, site and duration, (3) not primarily for the convenience of the patient or the practitioner, and (4) within the scope of practice of the practitioner.

Medical Policy means guidelines for determining coverage criteria for specific medical technologies, including procedures, equipment, and services.

Medicare Advantage (MA) Plan means any plan which is available to Medicare beneficiaries and that is operated by an entity that has been approved by CMS

Medicare Supplemental Plan means a health coverage plan that provides payment for services, in addition to what Medicare pays, after Medicare has made its payment.

Member means each Contract Holder and eligible Dependent.

Member Materials means those materials published by the Contractor for distribution to Members.

MPSERS means the Michigan Public School Employees Retirement System.

Network Provider means a Provider who has an agreement with the Contractor to provide services to Members.

New Work means any Services/Deliverables outside the scope of the Contract and not specifically provided under any Statement of Work, such that once added will result in the need to provide the Contractor with additional consideration. "New Work" does not include Additional Service.

Nurse Line means a program whereby Members have telephonic access to a registered nurse or other qualified clinical resource who answers questions about health care-related issues.

ORS means Office of Retirement Services.

Out-of-Pocket means Deductibles, Copayments and Coinsurance (i.e. expenses that the Plan does not cover) that the Member is required to pay for health care services and products.

Pass-Through Pricing means that all charges to the Plan are equal to the Contractor's payments to Providers without any additional charges that have not been explicitly disclosed to the Plan Sponsor.

Pharmacy and Therapeutics Committee (P & T Committee) means the group within the PBM that is responsible for developing, managing, updating and administering a formulary.

Pharmacy Benefits Manager (PBM) means a third party administrator of prescription pharmaceutical programs that has been assigned a Business Identification Number (BIN) by The National Council for Prescription Drug Programs, Inc (NCPDP).

Plan means the Plan Sponsor's program which provides hospital and medical coverage to Members.

Plan Design means a description of the Plan Sponsor's Plan related to medical coverages and limitations thereto, including the framework of policies, interpretations, rules, practices and procedures applicable to such coverages, required and signed by the Plan Sponsor and submitted to Contractor.

Plan Sponsor means the Office of Retirement Services.

Plan Year means a calendar year, from January 1st through December 31st.

Practitioner means a licensed physician or other licensed health care provider authorized to provide health care services.

Preferred Provider Organization (PPO) means a network of providers under contract with the Contractor to provide healthcare services to Members.

Prescription Drug Plan (PDP) means the stand-alone Medicare Part D Prescription drug coverage provided for Medicare recipients.

Prior Authorization (PA) means an advance verification or confirmation that certain criteria required by the Plan Sponsor are satisfied for specific Covered Services and Products before processing the Claim for Covered Services or Products.

Private Fee for Service (PFFS) means a Medicare Advantage Plan that does not restrict the use of providers, other than mandating participation in Medicare.

Protected Health Information (PHI) means individually identifiable health information related to the past, present, or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present or future payment for the provision of health care to a Member, as more fully defined in 45 CFR §164.501 or otherwise considered confidential under federal or state law.

Provider means a health care professional or a health care facility that provides medical services to Members.

Provider Discount means the difference between what a Network Provider charges for Covered Services or Covered Products and the contractual amount that the Contractor is obligated to pay for those services or products.

Provider Network means that set of Providers with which the Contractor has contracted to provide services to Members.

Quality Management means a program, implemented and overseen by the Contractor, that works both internally and with Network Providers to improve the quality of services and medical care provided to Members.

Retirant means a member who retires with a retirement allowance payable from reserves of the retirement system**.** The Public School Employees Retirement Act. MCL 38.1307(4).

Revenue Management Program means the process of ensuring that all appropriate risk scores are obtained for Medicare Advantage Members and the corresponding CMS revenue is received by the Plan Sponsor.

RFP means a Request for Proposal used to solicit proposals for services.

S & P means Standard and Poor's credit rating agency.

SAS-70 means is an auditing standard developed by the American Institute of Certified Public Accountants (AICPA).

Self-Insured means that the Plan Sponsor has financial responsibility for providing the funds used to pay Eligible Claims.

Services means any function performed for the Plan Sponsor as required in the Statement of Work.

Solicitation Materials means materials produced by the Contractor that describe the Plan to Members or eligible individuals.

Specialty Drugs means those biotech and pharmaceuticals identified as specialty drugs from time from time by the Plan Sponsor's designated PBM.

Specialty Pharmacy means a pharmacy that has entered into an agreement to dispense Specialty Drugs to Members.

State Location means any physical location where the Plan Sponsor performs work. State Location may include state-owned, leased, or rented space.

Subcontractor means a company selected by the Contractor who is chosen to perform a portion of the Services, but does not include independent contractors engaged by Contractor solely in a staff augmentation role.

Third Party Administrator (TPA) means an entity who processes Claims pursuant to a service contract and who may also provide one or more other administrative services pursuant to a service contract, other than under a worker's compensation self-insurance program pursuant to section 611 of the Worker's Disability Compensation Act of 1969, 1969 PA 317, MCL 418.611. Third Party Administrator does not include a carrier or employer sponsoring a plan.

Transparency means the full disclosure by the Contractor as to all of its sources of revenue to the Plan Sponsor (and its agents), as well as complete and full access to all information necessary to determine and verify that the Contractor has met all terms of this Contract.

Unauthorized Removal means the removal of Key Personnel without the prior written consent of the Plan Sponsor.

Utilization Management means the evaluation of the appropriateness and Medical Necessity of health care services procedures and facilities according to established criteria or guidelines and under the provisions of the Plan.

Vision Plan means a plan to provide for vision screening, eye glasses and contact lenses.

Work in Progress means a Deliverable that has been partially prepared, but has not been presented to the Plan Sponsor for Approval.

Work Product means any data compilations, reports, and other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of, and in furtherance of, performing the services required by this Contract.

Article 1 – Statement of Work (SOW)

1.010 Project Identification

1.011 Project Request

This is a CONTRACT AGREEMENT BETWEEN THE STATE OF MICHIGAN AND BLUE CROSS BLUE SHIELD OF MICHIGAN to provide administration of post-employment health coverage (hospital and medical services only) for the eligible Retirants, beneficiaries, COBRA participants, and their Dependents of the Michigan Public School Employees Retirement System (MPSERS), administered by the Office of Retirement Systems (ORS). The current plan is Self-Insured.

The Plan Sponsor may, for its Medicare-eligible Members, implement either a Medicare Advantage Plan or a Medicare Supplemental Plan or switch from one to the other depending on the financial benefits. It should be noted that some Members are not eligible for the Medicare Advantage Plan and therefore are enrolled in the Medicare Supplemental Plan.

No payment will be made to the Contractor during the implementation period. The implementation period begins with contract start date through the date that services must be provided to members. With a contract begin date of January 1, 2010; Contractor must begin providing all services to all Members under this contract, without interruption, effective January 1, 2010.

1.012 Background

ORS administers the MPSERS Plan which provides post-employment health coverage to non-Medicare eligible and Medicare eligible Retirants, beneficiaries and their Dependents enrolled in the health plan. MPSERS is a governmental entity and therefore not subject to the federal Employee Retiree Income Security Act (ERISA). MPSERS obligations are statutory, and the Contractor's obligations will be pursuant to this Contract.

Health coverage is provided to retired employees of local school districts, intermediate school districts, tax-supported community or junior colleges, and certain universities. Financing for MPSERS is provided through public school employer contributions and Contract Holder premiums. ORS currently manages health coverage for approximately 196,000 Members in the MPSERS health plans. Approximately 40% of the Members are not Medicare eligible and 60% are Medicare eligible. The self-funded portion of the Plan does not include participants in the HMOs, in which there are currently approximately 10,000 Members.

There are currently approximately 121,000 Members enrolled in the Medicare Advantage Plan, 4,000 Members enrolled in the Medicare Supplemental Plan, 61,000 members enrolled in the non-Medicare PPO and approximately 10,000 Members enrolled in the HMOs.

1.020 Scope of Work and Deliverables

1.021 Scope

Services considered within the scope of this Contract include, but are not limited to, the following:

(A) Provide a fully functional health plan for non-Medicare Members and Medicare Members which encompasses and manages the needs of an older, retired population.

(B) Provide world-class administration of Eligibility, Claims processing, and Member service.

(C) Provide state-of-the-art Medical Management to ensure a high quality of care at the lowest possible cost.

(D) Provide world-class account management that partners with ORS to manage the Plan effectively and that collaborates with the ORS to ensure the future success and ability of the Plan to continue to offer competitive health care coverage.

(E) Provide state-of-the-art financial management, reporting, and analytical support.

(F) Provide the Plan Sponsor with the lowest cost-per-service and highest discount levels that the Contractor has negotiated with Providers, either on its own behalf or that of its other customers for similar products covered under this Contract (for example rates offered to other non-Medicare PPOs, Medicare Advantage, and Medicare Supplemental customers).

(G) Ensure transparency for all Services provided on behalf of the Plan Sponsor.

1.022 Work and Deliverables

Contractor must provide all Deliverables, Services, and staff, and must do all things necessary for or incidental to the performance of the work set forth below:

(A) Plan Design

(1) Contractor agrees to administer coverage in accordance with the Plan Design.

(2) The Plan Design is subject to change throughout the duration of this Contract. Contractor must implement Plan changes as requested by the Plan Sponsor in a timely fashion, at no additional cost to the Plan Sponsor.

(B) Claims Processing and Payment

(1) Contractor must administer claims in conformity with Plan Design as described in section 1.022(A) and in compliance with any changes made to the Plan Design by the Plan Sponsor.

(2) Contractor must maintain an on-line claim processing system that interfaces with its eligibility system to verify coverage when processing claims. This system must be updated as Eligible Claims are paid and must include Dependents by name.

(3) Contractor must maintain a claims processing staff of qualified employees to administer the Plan, pursuant to § 1.031.

(4) Contractor must only charge against the Plan Sponsor's account claim payments authorized under the Plan Sponsor's Plan Design.

(5) Contractor must have a procedure approved by the Plan Sponsor for adjudicating Eligible Claims so as to reflect the status of Members' Deductible carry-over, Coinsurance Maximums, and Lifetime Maximums pursuant to the Plan, as of the commencement of its administration.

(6) Contractor must provide access to the Plan Sponsor to Claims data by means of a secured Internet portal.

(7) Contractor must agree to only pay Eligible Claims.

(8) Contractor must process paper Claims within 15 days of receipt of the Claim.

(9) Contractor must capture and store all Claim data elements involved in the processing or payment of Claims.

(10) Contractor Agrees to comply with the NAIC guidelines for Coordination of Benefits (COB) unless otherwise approved in the work plan.

(C) Provider Network

Requirements:

(1) Contractor must maintain a network of Providers in areas where Members reside.

(2) Contractor must manage the Provider Network for Members, including but not limited to:

(a) Contractor must have a valid process to credential Network Providers.

(b) Contractor must be able to add Providers to the Provider Network on a timely basis.

(3) Contractor must support Provider access to health information technology (i.e. e-Prescribing, patient registries, medical records) by means of a secured Internet portal.

(4) The Provider Network should be designed to direct Members to the highest quality and lowest cost Providers.

(a) Contractor's program should encourage the use of primary care Providers to eliminate unnecessary use of high-cost specialists.

(b) The Provider Network should address the needs which are specific to an older, retired population.

(c) The Plan Sponsor prefers that Contractor have specialized networks in place for laboratory services and DME in order to control cost and utilization of services and/or products.

(d) Provider Networks for other specialized services, such as high-tech radiology, should also be in place to control costs and assure the Medical Necessity of services prescribed.

(5) Contractor must provide Pass-Through Pricing to Plan Sponsor. Contractor must not charge Plan Sponsor or any Member any amount above that which is paid to the Provider under the terms of the contract between the Contractor and the Provider.

(D) Member Support

Requirements:

(1) Contractor must provide a Customer Service call center, where it will maintain staff dedicated to supporting the needs of the Members; t**he Plan Sponsor has a preference for a Michigan-based call center.** Customer Service activities must include, but not be limited to, the following:

(a) Single front-end toll-free telephone number with touch-tone routing (if necessary) for Member Services to respond to requests for participating Provider locations, for questions on Claims and access, and complaints about Provider practices and Services.

(b) The system must be scalable to future demand, as will be defined by the Plan Sponsor and State CCI prior to work plan implementation.

(c) Contractor must have an advanced telephone system that provides the Plan Sponsor with management tracking and reporting capabilities. Contractor must produce reports on usage of the toll-free numbers, including number of inquiries, types of inquiries, and timeliness of responses. Reports must also include Average Speed of Answer (ASA) and Abandonment Rate.

(d) Contractor's Customer Service staff must have complete on-line access to all computer files and databases that support the system for applicable programs.

(e) A voice response system with a user-friendly menu.

(f) Information on how to access Customer Services must be clearly communicated in all Plan specific booklets, claim kits and news letters.

(2) Contractor must provide web-based (Internet) support to the Plan Sponsor and its Members. This must be a Plan-specific website dedicated solely to the Plan Sponsor and Members.

The web-based system must include, but not be limited to, the following:

(a) Capabilities to provide Members with information specific to their own Claims and enrollment.

(b) Ability to list Providers based on accessibility to Member's home address

(c) Capabilities to answer Member questions about the Plan (Q&A)

(d) Capability to provide quality-of-care information about Providers

(3) Contractor must respond to Member inquiries and complaints timely, pursuant to § 1.022 (K),

Service Level Agreements.

(a) Contractor should attempt to resolve Member's telephonic issues during the initial contact with the Member.

(b) For those issues not resolved immediately, Contractor must send Members a written response to their issues within seven Days of receipt of the call or written Member inquiry. This response must either resolve the outstanding issue(s) or inform the Member as to when resolution can be expected.

(c) All issues must be resolved within 60 Days of Contractor's receipt of the original Member contact. Any issue that is not able to be resolved within this timeframe must be made known to the Plan Sponsor.

(E) Member Communication Materials and Meetings

Requirements

(1) Communication Meetings:

(a) Contractor must provide speakers at meetings designated by Plan Sponsor.

(b) In addition to MPSERS' designated meetings, Contractor may receive requests for speakers from Member support organizations. A reasonable effort must be made to accommodate requests for in-state meetings.

(c) Contractor must provide communication meeting activity reports two weeks following the close of each calendar quarter. The reports must contain the date, location, and size of the meetings as well as the sponsoring organization and contact person.

(d) Meeting requests may vary from year-to-year but will include up to 10 day-long sessions out-of-state (primarily in Florida, North Carolina, Tennessee and Arizona) and up to 13 day-long sessions in Michigan, of which three (3) may be in the Upper Peninsula. The out-of-state meetings will require the combined participation of the Contractor, up to two representatives from MPSERS, the Vision Plan contractor, the Pharmacy Benefit Manager contractor, and the Dental Plan contractor.

(e) Contractor will be responsible for all aspects of planning, organizing, and conducting the meetings designated, including notices, facilities, and travel arrangements, to be shared equally with the other MPSERS vendors.

(2) Communication Materials:

(a) Contractor must prepare and distribute at its own cost announcements, letters, notices, brochures, forms, postage and other supplies and Services for distribution to Members. Customized Member communications must be provided at no additional charge and are subject to the Plan Sponsor's approval.

(b) All communication materials must be approved by the Plan Sponsor in advance of distribution. All communication materials presented to Plan Sponsor for approval must allow adequate time for review and edit. This applies to all information placed on the Contractor's MPSERS-specific website relative to the Members and the Plan. Other specific material requirements include but are not limited to:

(i) Plan Sponsor-specific Plan booklets and claim kits for transitioning Members (approximately 200,000 each) and booklets and claim kits for new Members throughout the first contract year (approximately 20,000 of each). These materials must meet the following criteria:

- Display the MPSERS logo

- Be printed in large type readability (e.g., equal or equivalent to Arial 12 point font size)

- Be of comparable size and quality to the booklet and claim kit, as approved by Plan Sponsor.

(ii) Quarterly Member newsletter informing membership of current events, health and wellness topics, and plan changes.

- MPSERS newsletter must be under the MPSERS logo and must have sections devoted to the Plan, Dental Plan, Vision Plan, and the plan administered by the Pharmacy Benefit Manager as well as items of general interest.

- Dental Plan, Vision Plan, and Pharmacy Benefit Manager contractors will contribute articles to each quarterly newsletter. Contractor must bear responsibility of eliciting, reviewing/editing, and including these articles to final newsletter draft.

- Draft newsletter must be submitted to Plan Sponsor for review, edit, and ultimate approval and must allow at least seven Days for Plan Sponsor to review upon receipt of each draft version.

(iii) Other publications include, but are not limited to, the following:

- Benefit Guide
- Annual Notice(s) of Change
- Evidence of Coverage
- Grievances and Appeals procedures
- Annual Verification of Coverage
- Annual Summary of Benefits
- Explanation of Benefits (EOB)
- Other CMS-required publications

The Plan Sponsor intends to provide Members access to designated electronic documents on the Contractor's Plan-specific website.

(3) Member Satisfaction:
Contractor must measure Member satisfaction on an ongoing basis and report results to the Plan Sponsor. All areas where Member satisfaction levels are low must be remedied by the Contractor within a timeframe acceptable to the Plan Sponsor. Sample sizes of responses must be sufficient to produce statistically valid results. The methodology for gauging and monitoring this requirement is subject to Plan Sponsor approval.

(F) Medical Management
Requirements:

(1) Contractor must utilize effective Medical Management programs that ensure quality of care to Members and control costs.

(2) Medical Management programs must include, but not be limited to:

(a) Utilization Management: Contractor must provide a program to certify and monitor the appropriateness and duration of inpatient care and specified outpatient Services.

(b) Case Management: Contractor must provide a program that:

(i) Identifies Members at risk for high-cost care

(ii) Monitors high-cost care cases on an individual basis

(iii) Provides support to Members under treatment, their families, and Providers in order to facilitate the use of medically appropriate services and facilities.

(3) Contractor must offer a Disease Management program that Plan Sponsor may elect to participate in.

(4) Quality Management: Contractor must demonstrate quality assurance and a Quality Management program directed toward improving patient outcomes and the quality of care provided to Members.

(5) Contractor must provide to Members, at a minimum, the following:

(a) Nurse Line or an equivalent program

(b) Transplant Centers of Excellence

(c) Cardiac Centers of Excellence

(6) Contractor must offer Plan Sponsor support for and advice on Medical Policy. This should include, but not be limited to, the following:

(a) Identifying and notifying Plan Sponsor of new and emerging technological developments in the treatment and diagnosis of medical conditions.

(b) Providing cost benefit analyses of these emerging technologies.

(c) Providing follow up reporting that uses pre-determined measures and which illustrates the cost-effectiveness of newly implemented policies based on new and emerging technological developments.

(7) Contractor must monitor and manage Members on Specialty Drugs including, but not limited to, the following:

(a) Working with Plan Sponsor and its PBM to ensure that reimbursement is set at the lowest net cost for Specialty Drugs that are paid pursuant to the Plan Design.

(b) Working with the Plan Sponsor and its PBM to ensure compliance with prior authorization requirements for Specialty Drugs.

(c) Working with Plan Sponsor and its PBM to make sure that Members who are prescribed Specialty Drugs are appropriately included in the Contractor's other Medical Management Programs.

(8) Contractor must be able to support Plan Sponsor's existing wellness program structure, as well as play an active role in supporting and advising on future enhancements to the same. Elements of such a program must include, but not be limited to health assessments, member communication, member education and support, and administration of wellness-related plan provisions.

(G) Eligibility

Plan Sponsor is responsible for transmitting eligibility and enrollment information for Members Plan Sponsor has the sole authority to determine the effective date of a Member, including retroactive adjustments.

Eligibility information for Members will be transferred to Contractor from Plan Sponsor by electronic

medium including all necessary information with respect to current enrollees prior to December 1, 2009.

Payment of Administration Fee is predicated on the enrollment records of the Plan Sponsor.

Requirements:

Contractor must meet the following requirements:

(1) Contractor must comply with all applicable requirements of HIPAA.

(2) Contractor must maintain Member information.

(3) Contractor must verify Member Eligibility for coverage, at a minimum, on an annual basis. This includes verifying the availability of other primary coverage.

(4) Contractor must have the capability to accept electronic data transfer on a weekly basis from Plan Sponsor, in a HIPAA compliant 834 file provided through a data exchange gateway. Contractor must work with Plan Sponsor for approval of the implementation of this data transfer. Discrepancy reports must be supplied within 48 hours, in a format to be mutually agreed to by Plan Sponsor and Contractor.

(5) Contractor is responsible for any changes to their systems or processes required to support the receipt and processing of Plan Sponsor's enrollment files.

(6) Enrollment files must be processed and Member eligibility and/or enrollment update completed within 48 hours of notification from the Plan Sponsor or its designee, and assuming CMS approval has been granted relative to Medicare Members, with confirmation of changes submitted to Plan Sponsor.

(7) Contractor must have validation edits in place to ensure, for each data load, that all fields are properly populated and readable.

(8) Upon verbal notification from Plan Sponsor, Member eligibility and/or enrollment updates must be completed in real-time.

(9) Contractor must provide to the Plan Sponsor, by means of a secured Internet portal, access to the system used to maintain Eligibility.

(10) Contractor must provide to Providers, by means of a secured Internet portal, access to Eligibility.

(11) Contractor must have appropriate staff of information technology professionals to provide timely programming when needed to implement system changes and produce reports.

(12) Contractor must use a secure system for all administrative communications concerning Members, including transport of electronic files containing confidential information.

(13) Communication involving any identifiable Member information must be protected using passwords and a File Transfer Protocol for retrieval.

(14) Contractor must be able to provide summary enrollment statistics by various categories, along with other enrollment data, upon the Plan Sponsor's request.

(H) Identification Cards

Requirements:

(1) Contractor must produce and issue Identification (ID) cards to Members as needed and are subject to Plan Sponsor's approval. ID cards must include Contractor's toll-free number and URL address for Member Internet access.

(2) Contractor must be able to provide the capability to include other plans' information on an Identification Card, including but not limited to Vision, Dental, and Prescription Drug coverage.

(3) Contractor must produce ID Cards for Members within seven days of receiving eligibility record.

(4) Contractor must provide ID cards to all existing Members prior to the implementation date of this contract.

(I) Medicare Advantage

Requirements:

(1) Contractor must demonstrate expertise in the area of Medicare Advantage (MA) Plans and be prepared to advise Plan Sponsor as to the future of its MA Plan.

(2) Contractor must offer a MA Plan in all locations where the Plan Sponsor's Members reside (Refer to *Census* in Attachment E). Contractor must commit to improving Provider access in any area where the access standard is not currently being met [see §1.022 (C) (2) for iteration of access standards].

(3) Contractor should have sufficient experience in providing MA Plans to groups similar in size and demographics to Plan Sponsor's.

(4) Contractor must be committed to supporting the MA Plans as long as they remain a financially viable option to Plan Sponsor.

(5) Contractor must have a successful Revenue Management program, make all the necessary Claim submissions to CMS, and demonstrate ability to optimize CMS revenue at the appropriate level.

(6) Contractor must apply all CMS revenue to the Plan Sponsor on a monthly payment interval.

(J) Medicare Supplemental Plans

Requirements

(1) Contractor must offer a Medicare Supplemental Plan in all locations where the Plan Sponsor's Members reside. (Refer to *Census,* Attachment E.)

(2) Contractor should have sufficient experience in providing Medicare Supplemental Plans to groups similar in size and demographics to Plan Sponsor.

(K) SAS-70

Requirements:

(1) Contractor must have a Type II Statement of Auditing Standards ("SAS") 70 conducted annually.

(2) Contractor must supply Plan Sponsor with an annual copy of the results of this audit.

(3) Contractor must provide Plan Sponsor with a corrective action plan on all actionable items and provide regular updates on those items until they are resolved.

L) Financial Administration

Requirements

(1) Contractor must establish an account with the Plan Sponsor's bank, which will be used as a conduit or actual source for the payment of Eligible Claims at a frequency to be mutually determined by the Plan Sponsor and the Contractor.

(2) Contractor must establish an electronic mail link with the Plan Sponsor for purposes of communicating wire transfer requests. Such a link must be secure in order to protect the data communicated to the Plan Sponsor.

(3) Contractor must electronically transmit a signed written statement which certifies that the wire request accurately reflects Plan Sponsor's financial obligation for the time period defined.

(4) Contractor must prepare and provide to Providers Internal Revenue Service Forms 1099, as well

as any other state and federal forms required by law.

(5) All interest accrued from account(s) used to pay Eligible Claims, including revenue derived from CMS, will accrue to the Plan Sponsor.

(6) Financial errors made by the Contractor that are identified outside of a normal audit process and which would result in a financial settlement to the Plan Sponsor must be paid to the Plan Sponsor within 30 Days. Any payment—in part or in full—beyond 30 Days is subject to a prime interest rate + 1%.

(7) Contractor must provide COBRA administration Services including, but not limited to, the following:

(a) Member communication

(b) Enrollment

(c) Billing

(d) Reporting

(8) Contractor must undertake responsibility for providing benefit determination, including full and fair review of Claims Appeals by Members that have been denied either in full or in part.

(M) Performance Guarantees/Service Level Agreements (SLAs)

Requirements:

Contractor must ensure that the SLAs are quantifiable, subject to the Plan Sponsor approval. The Plan Sponsor reserves the right to independently verify the Contractor's assessment of its performance, either by Plan Sponsor employee or third party review. Disagreements regarding SLAs will be subject to Dispute Resolution (§2.190).

Within 45 Days after the end of each calendar quarter, Contractor must provide Plan Sponsor with a report assessing the Contractor's performance under each SLA and provide payment for any applicable penalties to the Plan Sponsor.

The following SLAs are related to ongoing Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised). SLAs are for all Services provided under this Contract for the Plan Sponsor. The maximum penalty that will be applied to the Contractor in any one year, regardless of the sum of the individual penalties in that year, will not exceed 35% of the annual Administration Fee. Separate penalties will be assessed as a percentage of applicable Medicare and non-Medicare monthly administration fees, with the exception of the following SLAs, which will be assessed a combined penalty if applicable: 3, 10, 11, 16, 17, 18, 19, 20, 21, 22, 23.

SLA# 1
ID Cards
Guarantee
For new Contract Holders, 100% of ID Cards must be mailed by Contractor within 7 days of Contractor receiving eligibility record. ID Cards must have an accuracy rate of 99.0% or higher.
Penalty
The penalty for failure to meet the ID Card Timeliness SLA is 1.0% of the quarterly Administration fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard. The penalty for failure to meet the ID Card Accuracy SLA is 1.0% of the quarterly Administration Fee, plus an additional 1.0% for each additional 1.0% Contractor falls below the standard.

SLA# 2
Timeliness of Member Enrollment Materials
Guarantee
99% of all Member enrollment materials must be mailed within three days of request. 100% of all Member enrollment materials must be mailed within 14 days of request.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee.

SLA# 3
Account Management - Satisfaction
Guarantee
Plan Sponsor must complete an annual satisfaction survey using a mutually-agreed upon survey tool, to be completed in January respective to the preceding year. A 5-point scale will be utilized. Contractor's account management team must score at least 4.00. A score under 3.50 will result in an additional penalty.

Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to score at least 3.50 will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 4
Satisfaction Surveys
Guarantee
One random sample member survey must be completed annually on a Plan Sponsor specific basis. A minimum satisfaction rate of 85% responses of satisfied is required. Failure to reach a satisfaction rate of at least 80% will result in an additional penalty.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's annual Administration Fee. Failure to reach a satisfaction rate of at least 80% will result in an additional 1.0% penalty of Contractor's annual Administration Fee.

SLA # 5
Customer Service Call – Average Speed of Answer
Guarantee
On a monthly basis, the calls must be answered an average of 30 seconds or less. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.5% of Contractor's total Administration fee for the quarter, plus 0.05% of its fee for each additional 5 seconds above the standard.

SLA # 6
Customer Service Response Time – Blockage Rate (Busy Signal)
Guarantee
The monthly blockage rate must not exceed 0.0%. Blockage is defined as a caller receiving a busy signal. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The penalty for failure to meet this SLA is 1.0% of the Contractor's quarterly Administration Fee, plus 0.5% of the quarterly Administration Fee for each additional 0.1% above the standard.

SLA # 7
First Call Resolution
Guarantee
85% of calls must be resolved on the first call. Members following up on same issue within seven calendar days cannot be considered resolved. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's Administration Fee for the quarter, plus 0.5% of its fee for each additional 5.0% below the standard.

SLA #8
Customer Service Response Time to Written Inquiries
Guarantee
Contractor must resolve 95% of all Member inquiries within 14 Days of receipt; 98% of all Member inquiries must be resolved within 28 Days; and 100% of all Member inquiries must be resolved within 60 Days. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's administrative fee for the quarter.

SLA #9
Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 3% (determined by the number of calls abandoned by the total number of calls). A call will be considered abandoned if the Member hangs up at any time after initiating a transfer out of the IVR. Contractor must measure their performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet this SLA is 2% of Contractor's Administration fee for the quarter, plus 0.5% of its fee for each additional 1.0% above the standard. .

SLA #10
Timely Production of Management Reports
Guarantee
Pursuant to Section 1.042, Contractor must provide monthly and quarterly reports within 30 Days of the end of the month, 45 Days of the end of the quarter, and annual reports within 90 Days of the end of the Plan Year. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee. The penalty for failure to meet the SLA for quarterly reports is 3.0% of Contractor's quarterly Administration Fee. The penalty for failure to meet the SLA for annual reports is 5.0% of Contractor's annual Administration Fee.

SLA #11
Timeliness of Data Transmission to Plan Sponsor's Data Vendor
Guarantee
Contractor must agree to deliver data files to Plan Sponsor's Data Vendor in agreed-upon format. Delivery of data files—with all required fields correctly populated—must be completed within 15 Days after the close of each month.
Penalty
The penalty for failure to meet the SLA for monthly reports is 1.0% of Contractor's monthly Administration Fee.

SLA #12
Financial Accuracy Rate
Guarantee
Financial accuracy on claims processing (as defined as the sum of the absolute value of financial errors on claims processed divided by the total dollar volume of claims paid) must not fall below 99%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 5.0% of Contractor's quarterly Administration Fee, plus an additional 1.0% of quarterly fee for each 0.5% below the standard.

SLA #13
Financial Error Rate
Guarantee
The financial error (as defined as the number of claims containing a financial error divided by the total number of claims) must not exceed 3%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee, plus 1.0% of the quarterly fee for each additional 1.0% below the standard.

SLA #14
Non-financial Error Rate
Guarantee
The non-financial error rate (as defined as the number of claims with a non-financial error divided by the total number of claims) must not exceed 3%. Contractor must measure its performance on this SLA based upon a statistically valid sample, not the entire claims population, on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's quarterly Administration Fee, plus 0.5% of the quarterly fee for each additional 1.0% below the standard.

SLA #15
Average Claims Turnaround
Guarantee
The average time between when Claims have been received and processed must not exceed 10 calendar days. Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.
Penalty
The penalty for failure to meet t the Claims Turn-Around SLA is 1.5% of Contractor's Administration Fee for the quarter, plus 1.5% of the quarterly fee for each additional 3 days above the standard.

SLA #16
Case Management
Guarantee
Contractor must review 100% of all cases referred for Case Management and either accept or reject each case within 2 business days of receipt. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #17
Case Management-Care Plans
Guarantee
Contractor must provide all Case Management cases a documented care plan within 7 business days of acceptance of the case to the program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 2.0% of Contractor's quarterly Administration Fee.

SLA #18
Disease Management-Outreach
Guarantee
Contractor must be in contact with 100% of all Members deemed eligible for a Disease Management program. Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.
Penalty
The penalty for failure to meet this SLA is 8.34% of Contractor's annual Disease Management program fee. Failure to achieve at least 95% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee. Failure to achieve at least 90% of this SLA will result in an additional penalty of 8.33% of Contractor's annual Disease Management program fee.

SLA #19
Disease Management-Clinical Improvement
Guarantee
Unless otherwise approved by Plan Sponsor and Contractor annual work plan, Plan Sponsor and Contractor must agree to a series of process and utilization measures for each Disease Management program selected by the Plan Sponsor. Initial year baselines will be established using the experience of the Plan year prior to Contractor assuming responsibility for administering the Plan. Subsequent performance baselines will be established each year and will be based on the previous year's statistics. Levels of improvement standards will be mutually agreed upon by Plan Sponsor and Contractor. Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet the standards as described in this SLA is 25.0% of Contractor's annual Disease Management program fee, with each measure assigned a proportionate share of the penalty.

SLA #20
Disease Management—Member Satisfaction
Guarantee
Plan Sponsor and Contractor must agree on the satisfaction survey to be sent to eligible Members in the Disease Management programs. Contractor must achieve a minimum of a 90% rating of "satisfied". Contractor must measure and report its performance on this SLA on an annual basis.
Penalty
The penalty for failure to meet this SLA is 25.0% of Contractor's annual Disease Management program fee.

SLA #21
Disease Management—Return on Investment
Guarantee
Savings resultant from the Disease Management program(s) must be commensurate with the annual fees for the program(s) and must be quantifiable, using prior claims experience and the year-over-year cost increase levels of the non-enrolled population. Contractor and Plan Sponsor must agree to the methodology and a formula to gauge this SLA and Contractor is requested to propose such a formula for Plan Sponsor review and approval.
Penalty
The penalty for failure to meet this SLA, in accordance with the mutually agreed to methodology and formulas, is 25.0% of Contractor's annual Disease Management program fee.

SLA #22
Clinical Quality Improvement
Guarantee
Relevant *Healthcare Effectiveness Data and Information Set (*HEDIS) measures or other recognized quality indicators (as approved by Plan Sponsor) will be used to establish baselines. Contractor must measure and report its performance on this SLA on an annual basis. Contractor must also show improvement from the previous year in the following quality-of-care measures (or as otherwise directed by Plan Sponsor in annual Work Plan): ➢ Percent of diabetic Members with an annual retinal eye exam ➢ Percent of female Members receiving cervical cancer screening tests ➢ Percent of Members who have suffered a heart attack who receive beta-blockers ➢ Percent of Members receiving LDL Cholesterol screening tests ➢ Percent of female Members over the age of 40 receiving mammography screening ➢ Percent of hospital readmissions
Penalty
The penalty for failure to meet this SLA is 1.0% of Contractor's annual Administration Fee for each measure for improvement that was not attained.

SLA #23
Quality Improvement Projects
Guarantee
During the third quarter of each Plan Year, the Contractor must develop three process improvement projects based on Plan performance evaluations reviewed during the previous quarters' management meetings. There projects will be reviewed and approved by the Plan Sponsor for implementation during the next Plan Year. Contractor will complete the three process improvement projects developed and approved during the previous Plan Year.
Penalty
The penalty for failure to meet this SLA is 1.0% of the Contractor's annual Administration Fee for each project that has not been developed and approved for the next Plan Year and 2.0% of the Contractor's annual Administration Fee for each project not completed for the current Plan Year.

(N) Administrative Meetings

Requirements:

(1) Management meetings must be held between the Contractor and Plan Sponsor on at least a monthly basis to review plan performance. Contractor must review all open Plan Sponsor projects and present the status, progress and results of each project compared to the work plan.

(2) Quarterly the meetings will be held at the Contractor's headquarters or its Michigan service center location, per the State CCI or Plan Sponsor's request. These meetings may be held via video conference, or teleconference, as deemed appropriate by the State's CCI.

(a) As part of this process, the Contractor must present a comprehensive review of the cost and utilization experience of the Plan compared to budget and revenue projections. Contractor must provide quarterly performance review reports five business days prior to each meeting and each performance review must identify—and provide proposed solutions to---performance variances (e.g. cost, utilization, and administrative performance) and their root causes.

(b) During the Quarterly meetings, the Contractor must also prepare and present to Plan Sponsor staff members information on industry trends (e.g., health care Plan Design, innovations in Care Management).

(3) Up to four additional meetings may be held each year at the State's CCI or Plan Sponsor's discretion.

(4) Contractor must participate in the Plan Sponsor's strategic planning process providing:

(a) Data analysis with commensurate recommendations and cost-coverage analysis in support of Plan modifications.
(b) Review of changes in the market and identification of emerging trends.
(c) Contractor must work collaboratively with Plan Sponsor's other vendor partners, including but not limited to the PBM, Vision Plan Administrator, and Dental Plan Administrator, on joint Plan improvement projects.

(5) Contractor must provide representation, and may be required to participate in, all Michigan Public School Employees Retirement System board and committee meetings.

1.030 Roles and Responsibilities

1.031 Contractor Staff, Roles, and Responsibilities

Pursuant to § 2.060, *Contract Management*, Contractor **must** provide sufficient staffing resources for completion of the tasks and services as defined in this agreement. As part of its project/work-plan, Contractor must also provide a detailed description of its company accreditations, licenses, and requirements listed below, and a detailed description of its key staff, additional staff, and its subcontractors as related to this project, for final review and approval by the respective, assigned State Contract Compliance Inspector (CCI), as follows:

(A) Key Personnel / Staff:
Key Personnel who are NOT located in Michigan must be made available to the Plan Sponsor at Contractor's Michigan office (or at another location in Michigan as approved by Plan Sponsor or CCI, as designated by the State) on a reasonably frequent basis (as determined or scheduled by Plan Sponsor or CCI, as designated by the State). The Michigan staffed office shall have assigned not less than the following key-staff:

(1) One (1) Senior Account Manager (SAM)'s role and responsibilities shall include:

- Keeping primary work location and assignment at the Contractor's Michigan office;
- Serving as the single point of accountability for all projects initiated between the Contractor and the Plan Sponsor for management of the Contractor's Account Team;
- Availability at a location in Michigan to be determined by the Plan Sponsor and availability upon Plan Sponsor's request;
- Authority to make day-to-day decisions regarding service issues;
- Ability within the Contractor's organization to obtain the use of Contractor's resources, both direct and indirect, as are necessary;
- Designating one (1) Back-up to the SAM, whose role and responsibilities shall include: involvement in account management and who is capable of performing the responsibilities of the SAM in the event that the SAM is unavailable; the Contractor's SAM back-up must be familiar with all specific requirements of this Contract; this back-up role may be filled by another key-staff person.

(2) Other Key Staff: These positions are also considered Key Personnel for purposes of this Contract and will work under the direction of the Plan Sponsor:

(a) One (1) Healthcare Consultant;
(b) Two (2) Data Analysts; and,
(c) One (1) Administrative Support.

(B) Additional Staff:
Additional staff assignments are not considered key, but their roles are considered an integral compliment to the roles, responsibilities, and abilities of the Contractor's key-staff. These roles may include not only the staff roles listed below but also may include other IT-System Technicians, Security Specialists, Accounting or Audit staff; Administrative support staff; etc. Contractor shall include a detailed description of these additional roles in its project / implementation plan to be approved by the State's CCI and Plan Sponsor:

(1) Enrollment & Customer Service Specialist: Contractor must provide at least one experienced enrollment and customer service specialist to work onsite at Plan Sponsor's Lansing office. This person is responsible for addressing enrollment and customer service issues and is an employee of the Contractor and is considered for purposes of this Contract to be a member of the account team and subject to the Requirements of the account team.

(2) Account Team: Account Team members are subject to review by the Plan Sponsor, prior to their appointment, to ensure that their qualifications and training are suitable to the needs of the Plan Sponsor. The Account Team must be responsible for, at a minimum, the following functions:

(a) Account management
(b) Banking/Financial Management
(c) Pharmacy
(d) Member communications
(e) Claims processing
(f) Enrollment and eligibility
(g) Customer service
(h) Medical Management & Medical Policy
(i) Data/Reporting

(3) Other Contractor-recommended Additional Staff

(C) Subcontractor(s):

Sub-Contractors are not considered key, but their roles are considered an integral compliment to the roles, responsibilities, and abilities of the Contractor's key-staff and additional staff. Pursuant to § 2.044, *Subcontracting by Contractor*, delegation of any portion of the services is subject to written, pre-approval by the State, and Contractor shall include a detailed description of these roles and responsibilities in its project / implementation plan.

1.040 Contract Implementation & Reporting

1.041 Contract Implementation Management

Requirements

(A) Contractor will carry out this project under the direction and control of the ORS; all transition and implementation plans are subject to the approval of the Plan Sponsor and the State's CCI.

(B) There must be continuous liaising with the Contractor during this contract and particularly during any process involving ORS partners or the Plan Sponsor. The ORS CCI and Plan Sponsor will meet with the Contractor's SAM for initial review of the Contractor's work plan prior to beginning service delivery and then periodically, as needed. The meetings will provide for reviewing progress and providing necessary guidance to the Contractor regarding the timing of activities and solving issues or problems.

(C) The project plan (also referred to as the *implementation-plan or the work plan*) ***and*** the corresponding timeline or calendar must describe in detail: all major project milestones; the anticipated outcomes for each milestone; and, all tasks, duties, or responsibilities associated with implementation, including a detailed discussion on how to manage a possible transition process from the prior or to the next vendor.

(D) The plan must also describe in detail not less than:

(1) Contractor's project management approach, and discuss in detail any identifying methods, tools, and processes, intended for oversight and completion of the implementation, including an updated description of its staff, roles, and responsibilities.

(2) Full disclosure for any anticipated issues or changes, when they may arise, and how those will be conveyed to the appropriate state staff, and include suggested resolution or risk mitigation strategies.

(3) Final Disruption Analysis and a plan for averting disruptions and communicating any disruptions to affected members.

(4) A detailed protocol and escalation communication process; the plan must also provide escalation procedures and contact information for issues that may need to be escalated above the SAM.

(5) Any additional information or considerations for implementation to begin January 01, 2010, and continue thereafter for the life of this Contract.

(E) At minimum, the following milestones and timeframe(s) will be accomplished and completed by Contractor, unless otherwise approved by the State's CCI (via the implementation plan, etc.):

(1) Final draft of Implementation / Work Plan submitted to CCI and Plan Sponsor within five State-business days from contract start date;
(2) Final approval of Implementation Plan obtained from CCI 14-days after submission of draft;
(3) Implementation and service begins January 01, 2010.

1.042 Reports/Data

Requirements

(A) Contractor must provide proper and timely analysis and reports, in a format as determined by the Plan Sponsor and approved in the annual work plan.

(B) Contractor must provide, by electronic media, a *Claim Detail Report* listing each Claim processed during the preceding month. Receipt of this report by Plan Sponsor is required no later than ten days following the end of the reporting month.

(C) Contractor must provide a *Quarterly Reconciliation Report* that includes, but is not limited to, the following:

(1) Claim Payments

(2) Administration Fees

(3) Other financial transactions

(D) Contractor must prepare a *Quarterly Claims and Service Experience Report* for the quarterly management meetings with Plan Sponsor.

(E) Contractor must provide a *Monthly Claims Detail Report*, within 15 days from the end of each month, to the Plan Sponsor's PBM vendor, in a mutually agreed upon format, that the PBM will use to manage its drug utilization programs.

(F) Contractor must provide a *Semi-Annual COB Report* that includes, but is not limited to, the following:

(1) Contractor activities and results in administering the Coordination of Benefits (COB) provisions of the Plan.

(2) Number of Claims during the period for which other coverage (coverage other than Medicare claims) was reported.

(3) Number of Claims for which other coverage was not reported but was identified upon investigation.

(4) The dollar amount and percentage of total Claims dollars saved as a result of COB administration.

(G) Contractor must prepare an *Annual Report* that includes not less than: a comprehensive record of claims and service experience for the year; analysis of trends; Services issues; and, performance guarantees that include plans of corrective action and recommendations to improve quality and reduce costs.

(H) Contractor must agree to work with the Plan Sponsor-chosen data management vendor (hereafter referred to as the "data vendor") in a manner inclusive of, but not limited to, the following:

(1) Contractor must provide the data vendor claims data as described in Appendix I. This information is to be provided to the data vendor monthly and by a date no later than the 15th Day from the last day of the reporting quarter.

(2) Data must be securely maintained for the duration of this Contract. Upon termination or expiration of the Contract, Contractor must deliver all data to the data vendor within five Days of a request for the same.

(3) Contractor is responsible for all expenses, including the cost of any subcontractors, related to producing the data and providing it to the data vendor. This includes any costs associated with resubmissions and processing costs incurred by the data vendor due to the transmittal of incomplete, inaccurate, or unreadable data files belonging to the Plan Sponsor.

(4) Contractor is responsible to work with the data vendor, including developing any process improvement procedures needed, to correct all issues that impede or prevent accurate data reporting from the database.

(I) Plan Sponsor, or its designee, reserves the right to examine the Contractor's database for the Plan to determine whether the Contractor is in compliance with the data requirements of this Contract.

1.050 Acceptance

1.051 Criteria

The following criteria will be used by the State to determine *Acceptance* of the Services and/or Deliverables provided under this contract:

- Timeliness of meetings and report completion;
- Adherence to Implementation Plan and approved calendar;
- Adherence to Performance Guarantees / Service Level Agreements;
- Demonstrated considerable knowledge and expertise of health care administration programs.

1.052 Final Acceptance – DELETED (Not Applicable)

1.060 Contract Pricing

1.061 Contract Pricing

(A) Contractor will be paid according to the approved *Price Quotation* (forms) in **Attachment A.**

(B) Contractor's out-of-pocket expenses are not separately reimbursable by the State unless, on a case-by-case basis for unusual expenses, the State has agreed in advance and in writing to reimburse Contractor for the expense at the State's current travel reimbursement rates. See **www.michigan.gov/dmb** for current rates.

(C) Pursuant to the State of Michigan's Administrative Guide *POLICY 0420: Travel*, issued January 1, 1994, "Travel: Classified and non-classified State employees who incur travel expenses in connection with official State business, and authorized non-State employee consultants, contractors, and advisors, shall comply with the Standardized Travel Regulations and associated rate schedules for reimbursement of applicable travel expenses, pursuant to the *Michigan Constitution, Article XI, §5* and *The Management and Budget Act, Public Act 431 of 1984, as amended, §217*.

1.062 Price Term

Prices quoted are firm and fixed for the entire length of the Contract.

1.063 Tax Excluded from Price – DELETED (Not Applicable)

1.064 Holdback – DELETED (Not Applicable)

1.070 Additional Requirements-DELETED (Not Applicable)

Article 2, Terms and Conditions

2.000 Contract Structure and Term

2.001 Contract Term

This Contract is for a period of three years beginning January 1, 2010 through December 31, 2012. All outstanding Purchase Orders must also expire upon the termination (cancellation for any of the reasons listed in §**2.150**) of the Contract, unless otherwise extended under the Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of the Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2.002 Options to Renew

This Contract may be renewed in writing by mutual agreement of the parties not less than 30 days before its expiration. The Contract may be renewed for up to two (2) additional two (2) year periods.

2.003 Legal Effect

Contractor must show acceptance of this Contract by signing two copies of the Contract and returning them to the Contract Administrator. Contractor must not proceed with the performance of the work to be done under the Contract, including the purchase of necessary materials, until both parties have signed the Contract to show acceptance of its terms, and the Contractor receives a contract release/purchase order that authorizes and defines specific performance requirements.

Except as otherwise agreed in writing by the parties, the State assumes no liability for costs incurred by Contractor or payment under this Contract, until Contractor is notified in writing that this Contract (or Change Order) has been approved by the State Administrative Board (if required), approved and signed by all the parties, and a Purchase Order against the Contract has been issued.

2.004 Attachments & Exhibits

All Attachments and Exhibits affixed to any and all Statement(s) of Work, or appended to or referencing this Contract, are incorporated in their entirety and form part of this Contract.

2.005 Ordering

The State will issue a written Purchase Order, Blanket Purchase Order, Direct Voucher or Procurement Card Order, which must be approved by the Contract Administrator or the Contract Administrator's designee, to order any Services/Deliverables under this Contract. All orders are subject to the terms and conditions of this Contract. No additional terms and conditions contained on either a Purchase Order or Blanket Purchase Order apply unless they are also specifically contained in that Purchase Order's or Blanket Purchase Order's accompanying Statement of Work. Exact quantities to be purchased are unknown; however, the Contractor will be required to furnish all such materials and Services as may be ordered during the Contract period. Quantities specified, if any, are estimates based on prior purchases, and the State is not obligated to purchase in these or any other quantities.

2.006 Order of Precedence

(A) The Contract, including any Statements of Work and Exhibits, to the extent not contrary to the Contract, each of which is incorporated for all purposes, constitutes the entire agreement between the parties with respect to the subject matter and supersedes all prior agreements, whether written or oral, with respect to the subject matter and as additional terms and conditions on the purchase order must apply as limited by **Section 2.005.**

(B) In the event of any inconsistency between the terms of the Contract and a Statement of Work, the terms of the Statement of Work will take precedence (as to that Statement of Work only); provided, however, that a Statement of Work may not modify or amend the terms of the Contract, which may be modified or amended only by a formal Contract amendment.

2.007 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 the Contract.

2.008 Form, Function & Utility

If the Contract is for use of more than one State agency and if the Deliverable/Service does not the meet the form, function, and utility required by that State agency, that agency may, subject to State purchasing policies, procure the Deliverable/Service from another source.

2.009 Reformation and Severability

Each provision of the Contract is severable from all other provisions of the Contract and, if one or more of the provisions of the Contract is declared invalid, the remaining provisions of the Contract remain in full force and effect.

2.010 Consents and Approvals

Except as expressly provided otherwise in the Contract, if either party requires the consent or approval of the other party for the taking of any action under the Contract, the consent or approval must be in writing and must not be unreasonably withheld or delayed.

2.011 No Waiver of Default

If a party fails to insist upon strict adherence to any term of the Contract then the party has not waived the right to later insist upon strict adherence to that term, or any other term, of the Contract.

2.012 Survival

Any provisions of the Contract that impose continuing obligations on the parties, including without limitation the parties' respective warranty, indemnity and confidentiality obligations, survive the expiration or termination of the Contract for any reason. Specific references to survival in the Contract are solely for identification purposes and not meant to limit or prevent the survival of any other section.

2.020 Contract Administration

2.021 Issuing Office

This Contract is issued by the Department of Management and Budget, Purchasing Operations, collectively, including all other relevant State of Michigan departments and agencies, the "State". Purchasing Operations is the sole point of contact in the State with regard to all procurement and contractual matters relating to the Contract. Purchasing Operations **is the only State office authorized to change, modify, amend, alter or clarify the prices, specifications, terms and conditions of this Contract.** Contractor Administrator within Purchasing Operations for this Contract is:

Malynda Little, CPPB, Buyer Specialist
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909
Email: littlem3@michigan.gov
Phone: 517-373-8622

2.022 Contract Compliance Inspector (CCI)

After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations will direct the person named below, or any other person so designated, to monitor and coordinate the activities for the Contract on a day-to-day basis during its term. However, monitoring of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of the Contract as that authority is retained by DMB Purchasing Operations**. The Contract Compliance Inspector for this Contract is:

Brian McLane
Office of Retirement Services
Email: mclaneb@michigan.gov
Phone: 517-322-1926

2.023 Project Manager – DELETED (Not Applicable)

2.024 Change Requests

During the course of ordinary business, it may become necessary for the State to discontinue certain business practices or create Additional Services/Deliverables. The State reserves the right, by giving Contractor written notice of a change request within a reasonable time, to request any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. In such an event, the Contractor must provide a detailed outline of all work to be done, including tasks necessary to accomplish the services/deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed proposal to implement the change.

The State may accept Contractor's proposal for change, reject it, or reach another agreement with Contractor. Should the parties agree on carrying out a change, a written Contract Change Notice must be prepared and issued under this Contract, describing the change and its effects on the Services and any affected components of this Contract (a "Contract Change Notice"). No proposed Change may be performed until the proposed Change has been specified in a duly executed Contract Change Notice issued by the Department of Management and Budget, Purchasing Operations. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities.

If the State requests or directs the Contractor to perform any activities that Contractor believes constitute a change to the Statement of Work, the Contractor must notify the State that it believes the requested activities are a change before beginning to work on the requested activities. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities. If the Contractor commences performing work outside the scope of this Contract and then ceases performing that work, the Contractor must, at the request of the State, retract any out-of-scope work that would adversely affect the Contract.

2.025 Notices

Any notice given to a party under the Contract must be deemed effective, if addressed to the party as addressed below, 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 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.

State:
State of Michigan
Department of Management & Budget – Purchasing Operations
Attention: Malynda Little, Buyer Specialist
PO Box 30026
530 West Allegan
Lansing, Michigan 48909
(517) 373-8622
littlem3@michigan.gov

Contractor:
Blue Cross Blue Shield of Michigan
ATTN: Barbara Murphy, Director, Key-State Accounts
600 Lafayette East
Detroit, MI 48226
(248) 448-7414
bmurphy@bcbsm.com

Either party may change its address where notices are to be sent by giving notice according to this Section.

2.026 Binding Commitments

Representatives of Contractor must have the authority to make binding commitments on Contractor's behalf within the bounds set forth in this Contract. Contractor may change the representatives from time to time upon written notice.

2.027 Relationship of the Parties

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

2.028 Covenant of Good Faith

Each party must act reasonably and in good faith. Unless stated otherwise in the Contract, the parties will not unreasonably delay, condition or withhold the giving of any consent, decision or approval that is either requested or reasonably required of them in order for the other party to perform its responsibilities under the Contract.

2.029 Assignments

(A) Neither party may assign the Contract, or assign or delegate any of its duties or obligations under the Contract, to any other party (whether by operation of law or otherwise), without the prior written consent of the other party; provided, however, that the State may assign the Contract to any other State agency, department, division or department without the prior consent of Contractor and Contractor may assign the Contract to an affiliate so long as the affiliate is adequately capitalized and can provide adequate assurances that the affiliate can perform the Contract. The State may withhold consent from proposed assignments, subcontracts, or novations when the transfer of responsibility would operate to decrease the State's likelihood of receiving performance on the Contract or the State's ability to recover damages.

(B) Contractor may not, without the prior written approval of the State, assign its right to receive payments due under the Contract. If the State permits an assignment, the Contractor is not relieved of its responsibility to perform any of its contractual duties, and the requirement under the Contract that all payments must be made to one entity continues.

(C) If the Contractor intends to assign the contract or any of the Contractor's rights or duties under the Contract, the Contractor must notify the State in writing at least 90 days before the assignment. The Contractor also must provide the State with adequate information about the assignee within a reasonable amount of time before the assignment for the State to determine whether to approve the assignment.

2.030 General Provisions

2.031 Media Releases

News releases (including promotional literature and commercial advertisements) pertaining to the RFP and Contract or project to which it relates shall not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with the RFP and Contract are to be released without prior written approval of the State and then only to persons designated.

2.032 Contract Distribution

Purchasing Operations retains the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Purchasing Operations.

2.033 Permits

Contractor must obtain and pay any associated costs for all required governmental permits, licenses and approvals for the delivery, installation and performance of the Services. The State must pay for all costs and expenses incurred in obtaining and maintaining any necessary easements or right of way.

2.034 Website Incorporation

The State is not bound by any content on the Contractor's website, even if the Contractor's documentation specifically referenced that content and attempts to incorporate it into any other communication, unless the State has actual knowledge of the content and has expressly agreed to be bound by it in a writing that has been manually signed by an authorized representative of the State.

2.035 Future Bidding Preclusion – DELETED (Not applicable)

2.036 Freedom of Information

All information in any proposal submitted to the State by Contractor and this Contract is subject to the provisions of the Michigan Freedom of Information Act (FOIA), 1976 P A 442, , MCL 15.231, *et seq* (the "FOIA").

2.037 Disaster Recovery

Contractor, solely, must maintain adequate backup to ensure continued automated and manual provision of required work and deliverables. The State reserves the right to inspect the Contractor's disaster recovery backup site(s) and procedures at any time with 24 hour notification to the Contractor.

(A) ***Alternative Operations Site*** – The Contractor must maintain or otherwise arrange for alternate site(s) for its system operations, in particular POS claims processing, in the event a catastrophic or other disastrous event prevents continued operations at the Contractor's primary site(s).

(B) ***Backup Files and Secure Off-Site Storage*** – The Contractor must maintain off-site storage of crucial transactions and master files.

(C) ***Call Center Support*** – The Contractor must maintain a plan for immediate rollover of the call centers to alternate locations in the event of the disruption of public utilities or other interruptions of the call center or help lines.

2.040 Financial Provisions

2.041 Fixed Prices for Services / Deliverables

Each Statement of Work or Purchase Order issued under this Contract shall specify (or indicate by reference to the appropriate Contract Exhibit) the firm, fixed prices for all Services/Deliverables, and the associated payment milestones and payment amounts. The State may make progress payments to the Contractor when requested as work progresses, but not more frequently than monthly, in amounts approved by the Contract Administrator, after negotiation. Contractor must show verification of measurable progress at the time of requesting progress payments.

2.042 Adjustments for Reductions in Scope of Services / Deliverables

If the scope of the Services/Deliverables under any Statement of Work issued under this Contract is subsequently reduced by the State, the parties shall negotiate an equitable reduction in Contractor's charges under such Statement of Work commensurate with the reduction in scope.

2.043 Services / Deliverables Covered

For all Services/Deliverables to be provided by Contractor (and its Subcontractors, if any) under this Contract, the State shall not be obligated to pay any amounts in addition to the charges specified in this Contract.

2.044 Invoicing and Payment – In General

(A) Each Statement of Work issued under this Contract shall list (or indicate by reference to the appropriate Contract Exhibit) the prices for all Services/Deliverables, equipment and commodities to be provided, and the associated payment milestones and payment amounts.

(B) Payment of Administration Fee will be predicated on the enrollment records of the Plan Sponsor.

(C) Each Contractor invoice will show details as to charges by Service/Deliverable component and location at a level of detail reasonably necessary to satisfy the State's accounting and charge-back requirements. Invoices for Services performed on a time and materials basis will show, for each individual, the number of hours of Services performed during the billing period, the billable skill/labor category for such person and the applicable hourly billing rate. Prompt payment by the State is contingent on the Contractor's invoices showing the amount owed by the State minus any holdback amount to be retained by the State in accordance with **Section 1.064**.

(D) Correct invoices will be due and payable by the State, in accordance with the State's standard payment procedure as specified in 1984 Public Act No. 279, MCL 17.51 et seq., within 45 days after receipt, provided the State determines that the invoice was properly rendered.

(E) All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the Contract Administrator and the Contractor after the proposed Contract Agreement has been signed and accepted by both the Contractor and the Director of Purchasing Operations, Department of Management & Budget. This activity will occur only upon the specific written direction from Purchasing Operations.

(F) The specific payment schedule for any Contract(s) entered into, as the State and the Contractor(s) will mutually agree upon. 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.

2.045 Pro-ration

To the extent there are any Services that are to be paid for on a monthly basis, the cost of such Services shall be pro-rated for any partial month.

2.046 Antitrust Assignment

Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or Services supplied by third parties to the Contractor, toward fulfillment of this Contract.

2.047 Final Payment

The making of final payment by the State to Contractor does not constitute a waiver by either party of any rights or other claims as to the other party's continuing obligations under the Contract, nor will it constitute a waiver of any claims by one party against the other arising from unsettled claims or failure by a party to comply with this Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard. Contractor's acceptance of final payment by the State under this Contract shall constitute a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still unsettled.

2.048 Electronic Payment Requirement

Electronic transfer of funds is required for payments on State Contracts. Contractors are required to register with the State electronically at http:// www.cpexpress.state.mi.us . As stated in 1984 PA 431, all contracts that the State enters into for the purchase of goods and Services shall provide that payment will be made by electronic fund transfer (EFT).

2.050 Taxes

2.051 Employment Taxes

Contractors must collect and pay all applicable federal, state, and local employment taxes, including the taxes.

2.052 Sales and Use Taxes

Contractors must be registered and to remit sales and use taxes on taxable sales of tangible personal property or Services delivered into the State. Contractors that lack sufficient presence in Michigan to be required to register and pay tax must do so as a volunteer. This requirement extends to: (1) all members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member, and (2) all organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes. In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

2.060 Contract Management

2.061 Contractor Personnel Qualifications

All persons assigned by Contractor to the performance of Services under this Contract must be employees of Contractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved Subcontractor) and must be fully qualified to perform the work assigned to them. Contractor must include a similar provision in any subcontract entered into with a Subcontractor. For the purposes of this Contract, independent contractors engaged by Contractor solely in a staff augmentation role must be treated by the State as if they were employees of Contractor for this Contract only; however, the State understands that the relationship between Contractor and Subcontractor is an independent contractor relationship.

2.062 Contractor Key Personnel

(A) The Contractor must provide the Contract Compliance Inspector with the names of the Key Personnel.

(B) Key Personnel must be dedicated as defined in the Statement of Work to the Project for its duration in the applicable Statement of Work with respect to other individuals designated as Key Personnel for that Statement of Work.

(C) The State will have the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor will notify the State of the proposed assignment, will introduce the individual to the appropriate State representatives, and will provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection.

(D) Contractor must not remove any Key Personnel from their assigned roles or the Contract without the prior written consent of the State. The Contractor's removal of Key Personnel without the prior written consent of the State is an unauthorized removal ("Unauthorized Removal"). Unauthorized Removals does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances, resignation, or for cause termination of the Key Personnel's employment. Unauthorized Removals does not include replacing Key Personnel because of promotions or other job movements allowed by Contractor personnel policies or Collective Bargaining Agreement(s) as long as the State receives prior written notice before shadowing occurs and Contractor provides 30 days of shadowing unless parties agree to a different time period. The Contractor with the State must review any Key Personnel replacements, and appropriate transition planning will be established. Any Unauthorized Removal may be considered by the State to be a material breach of the Contract, in respect of which the State may elect to exercise its termination and cancellation rights.

(E) Contractor must notify the Contract Compliance Inspector and the Contract Administrator at least 10 business days before redeploying non-Key Personnel, who are dedicated to primarily to the Project, to other projects. If the State does not object to the redeployment by its scheduled date, the Contractor may then redeploy the non-Key Personnel.

2.063 Re-assignment of Personnel at the State's Request

The State reserves the right to require the removal from the Project of Contractor personnel found, in the judgment of the State, to be unacceptable. The State's request must be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request must be based on legitimate, good-faith reasons. Replacement personnel for the removed person must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed personnel, the State agrees to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any incident with removed personnel results in delay not reasonably anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Service will not be counted for a time as agreed to by the parties.

2.064 Contractor Personnel Location

All staff assigned by Contractor to work on the Contract will perform their duties either primarily at Contractor's offices and facilities or at State facilities. Without limiting the generality of the foregoing, Key Personnel will, at a minimum, spend at least the amount of time on-site at State facilities as stated in the applicable Statement of Work. Subject to availability, selected Contractor personnel may be assigned office space to be shared with State personnel.

2.065 Contractor Identification

Contractor employees must be clearly identifiable while on State property by wearing a State-issued badge, as required. Contractor employees are required to clearly identify themselves and the company they work for whenever making contact with State personnel by telephone or other means.

2.066 Cooperation with Third Parties

Contractor agrees to cause its personnel and the personnel of any Subcontractors to cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, the Contractor will provide to the State's agents and other contractors reasonable access to Contractor's Project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and will not interfere or jeopardize the safety or operation of the systems or facilities. The State acknowledges that Contractor's time schedule for the Contract is very specific and agrees not to unnecessarily or unreasonably interfere with, delay or otherwise impeded Contractor's performance under this Contract with the requests for access.

2.067 Contractor Return of State Equipment/Resources

Contractor must return to the State any State-furnished equipment, facilities and other resources when no longer required for the Contract in the same condition as when provided by the State, reasonable wear and tear excepted.

2.068 Contract Management Responsibilities

Contractor will be required to assume responsibility for all contractual activities, whether or not that Contractor performs them. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the anticipated Contract. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted. The State reserves the right to approve Subcontractors and to require the Contractor to replace Subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract. Any change in Subcontractors must be approved by the State, in writing, prior to such change.

2.070 Subcontracting by Contractor

2.071 Contractor Full Responsibility

Contractor shall have full responsibility for the successful performance and completion of all of the Services and Deliverables. The State will consider Contractor to be the sole point of contact with regard to all contractual matters under this Contract, including payment of any and all charges for Services and Deliverables.

2.072 State Consent to Delegation

Contractor shall not delegate any duties under this Contract to a Subcontractor unless the Department of Management and Budget, Purchasing Operations has given written consent to such delegation. The State shall have the right of prior written approval of all Subcontractors and to require Contractor to replace any Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request shall be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request shall be based on legitimate, good-faith reasons. Replacement Subcontractor(s) for the removed Subcontractor shall be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed Subcontractor, the State will agree to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any such incident with a removed Subcontractor results in delay not reasonable anticipatable under the circumstances and which is attributable to the State, the applicable SLA for the affected Work will not be counted for a time agreed upon by the parties.

2.073 Subcontractor Bound to Contract

In any subcontracts entered into by Contractor for the performance of the Services, Contractor shall require the Subcontractor, to the extent of the Services to be performed by the Subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The management of any Subcontractor will be the responsibility of Contractor, and Contractor shall remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not subcontracted such performance. Contractor shall make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State will not be obligated to direct payments for the Services other than to Contractor. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under this Contract shall not relieve Contractor of any obligations or performance required under this Contract.

2.074 Flow Down

Except where specifically approved in writing by the State on a case-by-case basis, Contractor shall flow down the obligations in **Sections 2.031, 2.060, 2.100, 2.110, 2.120, 2.130, 2.200** in all of its agreements with any Subcontractors.

2.075 Competitive Selection

Contractor shall select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the Contract.

2.080 State Responsibilities

2.081 Equipment

The State will provide only the equipment and resources identified in the Statements of Work and other Contract Exhibits.

2.082 Facilities

The State must designate space as long as it is available and as provided in the Statement of Work, to house the Contractor's personnel whom the parties agree will perform the Services/Deliverables at State facilities (collectively, the "State Facilities"). Contractor must have reasonable access to, and, unless agreed otherwise by the parties in writing, must observe and comply with all rules and regulations relating to each of the State Facilities (including hours of operation) used by the Contractor in the course of providing the Services. Contractor agrees that it will not, without the prior written consent of the State, use any State Facilities or access any State information systems provided for the Contractor's use, or to which the Contractor otherwise gains access in the course of performing the Services, for any purpose other than providing the Services to the State.

2.090 Security

2.091 Background Checks

On a case-by-case basis, the State may investigate the Contractor's personnel before they may have access to State facilities and systems. The scope of the background check is at the discretion of the State and the results will be used to determine Contractor personnel eligibility for working within State facilities and systems. The investigations will include Michigan State Police Background checks (ICHAT) and may include the National Crime Information Center (NCIC) Finger Prints. Proposed Contractor personnel may be required to complete and submit an RI-8 Fingerprint Card for the NCIC Finger Print Check. Any request for background checks will be initiated by the State and will be reasonably related to the type of work requested.

All Contractor personnel will also be expected to comply with the State's security and acceptable use policies for State IT equipment and resources. See http://www.michigan.gov/dit. Furthermore, Contractor personnel will be expected to agree to the State's security and acceptable use policies before the Contractor personnel will be accepted as a resource to perform work for the State. It is expected the Contractor will present these documents to the prospective employee before the Contractor presents the individual to the State as a proposed resource. Contractor staff will be expected to comply with all Physical Security procedures in place within the facilities where they are working.

2.092 Security, Breach, and Notification

If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and state laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State in writing any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by the Contract within 10 days of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

Further, Contractor's work and deliverables must comply with all applicable State information technology policies and standards including the Michigan Department of Information Technology (MDIT) 1350 Enterprise Security Policy and 1410.17 Michigan State Government Network Security Policy, as applicable and including that:

(A) Contractor must develop a security plan that includes physical security, business continuity, change management, and that identifies all controls for confidentiality, integrity, and availability.

(B) Contractor must have written policies and procedures addressing the use of any protected health data and information that falls under the Health Insurance Portability and Accountability Act (HIPAA) requirements. The policies and procedures must meet all applicable federal and State requirements including the HIPAA requirements. These policies and procedures must include restricted access to the protected health data and information by the Contractor's employees.

(C) Contractor must immediately notify the Department upon learning of any suspected or actual unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements, about which the Contractor becomes aware. The Contractor must work with the Department to mitigate any breach, and provide assurances to the Department on corrective actions to prevent future unauthorized uses or disclosures.

(D) Failure to comply with any of these contractual requirements may result in the termination of the Contract. In accordance with HIPAA requirements, the Contractor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Contractor received from the Department or any other source.

(E) Contractor must immediately notify the Department upon learning of any breach of system or data security. Subject to the approval of the Department, the Contractor must undertake such additional safeguards or changes as recommended by a subsequent independent security audit at the Contractor's expense.

2.093 PCI Data Security Requirements – DELETED (Not Applicable)

2.100 Confidentiality

2.101 Confidentiality

Contractor and the State each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" of Contractor must mean all non-public proprietary information of Contractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary or with a similar designation. "Confidential Information" of the State must mean any information which is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, state and local laws and regulations) or which, in the case of tangible materials provided to Contractor by the State under its performance under this Contract, is marked as confidential, proprietary or with a similar designation by the State. "Confidential Information" excludes any information (including this Contract) that is publicly available under the Michigan FOIA.

2.102 Protection and Destruction of Confidential Information

The State and Contractor will each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Contractor nor the State will (i) make any use of the Confidential Information of the other except as contemplated by this Contract, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party will limit disclosure of the other party's Confidential Information to employees and Subcontractors who must have access to fulfill the purposes of this Contract. Disclosure to, and use by, a Subcontractor is permissible where (A) use of a Subcontractor is authorized under this Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Subcontractor's scope of responsibility, and (C) Contractor obligates the Subcontractor in a written Contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor and of any Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Contractor's and the Subcontractor's obligations under this Section and of the employee's obligation to Contractor or Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure.

2.103 Exclusions

Notwithstanding the foregoing, the provisions of **Section 2.100** will not apply to any particular information which the State or Contractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Further, the provisions of **Section 2.100** will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

2.104 No Implied Rights

Nothing contained in this Section must be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

2.105 Respective Obligations

The parties' respective obligations under this Section must survive the termination or expiration of this Contract for any reason.

2.110 Records and Inspections

2.111 Inspection of Work Performed

The State's authorized representatives must at all reasonable times and with seven days prior written request, have the right to enter Contractor's premises, or any other places, where the Services are being performed, and must have access, upon reasonable request, to interim drafts of Deliverables or work-in-progress. Upon seven days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Contractor must provide all reasonable facilities and assistance for the State's representatives.

Contractor must maintain and make available the following to the State's auditors: **Audits will review multiple items, including but not limited to:**

(A) Contracts with providers and subcontractors

(B) Recoveries by the Contractor from provider audits

(C) Contractor compliance with contract pricing terms

(D) Adherence to Performance Guarantees

(E) Proper and accurate administration of the coverage design

(F) Any Claims paid by the Contractor to ineligibles

(G) Programs including, but not limited to, medical management

2.112 Examination of Records

For seven years after the Contractor provides any work under this Contract (the "Audit Period"), the State may examine and copy any of Contractor's books, records, documents, database(s) and papers pertinent to establishing Contractor's compliance with the Contract and with applicable laws and rules. The State must notify the Contractor seven days before examining the Contractor's books and records. This provision also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor, or any Subcontractor of Contractor performing Services in connection with the Contract.

The State will, periodically at timeframes to be determined at the sole discretion of Plan Sponsor, perform on-site audits of the Contractor. The State reserves the right to choose the audit methodology. The Contractor must make records associated with the administration of this Contract available to, and must cooperate with, such auditors and audits as the State may designate. The Contractor must maintain and make available to the State's auditors the following claim source documents for the audit:

- Paper claim submission - Original document or microfilm or print-out of imaged claim document
- Optical Character Recognition (OCR) - Copy of original paper document
- Electronic Data Interchange (EDI) - Documentation in a readable format of original submitted data as it appeared when received by administrator

2.113 Retention of Records

Contractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Contract and to the Services, equipment, and commodities provided under the Contract) pertaining to the Contract according to generally accepted accounting principles and other procedures specified in this Section.

Financial and accounting records must be made available, upon request, to the State at any time during the Audit Period. If an audit, litigation, or other action involving Contractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later.

2.114 Audit Resolution

If necessary, the Contractor and the State will meet to review each audit report promptly after issuance. The Contractor must respond to each audit report in writing within 30 days from receipt of the report, unless a shorter response time is specified in the report. The Contractor must develop, and the State must agree to an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report. The Contractor cannot hold a Member, a Provider or the Plan Sponsor financially responsible for the Contractor's errors that are identified in an audit. If a pattern of payment errors is identified for a particular provider, the Contractor must assume the cost of auditing that provider.

2.115 Errors

(A) Contractor must initiate recovery of mispayments and reimburse the Plan Sponsor for incorrect payments identified through the audit process.

(B) If the audit demonstrates any errors in the documents provided to the State, then the amount in error must 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 invoices. If a balance remains after four invoices, then the remaining amount will be due as a payment or refund within 45 days of the last quarterly invoice that the balance appeared on or termination of the Contract, whichever is earlier.

(C) If a pattern of systematic claims payment errors is found through an audit or series of audits, the Contractor must assume the cost of auditing all claims/transactions that may be subject to the systematic error and initiate recovery activities on any mispayments discovered through this expanded audit.

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

2.120 Warranties

2.121 Warranties and Representations

The Contractor represents and warrants:

(A) It is capable in all respects of fulfilling and must fulfill all of its obligations under this Contract. The performance of all obligations under this Contract must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under this Contract.

(B) The Contract Appendices, Attachments and Exhibits identify the equipment and software and Services necessary for the Deliverable(s) to perform and Services to operate in compliance with the Contract's requirements and other standards of performance.

(C) It is the lawful owner or licensee of any Deliverable licensed or sold to the State by Contractor or developed by Contractor under this Contract, and Contractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Contractor to the State under neither this Contract, nor their use by the State will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

(D) If, under this Contract, Contractor procures any equipment, software or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Contractor under Contractor's name), then in addition to Contractor's other responsibilities with respect to the items in this Contract, Contractor must assign or otherwise transfer to the State or its designees, or afford the State the coverages of, any manufacturer's warranty for the Deliverable.

(E) Contract signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Contract, on behalf of Contractor.

(F) It is qualified and registered to transact business in all locations where required.

(G) Neither the Contractor nor any Affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of its duties and responsibilities to the State under this Contract or otherwise create an appearance of impropriety with respect to the award or performance of this Agreement. Contractor must notify the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

(H) Neither Contractor nor any Affiliates, nor any employee of either has accepted or must accept anything of value based on an understanding that the actions of the Contractor or Affiliates or employee on behalf of the State would be influenced. Contractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

(I) Neither Contractor nor any Affiliates, nor any employee of either has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Contractor or the Affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of this Contract.

(J) The prices proposed by Contractor were arrived at independently, without consultation, communication, or agreement with any other bidder for the purpose of restricting competition; the prices quoted were not knowingly disclosed by Contractor to any other bidder; and no attempt was made by Contractor to induce any other person to submit or not submit a proposal for the purpose of restricting competition.

(K) All financial statements, reports, and other information furnished by Contractor to the State as part of its response to the RFP or otherwise in connection with the award of this Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Contractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information, there have been no material adverse change in the business, properties, financial condition, or results of operations of Contractor.

(L) All written information furnished to the State by or for the Contractor in connection with this Contract, including its bid, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

(M) It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Contractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Contractor failed to perform or otherwise breached an obligation of the Contract.

(N) If any of the certifications, representations, or disclosures made in the Contractor's original bid response change after contract award, the Contractor is required to report those changes immediately to the Department of Management and Budget, Purchasing Operations.

2.122 Warranty of Merchantability – DELETED (Not Applicable)

2.123 Warranty of Fitness for a Particular Purpose – DELETED (Not Applicable)

2.124 Warranty of Title – DELETED (Not Applicable)

2.125 Equipment Warranty – DELETED (Not Applicable)

2.126 Equipment to be New – DELETED (Not Applicable)

2.127 Prohibited Products – DELETED (Not Applicable)

2.128 Consequences for Breach

In addition to any remedies available in law, if the Contractor breaches any of the warranties contained in this section, the breach may be considered as a default in the performance of a material obligation of this Contract.

2.130 Insurance

2.131 Liability Insurance

Contractor must provide proof of the minimum levels of insurance coverage as stated below. The insurance must protect the State from claims which may arise out of or result from the Contractor's performance of Services under the terms of this Contract, whether the Services are performed by the Contractor, or by any subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain under this Contract.

All insurance coverage's provided relative to this Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The insurance must be written for not less than any minimum coverage specified in this Contract or required by law, whichever is greater.

The insurers selected by Contractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required in this Contract must be issued by companies that have been approved to do business in the State.
See www.michigan.gov/dleg.

Where specific limits are shown, they are the minimum acceptable limits. If Contractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits.

Contractor is required to pay for and provide the type and amount of insurance checked ☑ below:

☑ **1**. **Commercial General Liability** with the following minimum coverage:
$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ **2.** If a motor vehicle is used to provide Services or products under this Contract, the Contractor must have **vehicle liability** insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ **3**. **Workers' compensation** coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ **4**. **Employers liability** insurance with the following minimum limits:
$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☑ **5**. **Employee Fidelity**, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of three million dollars ($3,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☑ **6**. **Umbrella** or Excess Liability Insurance in a minimum amount of ten million dollars ($10,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☑ **7**. **Professional Liability** (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

2.132 Subcontractor Insurance Coverage

Except where the State has approved in writing a Contractor subcontract with other insurance provisions, Contractor must require all of its Subcontractors under this Contract to purchase and maintain the insurance coverage as described in this Section for the Contractor in connection with the performance of work by those Subcontractors. Alternatively, Contractor may include any Subcontractors under Contractor's insurance on the coverage required in this Section. Subcontractor(s) must fully comply with the insurance coverage required in this Section. Failure of Subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

2.133 Certificates of Insurance and Other Requirements

Contractor must furnish to DMB-Purchasing Operations, certificate(s) of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificate must be on the standard "accord" form or equivalent. **THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** All Certificate(s) are to be prepared and submitted by the Insurance Provider. All Certificate(s) must contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include the Contract or Purchase Order number affected. Before the Contract is signed, and not less than 20 days before the insurance expiration date every year thereafter, the Contractor must provide evidence that the State and its agents, officers and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

Contractor must maintain all required insurance coverage throughout the term of the Contract and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of this Contract. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Contractor under this Contract to any indemnified party or other persons. Contractor is responsible for all deductibles with regard to the insurance. If the Contractor fails to pay any premium for required insurance as specified in this Contract, or if any insurer cancels or significantly reduces any required insurance as specified in this Contract without the State's written consent, then the State may, after the State has given the Contractor at least 30 days written notice, pay the premium or procure similar insurance coverage from another company or companies. The State may deduct any part of the cost from any payment due the Contractor, or the Contractor must pay that cost upon demand by the State.

2.140 Indemnification

2.141 General Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from liability, including all claims and losses, and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties), accruing or resulting to any person, firm or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or tortious acts of the Contractor or any of its Subcontractors, or by anyone else for whose acts any of them may be liable.

2.142 Code Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from any claim, loss, or expense arising from Contractor's breach of the No Surreptitious Code Warranty.

2.143 Employee Indemnification

In any claims against the State of Michigan, its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its Subcontractors, the indemnification obligation under the Contract must not be limited in any way by the amount or type of damages, compensation or coverages payable by or for the Contractor or any of its Subcontractors under worker's disability compensation acts, disability coverage acts or other employee coverage acts. This indemnification clause is intended to be comprehensive. Any overlap in provisions, 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 provisions.

2.144 Patent/Copyright Infringement Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that the action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of the equipment, software, commodity or service, or the use or reproduction of any documentation provided with the equipment, software, commodity or service infringes any United States patent, copyright, trademark or trade secret of any person or entity, which is enforceable under the laws of the United States.

In addition, should the equipment, software, commodity, or service, or its operation, become or in the State's or Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor must at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if the option is not reasonably available to the Contractor, (ii) replace or modify to the State's satisfaction the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if the option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

Notwithstanding the foregoing, the Contractor has no obligation to indemnify or defend the State for, or to pay any costs, damages or attorneys' fees related to, any claim based upon (i) equipment developed based on written specifications of the State; (ii) use of the equipment in a configuration other than implemented or approved in writing by the Contractor, including, but not limited to, any modification of the equipment by the State; or (iii) the combination, operation, or use of the equipment with equipment or software not supplied by the Contractor under this Contract.

2.145 Continuation of Indemnification Obligations

Contractor's duty to indemnify under this Section continues in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred before expiration or cancellation.

2.146 Indemnification Procedures

The procedures set forth below must apply to all indemnity obligations under this Contract.

(A) After the State receives notice of the action or proceeding involving a claim for which it will seek indemnification, the State must promptly notify Contractor of the claim in writing and take or assist Contractor in taking, as the case may be, any reasonable action to avoid the imposition of a default judgment against Contractor. No failure to notify the Contractor relieves the Contractor of its indemnification obligations except to the extent that the Contractor can prove damages attributable to the failure. Within 10 days following receipt of written notice from the State relating to any claim, the Contractor must notify the State in writing whether Contractor agrees to assume control of the defense and settlement of that claim (a "Notice of Election"). After notifying Contractor of a claim and before the State receiving Contractor's Notice of Election, the State is entitled to defend against the claim, at the Contractor's expense, and the Contractor will be responsible for any reasonable costs incurred by the State in defending against the claim during that period.

(B) If Contractor delivers a Notice of Election relating to any claim: (i) the State is entitled to participate in the defense of the claim and to employ counsel at its own expense to assist in the handling of the claim and to monitor and advise the State about the status and progress of the defense; (ii) the Contractor must, at the request of the State, demonstrate to the reasonable satisfaction of the State, the Contractor's financial ability to carry out its defense and indemnity obligations under this Contract; (iii) the Contractor must periodically advise the State about the status and progress of the defense and must obtain the prior written approval of the State before entering into any settlement of the claim or ceasing to defend against the claim and (iv) to the extent that any principles of Michigan governmental or public law may be involved or challenged, the State has the right, at its own expense, to control the defense of that portion of the claim involving the principles of Michigan governmental or public law. But the State may retain control of the defense and settlement of a claim by notifying the Contractor in writing within 10 days after the State's receipt of Contractor's information requested by the State under clause (ii) of this paragraph if the State determines that the Contractor has failed to demonstrate to the reasonable satisfaction of the State the Contractor's financial ability to carry out its defense and indemnity obligations under this Section. Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. In the event the insurer's attorney represents the State under this Section, the insurer's attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

(C) If Contractor does not deliver a Notice of Election relating to any claim of which it is notified by the State as provided above, the State may defend the claim in the manner as it may deem appropriate, at the cost and expense of Contractor. If it is determined that the claim was one against which Contractor was required to indemnify the State, upon request of the State, Contractor must promptly reimburse the State for all the reasonable costs and expenses.

2.150 Termination/Cancellation

2.151 Notice and Right to Cure

If the Contractor breaches the Contract, and the State in its sole discretion determines that the breach is curable, then the State will provide the Contractor with written notice of the breach and a time period (not less than 30 days) to cure the Breach. The notice of breach and opportunity to cure is inapplicable for successive or repeated breaches or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage, or destruction of any real or tangible personal property.

2.152 Termination for Cause

(A) The State may terminate this Contract, for cause, by notifying the Contractor in writing, if the Contractor (i) breaches any of its material duties or obligations under this Contract (including a Chronic Failure to meet any particular SLA), or (ii) fails to cure a breach within the time period specified in the written notice of breach provided by the State.

(B) If this Contract is terminated for cause, the Contractor must pay all costs incurred by the State in terminating this Contract, including but not limited to, State administrative costs, reasonable attorneys' fees and court costs, and any reasonable additional costs the State may incur to procure the Services/Deliverables required by this Contract from other sources. Re-procurement costs are not consequential, indirect or incidental damages, and cannot be excluded by any other terms otherwise included in this Contract, provided the costs are not in excess of 50% more than the prices for the Service/Deliverables provided under this Contract.

(C) If the State chooses to partially terminate this Contract for cause, charges payable under this Contract will be equitably adjusted to reflect those Services/Deliverables that are terminated and the State must pay for all Services/Deliverables for which Final Acceptance has been granted provided up to the termination date. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

(D) If the State terminates this Contract for cause under this Section, and it is determined, for any reason, that Contractor was not in breach of contract under the provisions of this section, that termination for cause must be deemed to have been a termination for convenience, effective as of the same date, and the rights and obligations of the parties must be limited to that otherwise provided in this Contract for a termination for convenience.

2.153 Termination for Convenience

The State may terminate this Contract for its convenience, in whole or part, if the State determines that a termination is in the State's best interest. Reasons for the termination must be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the Services or products specified in the Contract, (b) relocation of office, program changes, changes i laws, rules, or regulations make implementation of the Services no longer practical or feasible, (c) unacceptable prices for Additional Services or New Work requested by the State, or (d) falsification or misrepresentation, by inclusion or non-inclusion, of information material to a response to any RFP issued by the State. The State may terminate this Contract for its convenience, in whole or in part, by giving Contractor written notice at least 30 days before the date of termination. If the State chooses to terminate this Contract in part, the charges payable under this Contract must be equitably adjusted to reflect those Services/Deliverables that are terminated. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

2.154 Termination for Non-Appropriation

(A) Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this Contract. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State must terminate this Contract and all affected Statements of Work, in whole or in part, at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to Contractor. The State must give Contractor at least 30 days advance written notice of termination for non-appropriation or unavailability (or the time as is available if the State receives notice of the final decision less than 30 days before the funding cutoff).

(B) If funding for the Contract is reduced by law, or funds to pay Contractor for the agreed-to level of the Services or production of Deliverables to be provided by Contractor are not appropriated or otherwise unavailable, the State may, upon 30 days written notice to Contractor, reduce the level of the Services or the change the production of Deliverables in the manner and for the periods of time as the State may elect. The charges payable under this Contract will be equitably adjusted to reflect any equipment, services or commodities not provided by reason of the reduction.

(C) If the State terminates this Contract, eliminates certain Deliverables, or reduces the level of Services to be provided by Contractor under this Section, the State must pay Contractor for all Work-in-Process performed through the effective date of the termination or reduction in level, as the case may be and as determined by the State, to the extent funds are available. This Section will not preclude Contractor from reducing or stopping Services/Deliverables or raising against the State in a court of competent jurisdiction, any claim for a shortfall in payment for Services performed or Deliverables finally accepted before the effective date of termination.

2.155 Termination for Criminal Conviction

The State may terminate this Contract immediately and without further liability or penalty in the event Contractor, an officer of Contractor, or an owner of a 25% or greater share of Contractor is convicted of a criminal offense related to a State, public or private Contract or subcontract.

2.156 Termination for Approvals Rescinded

The State may terminate this Contract if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services under Constitution 1963, Article 11, § 5, and Civil Service Rule 7-1. In that case, the State will pay the Contractor for only the work completed to that point under the Contract. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in the written notice.

2.157 Rights and Obligations upon Termination

(A) If the State terminates this Contract for any reason, the Contractor must (1) stop all work as specified in the notice of termination, (2) take any action that may be necessary, or that the State may direct, for preservation and protection of Deliverables or other property derived or resulting from this Contract that may be in Contractor's possession, (3) return all materials and property provided directly or indirectly to Contractor by any entity, agent or employee of the State,

(4) transfer title in, and deliver to, the State, unless otherwise directed, all Deliverables intended to be transferred to the State at the termination of the Contract and which are resulting from the Contract (which must be provided to the State on an "As-Is" basis except to the extent the amounts paid by the State in respect of the items included compensation to Contractor for the provision of warranty services in respect of the materials), and (5) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or termination settlement costs, to the maximum practical extent, including terminating or limiting as otherwise applicable those subcontracts and outstanding orders for material and supplies resulting from the terminated Contract.

(B) If the State terminates this Contract before its expiration for its own convenience, the State must pay Contractor for all charges due for Services provided before the date of termination and, if applicable, as a separate item of payment under this Contract, for Work In Process, on a percentage of completion basis at the level of completion determined by the State. All completed or partially completed Deliverables prepared by Contractor under this Contract, at the option of the State, becomes the State's property, and Contractor is entitled to receive equitable fair compensation for the Deliverables. Regardless of the basis for the termination, the State is not obligated to pay, or otherwise compensate, Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

(C) Upon a good faith termination, the State may assume, at its option, any subcontracts and agreements for services and deliverables provided under this Contract, and may further pursue completion of the Services/Deliverables under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

2.158 Reservation of Rights

Any termination of this Contract or any Statement of Work issued under it by a party must be with full reservation of, and without prejudice to, any rights or remedies otherwise available to the party with respect to any claims arising before or as a result of the termination.

2.160 Termination by Contractor – DELETED (Not Applicable)

2.170 Transition Responsibilities

2.171 Contractor Transition Responsibilities

If the State terminates this Contract, for convenience or cause, or if the Contract is otherwise dissolved, voided, rescinded, nullified, expires or rendered unenforceable, the Contractor agrees to comply with direction provided by the State to assist in the orderly transition of equipment, services, software, leases, etc. to the State or a third party designated by the State. If this Contract expires or terminates, the Contractor agrees to make all reasonable efforts to effect an orderly transition of services within a reasonable period of time that in no event will exceed 365 days. These efforts must include, but are not limited to, those listed in **Sections 2.171, 2.172, 2.173, 2.174, and 2.175.**

2.172 Contractor Personnel Transition

Contractor must work with the State, or a specified third party, to develop a transition plan setting forth the specific tasks and schedule to be accomplished by the parties, to effect an orderly transition. The Contractor must allow as many personnel as practicable to remain on the job to help the State, or a specified third party, maintain the continuity and consistency of the services required by this Contract. In addition, during or following the transition period, in the event the State requires the Services of the Contractor's subcontractors or vendors, as necessary to meet its needs, Contractor agrees to reasonably, and with good-faith, work with the State to use the Services of Contractor's subcontractors or vendors. Contractor will notify all of Contractor's subcontractors of procedures to be followed during transition.

2.173 Contractor Information Transition

Contractor agrees to provide reasonable detailed specifications for all Services/Deliverables needed by the State, or specified third party, to properly provide the Services/Deliverables required under this Contract. The Contractor will provide the State with asset management data generated from the inception of this Contract through the date on which this Contractor is terminated in a comma-delineated format unless otherwise requested by the State. The Contractor will deliver to the State any remaining owed reports and documentation still in Contractor's possession subject to appropriate payment by the State.

2.174 Contractor Software Transition

Contractor must reasonably assist the State in the acquisition of any Contractor software required to perform the Services/use the Deliverables under this Contract. This must include any documentation being used by the Contractor to perform the Services under this Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level. Upon notification by the State, Contractor may be required to freeze all non-critical changes to Deliverables/Services.

2.175 Transition Payments

If the transition results from a termination for any reason, reimbursement must be governed by the termination provisions of this Contract. If the transition results from expiration, the Contractor will be reimbursed for all reasonable transition costs (i.e. costs incurred within the agreed period after contract expiration that result from transition operations) at the rates agreed upon by the State. The Contractor will prepare an accurate accounting from which the State and Contractor may reconcile all outstanding accounts.

2.176 State Transition Responsibilities

In the event that this Contract is terminated, dissolved, voided, rescinded, nullified, or otherwise rendered unenforceable, the State agrees to perform the following obligations, and any others upon which the State and the Contractor agree to:

(A) Reconciling all accounts between the State and the Contractor;

(B) Completing any pending post-project reviews.

2.180 Stop Work

2.181 Stop Work Orders

The State may, at any time, by written stop work order to Contractor, require that Contractor stop all, or any part, of the work called for by the Contract for a period of up to 90 calendar days after the stop work order is delivered to Contractor, and for any further period to which the parties may agree. The stop work order must be identified as a stop work order and must indicate that it is issued under this **Section 2.180**. Upon receipt of the stop work order, Contractor must immediately comply with its terms and take all reasonable steps to minimize incurring costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State must either: (a) cancel the stop work order; or (b) terminate the work covered by the stop work order as provided in **Section 2.150**.

2.182 Cancellation or Expiration of Stop Work Order

Contractor must resume work if the State cancels a Stop Work Order or if it expires. The parties will agree upon an equitable adjustment in the delivery schedule, the Contract price, or both, and the Contract must be modified, in writing, accordingly, if: (a) the stop work order results in an increase in the time required for, or in Contractor's costs properly allocable to, the performance of any part of the Contract; and (b) Contractor asserts its right to an equitable adjustment within 30 calendar days after the end of the period of work stoppage; provided that, if the State decides the facts justify the action, the State may receive and act upon a Contractor proposal submitted at any time before final payment under the Contract. Any adjustment will conform to the requirements of **Section 2.024**.

2.183 Allowance of Contractor Costs

If the stop work order is not canceled and the work covered by the stop work order is terminated for reasons other than material breach, the termination must be deemed to be a termination for convenience under **Section 2.150**, and the State will pay reasonable costs resulting from the stop work order in arriving at the termination settlement. For the avoidance of doubt, the State is not liable to Contractor for loss of profits because of a stop work order issued under this **Section 2.180.**

2.190 Dispute Resolution

2.191 In General

Any claim, counterclaim, or dispute between the State and Contractor arising out of or relating to the Contract or any Statement of Work must be resolved as follows. For all Contractor claims seeking an increase in the amounts payable to Contractor under the Contract, or the time for Contractor's performance, Contractor must submit a letter, together with all data supporting the claims, executed by Contractor's Contract Administrator or the Contract Administrator's designee certifying that (a) the claim is made in good faith, (b) the amount claimed accurately reflects the adjustments in the amounts payable to Contractor or the time for Contractor's performance for which Contractor believes the State is liable and covers all costs of every type to which Contractor is entitled from the occurrence of the claimed event, and (c) the claim and the supporting data are current and complete to Contractor's best knowledge and belief.

2.192 Informal Dispute Resolution

(A) All disputes between the parties must be resolved under the Contract Management procedures in this Contract. If the parties are unable to resolve any disputes after compliance with the processes, the parties must meet with the Director of Purchasing Operations, DMB, or designee, for the purpose of attempting to resolve the dispute without the need for formal legal proceedings, as follows:

(1) The representatives of Contractor and the State must meet as often as the parties reasonably deem necessary to gather and furnish to each other all information with respect to the matter in issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives must discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding.

(2) During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to the Contract will be honored in order that each of the parties may be fully advised of the other's position.

(3) The specific format for the discussions will be left to the discretion of the designated State and Contractor representatives, but may include the preparation of agreed upon statements of fact or written statements of position.

(4) Following the completion of this process within 60 calendar days, the Director of Purchasing Operations, DMB, or designee, must issue a written opinion regarding the issue(s) in dispute within 30 calendar days. The opinion regarding the dispute must be considered the State's final action and the exhaustion of administrative remedies.

(B) This Section will not be construed to prevent either party from instituting, and a party is authorized to institute, formal proceedings earlier to avoid the expiration of any applicable limitations period, to preserve a superior position with respect to other creditors, or under **Section 2.193**.

(C) The State will not mediate disputes between the Contractor and any other entity, except state agencies, concerning responsibility for performance of work under the Contract.

2.193 Injunctive Relief

The only circumstance in which disputes between the State and Contractor will not be subject to the provisions of **Section 2.192** is where a party makes a good faith determination that a breach of the terms of the Contract by the other party is the that the damages to the party resulting from the breach will be so immediate, so large or severe and so incapable of adequate redress after the fact that a temporary restraining order or other immediate injunctive relief is the only adequate remedy.

2.194 Continued Performance

Each party agrees to continue performing its obligations under the Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate the Contract as provided in **Section 2.150**, as the case may be.

2.200 Federal and State Contract Requirements

2.201 Nondiscrimination

In the performance of the Contract, Contractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her 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. Contractor further agrees that every subcontract entered into for the performance of this Contract or any purchase order resulting from this Contract will contain a provision requiring non-discrimination in employment, as specified here, binding upon each Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., and any breach of this provision may be regarded as a material breach of the Contract.

2.202 Unfair Labor Practices

Under 1980 PA 278, MCL 423.321, et seq., the State must 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 under Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. A Contractor of the State, in relation to the Contract, must not enter into a contract with a Subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any Contract if, after award of the Contract, the name of Contractor as an employer or the name of the Subcontractor, manufacturer or supplier of Contractor appears in the register.

2.203 Workplace Safety and Discriminatory Harassment

In performing Services for the State, the Contractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see www.mi.gov/mdcs/0,1607,7-147-6877---,00.html.

2.210 Governing Law

2.211 Governing Law

This Contract must in all respects be governed by, and construed according to, the substantive laws of the State of Michigan without regard to any Michigan choice of law rules that would apply the substantive law of any other jurisdiction to the extent not inconsistent with, or pre-empted by federal law.

2.212 Compliance with Laws

Contractor shall comply with all applicable state, federal and local laws and ordinances in providing the Services/Deliverables.

2.213 Jurisdiction

Any dispute arising from the Contract must be resolved in the State of Michigan. With respect to any claim between the parties, Contractor consents to venue in Ingham County, Michigan, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non conveniens or otherwise. Contractor agrees to appoint agents in the State of Michigan to receive service of process.

2.220 Limitation of Liability – DELETED (Not Applicable)

2.230 Disclosure Responsibilities

2.231 Disclosure of Litigation

(A) Disclosure. Contractor must disclose any material criminal litigation, investigations or proceedings involving the Contractor (and each Subcontractor) or any of its officers or directors or any litigation, investigations or proceedings under the Sarbanes-Oxley Act.

In addition, each Contractor (and each Subcontractor) must notify the State of any material civil litigation, arbitration or proceeding which arises during the term of the Contract and extensions, to which Contractor (or, to the extent Contractor is aware, any Subcontractor) is a party, and which involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Contractor or any Subcontractor; or (ii) a claim or written allegation of fraud against Contractor or, to the extent Contractor is aware, any Subcontractor by a governmental or public entity arising out of their business dealings with governmental or public entities. The Contractor must disclose in writing to the Contract Administrator any litigation, investigation, arbitration or other proceeding (collectively, "Proceeding") within 30 days of its occurrence. Details of settlements which are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Contractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section.

(B) Assurances. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of this Contract would cause a reasonable party to be concerned about:

(1) The ability of Contractor (or a Subcontractor) to continue to perform this Contract according to its terms and conditions, or

(2) Whether Contractor (or a Subcontractor) in performing Services for the State is engaged in conduct which is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of this Contract or a violation of Michigan law, regulations or public policy, then the Contractor must provide the State all reasonable assurances requested by the State to demonstrate that:

(a) Contractor and its Subcontractors will be able to continue to perform this Contract and any Statements of Work according to its terms and conditions, and

(b) Contractor and its Subcontractors have not and will not engage in conduct in performing the Services which is similar in nature to the conduct alleged in the Proceeding.

(C) Contractor must make the following notifications in writing:

(1) Within 30 days of Contractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records, Contractor must notify DMB Purchasing Operations.

(2) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers.

(3) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to company affiliations occur.

2.232 Call Center Disclosure

Contractor and/or all Subcontractors involved in the performance of this Contract providing call or contact center services to the State must disclose the location of its call or contact center services to inbound callers. Failure to disclose this information is a material breach of this Contract.

2.233 Bankruptcy

The State may, without prejudice to any other right or remedy, terminate this Contract, in whole or in part, and, at its option, may take possession of the "Work in Process" and finish the Works in Process by whatever appropriate method the State may deem expedient if:

(A) Contractor files for protection under the bankruptcy laws;

(B) An involuntary petition is filed against the Contractor and not removed within 30 days;

(C) Contractor becomes insolvent or if a receiver is appointed due to the Contractor's insolvency;

(D) Contractor makes a general assignment for the coverage of creditors; or

(E) Contractor or its affiliates are unable to provide reasonable assurances that the Contractor or its affiliates can deliver the services under this Contract.

Contractor will fix appropriate notices or labels on the Work in Process to indicate ownership by the State. To the extent reasonably possible, materials and Work in Process must be stored separately from other stock and marked conspicuously with labels indicating ownership by the State.

2.240 Performance

2.241 Time of Performance

(A) Contractor must use commercially reasonable efforts to provide the resources necessary to complete all Services and Deliverables according to the time schedules contained in the Statements of Work and other Exhibits governing the work, and with professional quality.

(B) Without limiting the generality of **Section 2.241(a),** Contractor must notify the State in a timely manner upon becoming aware of any circumstances that may reasonably be expected to jeopardize the timely and successful completion of any Deliverables/Services on the scheduled due dates in the latest State-approved delivery schedule and must inform the State of the projected actual delivery date.

(C) If the Contractor believes that a delay in performance by the State has caused or will cause the Contractor to be unable to perform its obligations according to specified Contract time periods, the Contractor must notify the State in a timely manner and must use commercially reasonable efforts to perform its obligations according to the Contract time periods notwithstanding the State's failure. Contractor will not be in default for a delay in performance to the extent the delay is caused by the State.

2.242 Service Level Agreements (SLAs)

(A) SLAs will be completed with the following operational considerations:

(1) SLAs will not be calculated for individual Incidents where any event of Excusable Failure has been determined; Incident means any interruption in Services.

(2) SLAs will not be calculated for individual Incidents where loss of service is planned and where the State has received prior notification or coordination.

(3) SLAs will not apply if the applicable Incident could have been prevented through planning proposed by Contractor and not implemented at the request of the State. To invoke this consideration, complete documentation relevant to the denied planning proposal must be presented to substantiate the proposal.

(4) Time period measurements will be based on the time Incidents are received by the Contractor and the time that the State receives notification of resolution based on 24x7x365 time period, except that the time period measurement will be suspended based on the following:

(a) Time period(s) will not apply where Contractor does not have access to a physical State Location and where access to the State Location is necessary for problem identification and resolution.

(b) Time period(s) will not apply where Contractor needs to obtain timely and accurate information or appropriate feedback and is unable to obtain timely and accurate information or appropriate feedback from the State.

(B) Chronic Failure for any Service(s) will be defined as three unscheduled outage(s) or interruption(s) on any individual Service for the same reason or cause or if the same reason or cause was reasonably discoverable in the first instance over a rolling 30 day period. Chronic Failure will result in the State's option to terminate the effected individual Service(s) and procure them from a different vendor for the chronic location(s) with Contractor to pay the difference in charges for up to three additional months. The termination of the Service will not affect any tiered pricing levels.

(C) Root Cause Analysis will be performed on any Business Critical outage(s) or outage(s) on Services when requested by the Contract Administrator. Contractor will provide its analysis within two weeks of outage(s) and provide a recommendation for resolution.

(D) All decimals must be rounded to two decimal places with five and greater rounding up and four and less rounding down unless otherwise specified.

2.243 Liquidated Damages – DELETED (Not Applicable)

2.244 Excusable Failure

Neither party will be liable for any default, damage or delay in the performance of its obligations under the Contract to the extent the default, damage or delay is caused by government regulations or requirements (executive, legislative, judicial, military or otherwise), earthquake, war, water or other forces of nature or acts of God, delays or failures of transportation, equipment shortages, suppliers' failures, or acts or omissions of common carriers, fire; riots, civil disorders; strikes or other labor disputes, embargoes; 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 a party; provided the non-performing party and its Subcontractors are without fault in causing the default or delay, and the 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.

If a party does not perform its contractual obligations for any of the reasons listed above, the non-performing party will be excused from any further performance of its affected obligation(s) for as long as the circumstances prevail. But the party must use commercially reasonable efforts to recommence performance whenever and to whatever extent possible without delay. A party must promptly notify the other party in writing immediately after the excusable failure occurs, and also when it abates or ends.

If any of the above-enumerated circumstances substantially prevent, hinder, or delay the Contractor's performance of the Services/provision of Deliverables for more than 10 Business 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/Deliverables from an alternate source, and the State is not be liable for payment for the unperformed Services/ Deliverables not provided under the Contract for so long as the delay in performance continues; (b) the State may terminate any portion of the Contract so affected and the charges payable will be equitably adjusted to reflect those Services/Deliverables terminated; or (c) the State may terminate the affected Statement of Work without liability to Contractor as of a date specified by the State in a written notice of termination to the Contractor, except to the extent that the State must pay for Services/Deliverables provided through the date of termination.

Contractor 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/Deliverables not provided as a result of the Excusable Failure condition. Defaults or delays in performance by Contractor which are caused by acts or omissions of its Subcontractors will not relieve Contractor of its obligations under the Contract except to the extent that a Subcontractor is itself subject to an Excusable Failure condition described above and Contractor 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.

2.250 Approval of Deliverables – DELETED (Not Applicable)

2.260 Ownership

2.261 Ownership of Work Product by State

The State owns all Deliverables as they are works made for hire by the Contractor for the State. The State owns all United States and international copyrights, trademarks, patents or other proprietary rights in the Deliverables.

2.262 Vesting of Rights

With the sole exception of any preexisting licensed works identified in the SOW, the Contractor assigns, and upon creation of each Deliverable automatically assigns, to the State, ownership of all United States and international copyrights, trademarks, patents, or other proprietary rights in each and every Deliverable, whether or not registered by the Contractor, insofar as any the Deliverable, by operation of law, may not be considered work made for hire by the Contractor for the State. From time to time upon the State's request, the Contractor must confirm the assignment by execution and delivery of the assignments, confirmations of assignment, or other written instruments as the State may request. The State may obtain and hold in its own name all copyright, trademark, and patent registrations and other evidence of rights that may be available for Deliverables.

2.263 Rights in Data

(A) The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract. The Contractor will not use the State's data for any purpose other than providing the Services, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data. Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services and must disclose the information only to its employees who have a strict need-to-know the information. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

(B) The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees who have a strict need to know the information, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

2.264 Ownership of Materials

The State and the Contractor will continue to own their respective proprietary technologies developed before entering into the Contract. Any hardware bought through the Contractor by the State, and paid for by the State, will be owned by the State. Any software licensed through the Contractor and sold to the State, will be licensed directly to the State.

2.270 State Standards

2.271 Existing Technology Standards

Contractor will adhere to all existing standards as described within the comprehensive listing of the State's existing technology standards at http://www.michigan.gov/dit.

2.272 Acceptable Use Policy

To the extent that Contractor has access to the State computer system, Contractor must comply with the State's Acceptable Use Policy, see http://www.michigan.gov/ditservice. All Contractor employees must be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State system. The State reserves the right to terminate Contractor's access to the State system if a violation occurs.

2.273 Systems Changes

Contractor is not responsible for and not authorized to make changes to any State systems without written authorization from the Project Manager. Any changes Contractor makes to State systems with the State's approval must be done according to applicable State procedures, including security, access and configuration management procedures.

2.280 Extended Purchasing – DELETED (Not Applicable)

2.290 Environmental Provision – DELETED (Not Applicable)