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

CONTRACT CHANGE NOTICE

Change Notice Number **4 (REVISED)**
to
Contract Number **071B7700002**

CONTRACTOR	
	BLUE CROSS AND BLUE SHIELD OF MICHIGAN
	600 East Lafayette
	Detroit, MI 48226
	Patricia Soyemi
	313-448-6943
	psoyemi@bcbsm.com
	CV0024314

STATE			
	Program Manager	Danyelle Stoddard	DTMB
		517-284-4756	
		StoddardD1@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

MEDICAL ADMINISTRATION SERVICES FOR POST-EMPLOYMENT HEALTH INSURANCE FOR MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
January 1, 2017	December 31, 2020	4 - 1 Year	December 31, 2022

PAYMENT TERMS	DELIVERY TIMEFRAME
NET45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☐		☐		N/A

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$2,677,411,321.61	$0.00	$2,677,411,321.61

DESCRIPTION

Effective July 17, 2020, The attached Sublicense Agreement is incorporated into the Contract.

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

SUBLICENSE and SUPPORT AGREEMENT

This Sublicense and Support Agreement ("Sublicense Agreement"), dated as of July 17, 2020 (the "Effective Date"), is made by and between Blue Cross Blue Shield of Michigan ("BCBSM"), whose address is 600 Lafayette East, Detroit, Michigan 48226, and Office of Retirement Services, with offices at 530 W. Allegan St., Lansing, MI 48933 ("Sublicensee") (collectively, the "Parties").

RECITALS

WHEREAS, BCBSM administers healthcare claims on behalf of Sublicensee;

WHEREAS, Blue Health Intelligence ("BHI") has developed a proprietary application known as the WHYZEN Data Analysis Reporting Tool ("WHYZEN") to assist employers in managing their healthcare claims data as specifically described and permitted herein;

WHEREAS, BCBSM, through an agreement with BHI is permitted to sublicense WHYZEN and related BHI services to Sublicensee as provided herein; and

WHEREAS, Sublicensee desires to utilize, as further described and defined herein, WHYZEN to analyze and produce reports related to medical claims, pharmacy claims, enrollment and related data (collectively, as applicable, "healthcare data") of Sublicensee;

WHEREAS, BCBSM and Sublicensee have a current Business Associate Agreement

NOW, THEREFORE, for good and sufficient consideration, the Parties agree to the following terms and conditions:

1. Sublicense and Use of WHYZEN.

(a) Right and Sublicense; Scope of Sublicense. BCBSM licenses WHYZEN from BHI for use on the Internet and is permitted by the terms of the license to sublicense the use of WHYZEN. BCBSM hereby grants to Sublicensee and Sublicensee hereby accepts a non-transferable and non-assignable, non-exclusive sublicense that is not terminable during the Term (except to the extent provided in Section 3) to use WHYZEN, any user manual provided to Sublicensee by BCBSM or BHI, and any other documentation or other written materials related to WHYZEN which may be provided by BCBSM from time to time under this Sublicense Agreement (collectively, the "Sublicensed Product"), solely on behalf of itself for internal purposes to (i) analyze its own data (including healthcare data) and create reports therefrom, identify and manage its cost savings and expenditures, and

conduct internal health plan management, and (ii) allow a third party contractor and/or agent to use the Sublicensed Product solely on behalf of Sublicensee for the purposes described in clause (i) of this sentence, which use shall be subject to all obligations and restrictions in this Sublicense Agreement (and for which Sublicensee shall be responsible) as if such use were by Sublicensee (the foregoing, collectively, the "Sublicense").

Without limiting anything else to the contrary, under no circumstances is the Sublicensed Product to be used to provide service bureau, remote job entry, facilities management or timesharing services or under any outsourcing arrangement or otherwise to any third parties, except that the foregoing provision shall not prohibit use of the Sublicensed Product by Sublicensee as contemplated in this Sublicense Agreement.

Sublicensee will not remove any copyright, trademark, patent, or product identification notices contained in or on the Sublicensed Product or otherwise alter the Sublicensed Product. In addition, Sublicensee shall not be permitted to (A) translate, modify, adapt, disassemble, decompile, disclose or reverse engineer the Sublicensed Product, nor permit any third party to do so; (B) rent, lease, transfer, resell, distribute, network, create (or attempt to create) a derivative work based on, or copy the Sublicensed Product, except that Sublicensee may make copies of User Manuals provided by BCBSM or BHI.

(b) End Users.

(i) Sublicensee shall identify to BCBSM (and/or BHI, as directed by BCBSM), the names by BCBSM of any individuals (1) who are an employee of, third party or agent working on behalf of, Sublicensee, and (2) for which Sublicensee desires to have access to WHYZEN (collectively, "End Users"). In response, BCBSM (and/or BHI) will provide to Sublicensee logon identifiers for access by Sublicensee to WHYZEN. Throughout the term of this Sublicense Agreement, such logon identifiers may only be used by End Users whose information first has been provided to BCBSM and/or BHI as described in the first sentence of this paragraph. Sublicensee will assign and manage business and operations rules that control each of its own authorized End User's access to the Sublicensed Product.

(ii) Sublicensee will be responsible for requiring each of its authorized End Users to: (1) be responsible for the security and/or use of his or her logon identifier; (2) not disclose such logon identifier to any unauthorized person or entity; (3) not permit any other person or entity to use his or her logon identifier; and (4) use the

Sublicensed Product only in a manner consistent with the terms of this Sublicense Agreement.

(iii) Sublicensee will be responsible for: (1) advising its End Users of all obligations under this Sublicense Agreement that apply to or restrict such End Users and of the license restrictions (and of the confidential and proprietary nature of the Sublicensed Product), and (2) any actions of its End Users with respect to use of the Sublicensed Product. Sublicensee will ensure that End Users are provided access to the Sublicensed Product only to the extent necessary to utilize the Sublicensed Product for the purposes contemplated in this Agreement.

(c) Access. The components of the Sublicensed Product that are made available to Sublicensee through the Internet will be available on a 24-hour, 7-day per week basis from BHI'S website except during maintenance periods. Notwithstanding the foregoing, on an exception basis, BHI may interrupt access for (i) normal and customary maintenance, (ii) updates and upgrades to the website, upon reasonable advance written notice, and (iii) emergency service interruptions. Access may also be interrupted due to Sublicensee's inability to access BHI'S website for reasons that are beyond the control of BHI, and will not constitute a breach of this Sublicense Agreement.

2. WHYZEN Services. BCBSM will provide or have BHI provide the following standard database building and support and other services to Sublicensee, as applicable (such services, the "WHYZEN Services"), subject to the terms of this Sublicense Agreement.

(a) Acquire, interpret and convert Sublicensee's healthcare data (aggregated an de-identified) into an integrated database (or databases) for BHI customers, including other BlueCross BlueShield Plans and their employer customers ("BHI Database"), the master file(s) of which will be built and maintained by BHI on BHI'S premises;

(b) Provide periodic updates to the BHI Database with then-current healthcare data (aggregated and de-identified) of Sublicensee; and

(c) Enable certain WHYZEN reporting capabilities and ad hoc analysis capabilities for Sublicensee.

3. Termination.

(a) Either Party may terminate this Sublicense Agreement prior to the expiration of the Term with or without cause upon 60 days' prior written notice to the other Party; provided, however, that (i) if a default or delay

outside of BCBSM's control occurs which substantially prevents, hinders or delays performance of any services or access to WHYZEN for more than eight (8) consecutive business days, then BCBSM may terminate this Sublicense Agreement upon written notice to Sublicensee, and (ii) if there is a claim of infringement or other proprietary right violation with regard to the Sublicensed Product, which claim inhibits BCBSM's ability to provide the Sublicensed Product to Sublicensee without risk of loss or action against BCBSM or BHI, then BCBSM may terminate this Sublicense Agreement upon written notice to Sublicensee.

(b) Upon expiration or termination of this Sublicense Agreement for any reason, Sublicensee: (i) shall promptly return to BCBSM any and all documentation and materials related to the Sublicensed Product in its possession or under its control and any other confidential information provided to Sublicensee by BCBSM or BHI, and (ii) shall not be required to return any reports previously generated through the use of the Sublicensed Product.

(c) This Sublicense Agreement will terminate if BCBSM terminates its contract with BHI.

4. Ownership Rights.

(a) Sublicensee understands and acknowledges that the Sublicensed Product, including any related programs, documentation, and output formats, and all modifications and updates thereof (and all patent, copyright, trademark, trade secret, and other intellectual property rights inherent therein and appurtenant thereto), used in connection with this Sublicense Agreement are proprietary to BHI, BCBSM and/or a third party, in accordance with separate agreement(s) between and/or among such parties, and title thereto shall remain the sole and exclusive property of BHI, BCBSM, and/or any such third party. Sublicensee agrees that no rights in the Sublicensed Product have been conveyed to Sublicensee except to the extent that Sublicensee has the right to access and use (and allow third parties to do so on its behalf) the Sublicensed Product, and the right to sublicense such access and use, in each case subject to the terms of this Sublicense Agreement.

(b) Sublicensee shall not make any alterations, revisions, additions, enhancements, or improvements to the Sublicensed Product. Sublicensee may not use the Sublicensed Product except as expressly permitted by this Sublicense Agreement.

(c) The Parties acknowledge that BHI, or any of their respective third party subcontractors is not the owner of any healthcare data provided to BHI in connection with this Sublicense Agreement. Sublicensee hereby consents

to allow BCBSM and BHI to use Sublicensee's healthcare data that is stored in BHI's processing system and any other data that is provided to BCBSM or BHI by or on behalf of Sublicensee under this Sublicense Agreement, for such purposes as contemplated by this Sublicense Agreement.

5. Limitations on Use of Sublicensee Data; Certain Reports.

(a) BCBSM shall not aggregate, or cause to be aggregated, any healthcare data (i) provided by or on behalf of Sublicensee, including through BCBSM or other third parties such as pharmacy benefit managers (collectively, the "Sublicensee Data"), with (ii) other data received from third parties; provided, however, that Sublicensee Data may be stored on the BHI Database along with data provided by or on behalf of other BlueCross BlueShield Plans and their employer accounts, so long as the Sublicensee Data is not combined with such other data in a manner to create aggregate healthcare information; except as provided by section 7(c).

(b) BHI shall be prohibited from using any Sublicensee Data for purposes other than as contemplated under this Sublicense Agreement; and

(c) Sublicensee shall be able to generate reports containing "benchmark" information created from Sublicensee's Data, to the extent BHI generally offers such reporting capability as part of the Sublicensed Product.

6. Representations and Warranties.

(a) Sublicensee has the full right and authority (including, without limitation, licenses from third parties where necessary) to furnish to and permit BCBSM and BHI to use Sublicensee's Data, as permitted under this Sublicense Agreement. BCBSM represents and warrants that it has the full right to license the Sublicensed Product to Sublicensee.

(b) Sublicensee acknowledges that it is relying on its own expertise to evaluate and use the Sublicensed Product and the related data. In recognition of this, and given the potential for varying healthcare data, and materials, labor, insurance, and transportation for any given user: SUBLICENSEE AGREES TO ASSUME AND TO BEAR ALL RISKS (EXCEPT AS SET FORTH HEREIN) AS TO RESULTS OF ITS USE OF, OR ITS FAILURE TO BE ABLE TO USE, THE SUBLICENSED PRODUCT. NEITHER PARTY (NOR ITS AFFILIATES OR AGENTS, OR BHI) MAKES, AND EACH PARTY HEREBY SPECIFICALLY EXCLUDES AND DISCLAIMS, ALL WARRANTIES NOT EXPLICITLY STATED IN THIS SUBLICENSE AGREEMENT, WHETHER EXPRESS, IMPLIED, OR ARISING BY TRADE USAGE OR COURSE OF DEALING, INCLUDING WITHOUT LIMITATION ALL IMPLIED WARRANTIES

OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, RELIABILITY, ACCURACY, AND IMPLIED INDEMNITIES. BCBSM (AND ITS AFFILIATES, AGENTS OR BHI) DOES NOT GUARANTEE THAT THE SOFTWARE, MATERIALS, INFORMATION OR SERVICES PROVIDED UNDER THIS SUBLICENSE AGREEMENT WILL BE ERROR FREE, OR CONTINUOUSLY AVAILABLE. EACH PARTY HEREBY EXPRESSLY WAIVES ALL SUCH WARRANTIES AND INDEMNITIES (EXCEPT FOR THOSE SET FORTH HEREIN).

(c) Sublicensee acknowledges that the Sublicensed Product is in no way intended to prescribe, designate or limit medical care to be provided or procedures to be performed. Sublicensee accepts responsibility for and acknowledges that it will exercise its own independent judgment in its use of the Sublicensed Product and shall be solely responsible for such use. Sublicensee acknowledges and agrees that it is Sublicensee's responsibility to validate for correctness all output and reports generated through use of the Sublicensed Product.

7. Miscellaneous.

(a) Survival. The Parties' rights and obligations under Sections 4, 5, and 6, and the last sentence of Section 1(a), shall survive termination or expiration of this Sublicense Agreement and continue in full force and effect.

(b) Third Party Beneficiaries. This Sublicense Agreement shall not be deemed to create any rights in third parties, including employees, third party vendors, and customers of a Party, or to create any obligations of a Party to any such third parties.

IN WITNESS WHEREOF, BCBSM and Sublicensee each has caused this Sublicense Agreement to be executed by its duly authorized representative.

Blue Cross Blue Shield of Michigan	Sublicensee
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

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

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

CONTRACT CHANGE NOTICE

Change Notice Number **3**

to

Contract Number **071B7700002**

CONTRACTOR	
	BLUE CROSS AND BLUE SHIELD OF MICHIGAN
	600 East Lafayette
	Detroit, MI 48226
	Patricia Soyemi
	313-448-6943
	psoyemi@bcbsm.com
	CV0024314

STATE			
	Program Manager	Danyelle Stoddard	DTMB
		517-284-4756	
		StoddardD1@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

MEDICAL ADMINISTRATION SERVICES FOR POST-EMPLOYMENT HEALTH INSURANCE FOR MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
January 1, 2017	December 31, 2020	4 - 1 Year	December 31, 2020

PAYMENT TERMS	DELIVERY TIMEFRAME
NET45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	2 - One Year	☐		December 31, 2022

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$1,903,360,149.00	$774,051,172.61	$2,677,411,321.61

DESCRIPTION

Effective April 14, 2020, this Contract is exercising two option years and is increased by $744,051,172.61. In addition, the following amendment is incorporated into this Contract per attached Change Notice 3, Attachment 1. Changes include:

- Exhibit C, Pricing is amended to include pricing for 2021 and 2022
- Addition of Non-Claims Benefit Expense
- Update to 3.4 Key Personnel
- Update to Service Level Agreements with an effective date of 1/1/20
- Update to Utilization and Medical Management language
- Update to Subcontractors
- Correction to Invoice requirements

CHANGE NOTICE 3, ATTACHMENT 1

The following changes are incorporated into the Contract:

1. Exhibit C Pricing: The following pricing and information is incorporated into Exhibit C Pricing for 2021 and 2022:

Medicare Advantage	**2021**	**2022**
Administration Fee (per Member per month)	$63.88	$64.84
Target net cost (per Member per month)	$27.73	$21.83
BCBSM share of savings/loss	50%/50%	50%/50%
Max savings to BCBSM (net costs below target)	$30 million	$30 million
Max exposure to MPSERS (net costs above target)	$10 million	$10 million
Non-Medicare Administration Fee (per Member per month)	**2021**	**2022**
Basic Services	$32.15	$32.79
Optional- Coordinated Care	$3.03	$3.09
Total	**$35.18**	**$35.88**

Net Costs:
"Net Costs" are defined as the sum of the administrative fee plus Benefit Expenses for incurred claims and non-claim benefit expenses 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.

Target Net Cost:

The target net cost indicated above is subject to adjustment as follows:

1) The Contractor and Plan Sponsor agree to mutually determine an actuarial adjustment to the target net cost if there is a material change in benefit plan design
2) The Contractor and Plan Sponsor agree to mutually determine an adjustment to the target cost if CMS' annual Call Letter or Rate Announcement are interpreted to include risk model/factor, county rate, or other changes that deviate from the assumed 2% CMS funding impact incorporated into the targets above

Maximum Exposure:
The maximum exposure to Plan Sponsor will be capped at $10 million, Contractor will be liable for 100% of costs above the initial $10 million exposure to Plan Sponsor up to Contractor's total respective annual administrative fee (Projected at +$100 million). Thereafter, any additional Costs will be paid by the Plan Sponsor.

Routine Hearing Care Services:
Contractor must provide full Pass-Through Pricing to Plan Sponsor for routine hearing care services. Pricing must not exceed $1.00 per Member per month. Payment is predicated on the enrollment records of the Plan Sponsor.

2. Non-Claim Benefit Expense (NCBE) Definition and Details are incorporated as Exhibit C Pricing, Attachment 1 to the Contract (see lower in this document).

3. Exhibit A, Statement of Work Section 3.4 Key Personnel: The following changes are made to "Other Key Staff" Section:

- The following language is REMOVED from 3.4b.B.d (pertaining to Medicare):

  Other Key Staff: These positions are also considered Key Personnel for purposes of this Contract, are expected to be onsite to the Plan Sponsor, and must work under the direction of the Plan Sponsor. Plan Sponsor must be involved in the selection of those occupying these positions and any matters related to ensuring retention. Contractor must take into consideration, at a minimum, compensation, benefits, and leave in order to ensure placement and retention of qualified individuals. These positions must be contracted through a third party agency. The budget for these positions must 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 must report to the Plan Sponsor by January 31 of the following year the budgeted amount and the actual amount spent for these positions. If Contractor spends less money than originally budgeted, the amount of budget not spent for each plan year must be returned to the Plan Sponsor within 60 days.

- The language in 3.4a.B.d (pertaining to Non-Medicare) is REPLACED with the language below:

  Other Key Staff: These positions are also considered Key Personnel for purposes of this Contract, are expected to be onsite to the Plan Sponsor, and must work under the direction of the Plan Sponsor. Plan Sponsor must be involved in the selection of those occupying these positions and any matters related to ensuring retention. Contractor must take into consideration, at a minimum, compensation, benefits, and leave in order to ensure placement and retention of qualified individuals. These positions must be contracted through a third party agency. The Contractor must allot an internal budget of $300,000 for these positions in 2021, increasing annually by 2%. There is no cap on the number of Other Key Staff as long as the requested resources are within the budget. Contractor must report to the Plan Sponsor by January 31 of the following year the actual amount spent for these positions, regardless of the number of staff. If Contractor spends less money than originally budgeted, the amount of budget not spent for each plan year must be returned to the Plan Sponsor within 60 days.

4. Exhibit D and E Service Level Agreements (SLAs) for Non-Medicare Medical Plan and Medicare Medical Plan are hereby replaced in the Contract with the attached, revised Exhibit D and Exhibit E (See lower in this document).

5. Exhibit A, Statement of Work Section 1.0b.C Utilization and Medical Management: The language in 1.0b.C Utilization and Medical Management is REPLACED with the language below which contains an updated description of Contractor's Care Management Program:

C. Utilization and Medical Management

Contractor must ensure that its Medical management programs address the needs of an older, retired population. The program must include, but not be limited to, the below requirements:

a. *Contractor must utilize effective Medical Management programs that ensure quality of care to Members and control costs. Medical Management programs must address the continuum of Member health status, ranging from healthy population initiatives (wellness) through acute care management (utilization management, discharge planning, care transitions) through management of chronic conditions, and management of high utilizers with strategies designed to promote the most cost effective use of health care resources. The predictive modeling capabilities must include, but not limited to: the ingestion of behavioral health, lab values, prescription drug claims, Medical claims, and Gaps in care.*

The current program offerings are detailed below. If the Contractor makes any major improvements to their medical management programs, significantly modifies the current programs, or develops any new programs, Contractor will offer the updated programs as part of the all-inclusive administrative fee in an effort to provide the most cost effective use of health care resources.

Medicare Plan

Programs include:

24 Hour Nurse Line—Toll-free access to an experienced team of registered nurses 24 hours a day, seven days a week.

Engagement Center—Specially-trained, experienced staff help members understand and enroll in wellness and care management programs.

Care Management: Blue Cross Coordinated Care

The Blue Cross Coordinated Care Programs provides members with access to an integrated care team that will help them better manage their health. By providing support when members need it most, the integrated care management program places the member first. The program features enhanced analytics to identify and target the members who need it the most and a multi-disciplinary care team to support their care needs. The program allows members to interact with the care team according to their preferred communication method and includes a digital engagement platform to increase and enhance member touchpoints. The regional alignment of resources supports enhanced coordination with local providers and community resources and enables increased ability to address social determinants of health.

Program features include:

- *Enhanced identification methods to target high-risk members who are most likely to engage and most likely to benefit from the program. The identification model will also target members who are at risk for future cost and in the early stages of their disease progression; care managers will work with these members to improve the trajectory of their health.*
- *An integrated care team led by a nurse care coordinator who serves as the single point of contact for members and their families. This comprehensive team of specialists, led by a nurse care manager will include social workers, behaviorists, pharmacists, physician consultants and dietitians. The team will be employed by Blue Cross and will work in tandem to manage the member's care in a holistic and member-centric manner.*
- *Regional alignment of care teams and resources. This permits the development of stronger relationships between Blue Cross, Blue Care Network, local providers and the surrounding communities. Regions have been identified in Michigan and across the U.S. which will allow for enhanced coordination with out-of-state Blue Cross plans and seamless care coordination for members.*
- *Multi-channel communication that extends beyond traditional telephonic outreach. A cloud-based mobile platform and app that enables two-way communication between members*

and the lead nurse care coordinator will be used. Real-time alerts allow the lead nurse care coordinator to promptly respond to changes in member health status, potentially avoiding more serious and complex health issues.

- *Vended programs to further enhance program offerings for specific member populations. This includes second opinion support for preference sensitive surgeries, enhanced support for members with diabetes and end of life.*
- *High Dollar Claimant review based on threshold of $150,000 or more in a 12-month period to confirm appropriate care and identify quality or care opportunities. For cases that warrant intervention, referrals will be made and appropriate teams engaged.*

Diabetes Management: The Diabetes Management program focuses on high-risk and newly diagnosed members with diabetes. Certified Diabetes Educators (CDEs) deliver a highly targeted intervention to improve self- management and medication adherence. Throughout the program, CDEs follow-up with patients to see how they are faring, keeping in touch via multiple communication methods — phone calls, texts, emails, etc. To enhance learning, the coaching experience is reinforced by online videos, educational content and online peer-to-peer support

Tobacco Cessation Coaching is a telephone-based smoking cessation program designed to support members in their efforts to stop smoking. Members have access to counseling by specially trained health coaches. The goals of the program are to improve the quality of life for members and reduce costs and hospital utilization for conditions associated with cigarette smoking. This program is opt-in only and voluntary.

Blue365® and Healthy Blue XtrasSM—Offers discounts to members for health-related products and services needed to support a healthy, balanced lifestyle.

Non-Medicare Plan

The Contractor provides MPSERS with the following programs:

Online Wellness Program—Online, interactive platform, available through a partnership with WebMD® Health Services, that creates a seamless member experience and offers innovative capabilities, flexibility and technological functionality. The platform includes interactive online resources including a health assessment, Digital Health AssistantSM, integrated apps, message boards, trackers, videos, tools and other health information such as preventive reminders.

24 Hour Nurse Line—Toll-free access to an experienced team of registered nurses 24 hours a day, seven days a week.

Care Management. The program provides members with access to an integrated care team that will help them better manage their health. By providing support when members need it most, the integrated care management program places the member first. The program features enhanced analytics to identify and target the members who need it the most and a multi-disciplinary care team to support their care needs. The program allows members to interact with the care team according to their preferred communication method and includes a digital engagement platform to increase and enhance member touchpoints. The regional alignment of resources supports enhanced coordination with local providers and community resources and enables increased ability to address social determinants of health.

Program features include:

- *Enhanced identification methods to target high-risk members who are most likely to engage and most likely to benefit from the program. The identification model will also target members who are at risk for future cost and in the early stages of their disease*

progression; care managers will work with these members to improve the trajectory of their health.

- *An integrated care team led by a nurse care coordinator who serves as the single point of contact for members and their families. This comprehensive team of specialists, led by a nurse care manager will include social workers, behaviorists, pharmacists, physician consultants and dietitians. The team will be employed by Blue Cross and will work in tandem to manage the member's care in a holistic and member-centric manner.*
- *Regional alignment of care teams and resources. This permits the development of stronger relationships between Blue Cross, Blue Care Network, local providers and the surrounding communities. Regions have been identified in Michigan and across the U.S. which will allow for enhanced coordination with out-of-state Blue Cross plans and seamless care coordination for members.*
- *Multi-channel communication that extends beyond traditional telephonic outreach. A cloud-based mobile platform and app that enables two-way communication between members and the lead nurse care coordinator will be used. Real-time alerts allow the lead nurse care coordinator to promptly respond to changes in member health status, potentially avoiding more serious and complex health issues.*
- *High Dollar Claimant Review- When a high dollar claimant is identified, a dedicated audit team addresses cost quality or care opportunities. The team will make referrals for cases that will benefit from intervention.*

Win by Losing—Provides members with a toolkit that includes templates for tracking food intake and activity, health coaching videos, an eating plan and healthy recipes.

Blue365® and Healthy Blue XtrasSM—Offers discounts to members for health-related products and services needed to support a healthy, balanced lifestyle.

Predictive Modeling - robust analytics and enhanced data sets (e.g., social determinants of health) allow Contractor to target the members who would benefit most from care management. Reactive analytics and predictive analytics not only identify members who are already at high risk and clinically complex, but also identify those members who are likely to rise in risk or costs based on early indicators or potential future needs.

b. Medical Management programs must include, but not be limited to:

i. Wellness/Care Management

1. *Contractor must provide programs that address the concept of the compression of morbidity.*

   Contractor provides the following programs:
   - *Care Management Program*
   - *Wellness Programs – The Contractor's Health & Wellness programs include an integrated online wellness platform powered by WebMD® Health Services. It features a health assessment, a Digital Health Assistant, online trackers and message boards, and interactive online tools, articles and videos.*
   - *Educational Resources - All telephone-based program participants receive resources throughout the program, including educational materials on topics related to their specific health concerns. Members who participate in Digital Health Assistant programs receive a personalized online plan to help them achieve goals they've set and stay on track.*

2. *Contractor must be able to support Plan Sponsor's existing wellness program structure, as well as plan an active role in supporting and advising on future*

enhancements to the same. Elements of such programs must include, but not be limited to:

a. *Health assessments focused on an older, retired population with the ability to measure functional status and utilize a predictive modeling tool.*
b. *A strategy to administer different plan design provisions depending on whether a Member has completed a health assessment.*
c. *Member communication.*
d. *Member education and support concerning lifestyle/health risks, health management resources.*

ii. *Utilization Management*

1. *Contractor must provide a program to certify and monitor the appropriateness and duration of inpatient care and specified outpatient Services. Utilization management must address high frequency imaging procedures, admission, concurrent review and discharge planning, retrospective review when the process is started after discharge, and any other care to home transitional programs. Utilization management decisions must be communicated to Members and Providers, which includes information about the Appeals process.*

The Contractor's Precertification program ensures that health care services (including inpatient and outpatient services) are rendered in the appropriate setting. Utilization decisions are communicated to members and providers. Precertification services provide authorizations for admissions to:

- *Michigan and out-of-State skilled nursing facilities, rehabilitation facilities and long-term acute care facility admissions*
- *Out-of-state acute hospitals*

Precertification reviews include the use of evidence-based guidelines such as InterQual and physician consultant reviews to determine medical necessity of the admission and continued stay. A precertification authorization number is assigned when the level of care is medically appropriate given the patient's condition and the service(s) being rendered. Members that may benefit from Case Management are referred. Michigan hospitals submit a pre-notification for admission and based on targeting may receive a clinical review.

iii. *Care Management: Contractor must provide a program that:*

1. *Has predictive modeling trigger to identify Members that are at risk for high-cost care.*
2. *Reviews high dollar claimants on an individual basis (>$100,000.00 in rolling 12 months)*
3. *Provides support to Members under treatment, their families, and Providers in order to facilitate the use of medically appropriate services and facilities at a lowest net cost setting.*
4. *Has the ability to use prescription drug data from Plan Sponsor's PBM to help identify Members at risk for high-cost care.*
5. *Routinely evaluate members for depression using a validated age appropriate screening tool.*

c. *Contractor must provide to Members, at a minimum, the following:*

i. *Transplant Centers of Excellence*
ii. *Cardiac Centers of Excellence*
iii. *Nurse Line, with clinical resources*
iv. *Oncology Center of Excellence*

d. *Contractor must have a gaps in care process that compares clinical metrics to evidence based medicine best practice across a multitude of conditions. The Contractor must include this gaps in care information in their predictive modeling, provider relations and member education/care management process.*

e. *Contractor must offer Plan Sponsor support for, and advice on, Medical Policy (see Exhibit Q). This includes, but is not limited to, the following:*
   i. *Identifying and notifying Plan Sponsor, in writing, of new and emerging technological developments in the treatment and diagnosis of medical conditions.*
   ii. *Providing cost benefit analyses of these emerging technologies.*
   iii. *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.*

f. *Contractor must monitor and manage Members on Specialty Drugs when paid through the medical plan. Contractor must monitor and manage Members on Specialty Drugs including, but is not limited to, the following:*
   i. *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.*
   ii. *Working with the Plan Sponsor and its PBM to ensure compliance with Prior Authorization/ Step Therapy requirements for Specialty Drugs.*
   iii. *Working with Plan Sponsor and its PBM to make sure that Members who are prescribed Specialty Drugs are included in the Contractor's other Medical Management Programs.*

g. *Contractor must demonstrate quality assurance and a Quality Management program directed toward improving patient outcomes and the quality of care provided to Members that uses Claims data, including prescription drug data from Plan Sponsor's PBM, and that integrates all of the Medical Management program components and provides a framework for monitoring program effectiveness.*
   i. *Members must be issued written adverse benefit determinations in accordance with CMS regulations.*
   ii. *Contractor must have formal processes and structures in place to measure and improve clinical and service quality for both healthcare service delivery and administrative performance.*

6. Exhibit A, Statement of Work Section 3.6.2 Subcontractors: The Subcontractor Table in Section 3.6.2 is REPLACED with the following tables for Medicare Advantage and Non-Medicare Subcontractors:

Medicare Advantage Subcontractors				
Legal Business Name	**Address**	**Telephone Number**	**Complete description of Contract Activities and services that will be performed/provided by subcontractor**	**Of the total Contract, the price of the subcontractor's work**
2nd MD	2538A Briar Ridge Drive HOUSTON, TX, 77057	866-841-2575	Medical Record Review	Less than 5%

Accent	P.O. Box 543099 Omaha, NE 68154-9896	(800) 747-7243	Identifies MPSERS members who failed to respond to the verification of coverage survey.	Less than 5%
Advancing Monitoring Caregiving, Inc. (AMC)	39 BROADWAY SUITE 540, NEW YORK, NY, 10006	877-776-1746	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
Advantasure	4121 Cox Road Suite 200, GLEN ALLEN, VA, 23060	804-977-0500	Risk adjustment, Stars, In Home Assessments, Claims, Enrollment Member Billing processing systems.	Less than 5%
AIM Specialty Health	8600 WEST BRYN MAWR AVE SUITE 800, CHICAGO, IL, 60631	847-559-6714	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
American Well Corporation	75 STATE ST FLOOR 26, BOSTON, MA, 02109	617-204-3500	Member Servicing/Call Center/Telehealth Benefits	Less than 5%
Aspire Health	333 COMMERCE ST SUITE 700, NASHVILLE, TN, 37201	615-454-9850	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
AxisPoint Health (Formerly McKesson)	11000 Westmoor Circle 2nd Floor, Westminster, CO, 80021	800-224-0336	24 Hour Nurse Line	Less than 5%
Blue Health Intelligence	225 N Michigan Avenue Suite 970, CHICAGO, IL, 60601	312-540-5151	Online Reporting Tool for customer analytics	Less than 5%

Conduent Credit Balance Solutions LLC	100 Campus Drive, Suite 200 Florham Park NJ 07932	844-663-2638	Conduct provider financial reviews of credit balance accounts	Less than 1%
Change Healthcare	3055 LEBANON PIKE STE 1000, NASHVILLE, TN, 37214	224-279-5549	Coding Advisor	Less than 5%
Clarabridge	11400 COMMERCE PARK DRIVE #500, RESTON, VA, 20191	571-299-1384	Generate Reports	Less than 5%
Cotiviti (formerly iHT and Connolly)	115 Perimeter Center Place Suite 700 Atlanta, GA 30346	(470) 585-2916	Advanced Payment Analytics (2nd Pass) – Cotiviti will apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities. Cotiviti will identify and validate overpayments through the review and analysis prior to submitting to BCBSM for final review and recovery.	Less than 5%
CVS Health (Novologix)	ONE CVS DRIVE WOONSOCKET, RI, 02895	952-826-2585	Clinical Editing on Part B Drugs	Less than 5%
Decision Support Systems LP. Aka DSS Research	2111 WILSONN BOULEVARD SUITE 700, ARLINGTON, VA, 22201	703-351-5040	CAHPS and HOS Surveys	Less than 5%

Eliza	DEPT CH 16967 PALATINE, IL, 60055-6967	978-299-2780	Interactive voice response system calls member to remind them to schedule certain exams	Less than 5%
Escalent (Formerly Market Strategies)	17430 COLLEGE PARKWAY LIVONIA, MI, 48152	503-416-8515	Monthly Member Perceptions Survey	Less than 5%
Evicore (formerly Care Core, parent to Landmark)	1750 HOWE AVENUE SUITE 300, SACRAMENTO, CA, 95825	843-815-6577	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
Express Scripts	100 PARSONS POND DRIVE FRANKLIN LAKES, NJ, 07417	800-922-1557	PBM, Claims Processing	Less than 5%
Foresee	2500 GREEN ROAD SUITE 400, ANN ARBOR, MI, 48105	800-621-2850	Online Digital Experience Surveys	Less than 5%
Fresenius Health Partners	920 Winter Street, Suite 400, Waltham, MA 02451	781-699-2825	Fresenius Health Partners accepts patient assignment and provides care management services for patients with ESRD.	Less than 5%
Gongos Research	2365 PONTIAC ROAD AUBURN HILLS, MI, 48326	248-238-2300	Surveys and market research	Less than 5%
Greater Macomb PHO	43411 Garfield Road Suite A, Clinton Township, MI, 48038	586-542-0870	Patient information is shared for STARs gap closures for preventive screenings and care management outreach for the High Intensity Care Model.	Less than 5%
hms (formerly Health Data	302 E Carson Ave Las Vegas, NV,	702-243-6535	Operations / Customer Service / Enrollment / Claims / COB /	Less than 5%

Insights)	89101		etc.	
Home Access Health	2401 W HASSELL ROAD SUITE 1510, HOFFMAN ESTATES, IL, 60169	847-781-2525	Disease Management (home Hemoglobin and Albumin tests)	Less than 5%
HOV	P O BOX 142589 DRAWER 9092, IRVING, TX, 75014-2589	1-844-XELATEC	Printing and Fulfillment	Less than 5%
Huron Valley Ambulance	1200 STATE CIR ANN ARBOR, MI 48108-1691	800-507-7847	Members are connected to HVA afterhours. HVA gathers demographic information and passes call information on to our overnight staff to follow up. BH case managers are available 24/7.	Less than 5%
IHA	PO Box 0446 ANN ARBOR, MI, 48106-0446	734-747-6766	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
Indellient	2630 BRISTOL CIRCLE SUITE 100, OAKVILLE, ON, L6H 6Z7	855-544-9611	Vendor-Hosted Workflow Software Tool	Less than 5%
Inovalon	4321 Collington Road, Bowie, MD 20716	301-809-4000	Risk Adjustment- Identification and closure of diagnosis gaps for Medicare Advantage. Submission of risk adjustment information to CMS for Medicare Advantage	Less than 5%
J&B Medical Supplies	50496 WEST PONTIAC TRAIL	800-737-0045	Provider Contracting / Credentialing / HICM	Less than 5%

	WIXOM, MI, 48393			
Joint Venture Hospital Laboratories (JVHL)	999 REPUBLIC DR SUITE 300, ALLEN PARK, MI, 48101	313-271-3692	Provider Contracting / Credentialing / HICM	Less than 5%
Life Plans Inc.	1000 South Ave Suite 103, Staten Island, NY, 10314	781-893-7600	In-Home Assessments Post Discharge	Less than 5%
Matrix Medical Network	9201 E. Mountain View, Suite 220 Scottsdale, AZ 85258	888-822-3247	Matrix focuses on closing gaps in care for members who are due for mammograms and diabetic eye exams; if the member has additional gaps in care, these are addressed during their visits. Additional gaps in care that may be addressed are: Colorectal Cancer Screening, Diabetes measures (kidney disease monitoring and blood sugar screenings), Body Mass Index (BMI) assessments, Bone Mineral Density, Flu shots	Less than 5%
(MedXM) Mobile Medical Examination Services – Quest Quest Diagnostics	1241 E. Dyer Rd Ste 145 Santa Ana, CA 92705	888-306-0615	To identify and capture unreported health conditions, capture primary care physician information, refer members to care management programs and emphasize to member the importance of regular visits with their physician(s) through means of an In-Home Assessment (IHA) or an In-Facility Assessment (IFA) at a Skilled Nursing Facility (SNF)	Less than 5%
Merrill	ONE MERRILL	612-991-	Develop required	Less than 5%

Corporation	CIRCLE ST PAUL, MN, 55108	3601	communications / Print and fulfillment	
Michigan Health Information Network Shared Services	120 W SAGINAW STREET EAST LANSING, MI, 48823	989-621-7221	Routes admission and discharge transfer messages from hospitals to BCBSM/BCN	Less than 5%
Milliman	15800 WEST BLUEMOUND ROAD SUITE 100, BROOKFIELD, WI, 53005	813-282-9262	Bid Support	Less than 5%
Morley	One Morely Plaza Saginaw, MI, 48603	989-497-1825	Operations / Customer Service / Enrollment / Claims / COB / etc.	Less than 5%
MS Datastep	5340 PLYMOUTH ROAD SUITE 201, ANN ARBOR, MI 48105	734-996-1466	CRM Software	Less than 5%
naviHealth Inc.	210 Westwood Place, Suite 400, Brentwood, TN 37027	615-577-1900	naviHealth Inc. provides authorization review of post-acute care services for members who require a transfer from an acute inpatient facility to a skilled nursing, long-term acute care or inpatient rehabilitation facility.	Less than 5%
Nice Systems Inc.	221 RIVER ST 10TH FLOOR, HOBOKEN, NJ, 07030	551-256-5000	Member Call Analysis	Less than 5%
Northwood	7277 BERNICE SUITE 103,	248-54-2293	Operations / Customer Service / Enrollment / Claims / COB /	Less than 5%

	CETNERLINE, MI, 48015		etc.	
Novu INC	5401 GAMBLE DR STE 300, ST LOUIS PARK, MN, 55416	815-612-6688	CAHPS reward program and HEDIS quality reward program	Less than 5%
NTT (formerly DELL - Transaction Application Group)	2300 W PLANO PARKWAY PLANO, TX, 75075	972-5775267	Operations / Customer Service / Enrollment / Claims / COB / etc.	Less than 5%
Oakland Southfield	29200 Northwestern Highway Suite 325, SOUTHFIELD, MI, 48034	248-357-2049	Provider Contracting / Credentialing / HICM	Less than 5%
OpinionLab	600 CENTRAL AVENUE SUITE 265, HIGHLAND PARK, IL, 60035-3256	847-681-6101	Hosting of BCBSM's online feedback cards	Less than 5%
Pega Systems Inc.	PEGAWORLD C/O THE CASTLE GROUP 38 THIRD AVENUE 2ND FLOOR, CHARLESTOWN, MA, 02129	617-374-9600	Software for managing appeals, grievances and org determinations for MA PPO part C, BCN (commercial and MA) and Pharmacy	Less than 5%
Results Companies	2893 MOMENTUM PLACE CHICAGO, IL, 60689-5328	815-673-7090	Operations / Customer Service / Enrollment / Claims / COB / etc.	Less than 5%
Scantron	1313 Lone Oak	714-437-	Medicare Advantage Health Assessment. Mail, tabulate,	Less than 5%

	Road, Eagan, MN 55121	4285	assess, follow up and report	
SCIOinspire Corporation	111 RYAN COURT SUITE 300, PITTSBURGH, PA, 15205	860-676-8808	Operations / Customer Service / Enrollment / Claims / COB / etc.	Less than 5%
Signify Health (Formerly Advance Health)	4055 Valley View Ln Suite 400, Dallas, TX, 75244	972-715-3800	In-Home Assessments / In-Facility Assessments	Less than 5%
Solera Health	1018 W ROOSEVELT ST PHOENIX, AZ, 85007	800-858-1714	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
SQM Group (Service Quality Management Group)	4611 23RD STREET VERNON, BC, V1T 4K7	888-972-0844	Customer satisfaction surveys	Less than 5%
Tandem 365	1279 Cedar Street NE GRAND RAPIDS, MI, 49503	616-588-5290	Medical Management / Care Management / Utilization Management / Disease Management	Less than 5%
Tessellate (doing business as Advantasure)	4121 Cox Rd. Suite 200, Glen Allen, VA, 23060	804-977-0500	Risk adjustment and Stars	Less than 5%
TGI Direct	5365 HILL 23 DR FLINT, MI, 48507	810-239-5553	Print and Fulfillment	Less than 5%
Tivity Health Inc. (Formerly Healthways Inc.)	701 COOL SPRINGS BLVD FRANKLIN, TN, 37067	651-337-1360	Provider/Facility Contracting, Health Care Services Delivery	Less than 5%

TriZetto (Cognizant)	500 FRANK W. BURR BLVD TEANECK, NJ, 07666	515-306-6375	Claims Software	Less than 5%
Tru Hearing, Inc (MPSERS).	12936 FRONTRUNNER BLVD #100, DRAPER, UT 84020	608-397-6018	TruHearing provides a hearing program to MPSERS members called TruHearing Select. Through this program, TruHearing provides a nationwide network of providers who conduct a routine hearing exam, determine degree of hearing loss and fit two technology levels of hearing aids, TruHearing Advanced and TruHearing Premium, to MPSERS members.	Less than 5%
TurningPoint Healthcare Solutions	1000 Primera Blvd. Suite 3160, Lake Mary, FL 32746	855-253-1100	TurningPoint Healthcare Solutions provides authorization review of musculoskeletal procedures, including joint, spine and pain.	Less than 5%
Vital Decisions	399 THORNDALL STREET 8TH FLOOR, EDISON, NJ, 08837	800-301-3984	URMBT end of life consulting	Less than 5%
Web MD Health Corp	395 HUDSON STREET NEW YORK, NY, 10014	212-624-3700	Wellness Programs	Less than 5%
Web MD Health Services	WEBMD HEALTH SERVICES 12186 COLLECTIONS CENTER DRIVE, CHICAGO, IL, 60693	212-624-3700	Consumers turn to WebMD for reliable, accurate and easy-to-understand answers to their most pressing health-related questions.	Less than 5%
Welvie	400 N MAY STREET	703-598-7989	Helping members with information on surgery options, pre and post-surgery	Less than 5%

	SUITE 202, CHICAGO, IL, 60642		prep	
Wolverine Mailing Packaging	1601 CLAY ST DETROIT, MI 48211-1913	313-873-6800	Print/Mail/Imaging of Communications	Less than 5%

Non-Medicare Subcontractors				
Legal Business Name	**Address / Telephone Number**	**Services Provided**	**Complete description of Contract Activities that will be performed/provided by subcontractor**	**Of the total Contract, the price of the subcontractor's work.**
Accent (MPSERS)	Accent Corporate Headquarters 11808 Miracle Hills Drive Omaha, NE 68154 Mailing Address Accent P.O. Box 543099 Omaha, NE 68154-9896 Telephone Number (800) 747-7243	Accent is responsible for identifying BCBSM MA members who failed to respond to the verification of coverage survey. They also make outbound calls to these members to gather the required information.	Complete the annual verification of coverage campaign.	less than 1%

AIM (BCBSM Book of Business)	8600 West Byrne Mawr Ave. Ste. 800 Chicago, IL 60631 Telephone Number (773) 243-0500	Preauthorization services for diagnostics imaging, Echo-cardiology, Sleep Study Therapy and Proton Beam Therapy to provide medical appropriateness preauthorization for services requested	AIM Specialty Health provides preauthorization services for diagnostics imaging, echo-cardiology, sleep study therapy and proton beam therapy.	less than 1%
Cotiviti, LLC (BCBSM Book of Business)	115 Perimeter Center Place Suite 700 Atlanta, GA 30346 Telephone Number (470) 585-2916	Advanced Payment Analytics Services	Advanced Payment Analytics (2nd Pass) – Cotiviti will apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities. Cotiviti will identify and validate overpayments through the review and analysis prior to submitting to BCBSM for final review and recovery.	less than 1%
Conduent Credit Balance Solutions LLC (BCBSM	100 Campus Drive, Suite 200 Florham Park NJ 07932 Telephone Number 844-663-	Credit Balance Identification and Recovery Services	Conduct provider financial reviews of credit balance accounts.	less than 1%

Book of Business)	62638			
Change Health	3055 Lebanon Pike Ste 1000, Nashville, TN, 37214 224-279-5549	ClaimsXten - Clinical Editing of Claims, InterQual - Clinical Decision Support, Procedure Code Approval, Coding Advisor - Provider Education on correct coding	ClaimsXten - Clinical Editing of Claims, InterQual - Clinical Decision Support, Procedure Code Approval, Coding Advisor - Provider Education on correct coding	Less than 1%
Equian, LLC (BCBSM Book of Business)	5975 Castle Creek Parkway Suite 100 Indianapolis, Indiana 46250 Telephone Number (615) 784-8639	Pre-Pay Forensic Review Services Advanced Payment Analytics Services	Pre-Pay Forensic Review Services – Equian will review referred inpatient claims for potential billing issues. Once any potential billing issues have been identified, and if claim savings warrant it, Equian will prepare a Forensic Review Report that lists each identified issue and specifies BCBSM's payment liability for all uncontested charges. Equian's Resolution and Appeals staff will address and respond to Provider disputes or formal appeals until Claim Closure. Advanced Payment Analytics (3rd Pass) –	less than 1%

			Equian will apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities. Equian will identify and validate overpayments through the review and analysis prior to submitting to BCBSM for final review and recovery.	
Firstsource Transaction Services, LLC	10400 Linn Station Road, Suite 100 Louisville Ky 40223 Telephone Number 800-736-2107		Claims and enrollment processing support	Less than 1%
HMS (formerly Health Data Insights)	302 E Carson Ave Las Vegas, NV, 89101 702-243-6535		HMS performs retrospective provider auditing and validation services.	Less than 1%

Multiplan (BCBSM Book of Business)	115 Fifth Avenue New York, New York 10003-1004 Telephone Number: 301-548-2010	Non-Par Provider Negotiated Pricings Services Provided: non-participating provider claims payment solutions and negotiation services	a. MultiPlan's pricing and negotiation services will augment our industry-leading claims processing practices and will obtain lower pricing than how the claim would have paid. b. MultiPlan Network and Negotiation Services also guarantee member held harmless (no provider balance billing) since providers agree to the revised lower pricing before finalization of the claims. c. Data iSight is a pricing tool that incorporates public data and transparent benchmarking processes, to calculate a "fair" reimbursement that is cost-based for facilities and median reimbursement-based for	less than 1%

			providers. d. Average savings up to 70% off billed charges through the MultiPlan Complementary network inside Michigan.	
New Directions (BCBSM Book of Business)	8140 Ward Parkway Ste. 500 Kansas City, MO 64114 Telephone Number (816)237-2300)	New Directions would provide: Utilization Management; Autism Management; Member Services; Provider Services; Audit Process; Reporting; Case Management; rTMS Authorization Management; Appeals and Grievances; Quality Assurances.	New Directions will deliver a population management-grounded, data driven behavioral health program to support members in accessing their mental health, substance abuse, autism and rTMS benefits under commercial plans (PPO, Traditional, FEP, and Health Exchange) to produce better health outcomes.	less than 1%
Quest Diagnostics (Book of Business)	4444 Giddings Road Auburn Hills, MI 48326 Telephone Number (866)697-8378	Laboratory Services	Leading world provider of diagnostic testing	less than 1%

SCIOinspire Corporation	111 Ryan Court Suite 300, Pittsburg PA 15205 Telephone Number 860-676-8808	Provider bill audits and chart validations	Performs provider bill audits and chart validations.	Less than 1%
SSDC (MPSERS)	28125 Cabot Dr # 201, Novi, MI 48377 Telephone Number 248)344-444	Identification of members under age 65 that might qualify for Medicare due to a disability	SSDC has over 35 years' experience helping individuals win Social Security Disability Insurance (SSDI) awards We are the premier Medicare Controllership & Compliance partner to Fortune 500 and large public employers and municipalities We have helped more than 100,000 disabled individuals obtain SSDI benefits and our Medicare coordination services impact nearly 4 million plan participants annually	less than 1%
Tru Hearing, Inc (MPSERS).	12936 Frontrunner Blvd #100, Draper, UT 84020 Telephone Number (608)397-6018	Routine hearing exam and hearing aids	TruHearing provides a hearing program to MPSERS members called TruHearing Select. Through this program, TruHearing provides a nationwide network of providers who conduct a routine hearing exam,	less than 1%

			determine degree of hearing loss and fit two technology levels of hearing aids, TruHearing Advanced and TruHearing Premium, to MPSERS members.	
Web MD (Book of Business)	111 8th Ave New York NY,10111 Telephone Number (212)624-3700	Online Health platform	Blue Cross Blue Shield of Michigan and Blue Care Network members have access to a new set of health and wellness programs. Through a partnership with WebMD Health Services, Blue Cross offers a new online wellness platform – including a health assessment, digital health assistant and health information – along with other wellness programs to its group and individual members. The new partnership gives Michigan Blues' customers, including employer groups looking to keep costs down, the opportunity to incorporate wellness programs into their benefit structure.	less than 1%

7. Exhibit A, Statement of Work, Section 6.1 Invoice Requirements: The language in Section 6.1.4 is REPLACED with the following language to change the word "prescription" to "medical":

4. The Contractor must invoice the Plan Sponsor for medical claims on a weekly basis.

Exhibit C Pricing, Attachment 1
NCBE Definition and Details

1. Executive Summary

As a means of aligning ORS and BCBSM, the following document has been drafted to align our partnership around a consistent understanding of Non-Claims Benefit Expense (NCBE). Based on the passage of The Patient Protection and Affordable Care Act (PPACA), BCBSM instituted a NCBE classification process to ensure the identification of NCBE spend is in line with applicable CMS, as well as other regulatory and reporting, requirements. This process includes key criteria and definitions that were established to ensure a consistent methodology is in place that maintains accurate classification of spend. As programs are submitted for review, each program is compared against the criteria and if the program meets the requirements, will be approved with an NCBE classification.

2. Benefit Expense Classification

The following types of payments should be classified as benefit expense:

- Payments made to licensed health care professionals acting in their licensed professional capacity to provide covered clinical services directly to patients. This would include fee-for-service payments, capitations, bonuses and quality incentives, and risk sharing and hospital settlements.
- Nominal payments made to providers who directly care for patients for managing/coordinating care paid (such as a payment to PCPs in a medical home for care coordination).
- Payments to a third party vendor that, through its own employees, provides clinical services directly to enrollees. The entire portion of the amount paid to the third party vendor that is attributable to the third party vendor's direct provision of clinical services should be considered incurred claims, even if such amount includes reimbursement for third party vendor administrative costs directly related to the vendor's direct provision of clinical services (as long as it is not separately stated).
- Payments of non-clinical items/services are classified as benefit expense if they represent a cost that is a direct benefit to the member (typically supported by the certificate of coverage). These services can be provided by internal or external resources or covered by a contractual obligation. Examples of non-clinical benefits include fitness benefits, smoking cessation, and routine transportation.
- Payments that provide a direct operational benefit or support to facilities (hospitals) for rendering medical and related services to members. These services include quality improvement initiatives with like nature and characteristics to activities traditionally undertaken by facilities.

3. NCBE Criteria

BCBSM utilizes an internal committee to apply General Accounting policy for determining what non-claim cost can be booked as benefit expense and is tied to the following Key Criteria. Each of the four Clinical Services criteria or three Non-clinical services criteria below must be met for program or cost center under review for Non-Claims Benefit Expense (NCBE) Classification.

Criteria for Clinical Services:
1. Services related to diagnosis or treatment of a medical condition.
2. Provided directly to a member
3. By a licensed provider or:
4. By a qualified medical professional

Criteria for Non-Clinical Services:
1. Medical or health related expenses (services/products)

2. Contractual obligation
3. Direct benefit to members

Criteria for Facility Support:
1. Direct operational benefit to facilities for rendering medical and related services to members. Includes quality improvement initiative with like nature in characteristics to activities traditionally undertaken by facilities.

Proposed Governance Structure:
BCBSM proposes a structured governance process around NCBE to ensure transparency and awareness around program performance as well as program adds/deletes/changes. Using plan year 2021 as an example, the below timeline shows at a very high level how we can progress a more collaborative dialog on these programs on an annual basis, with this cycle being repeated for each plan year.

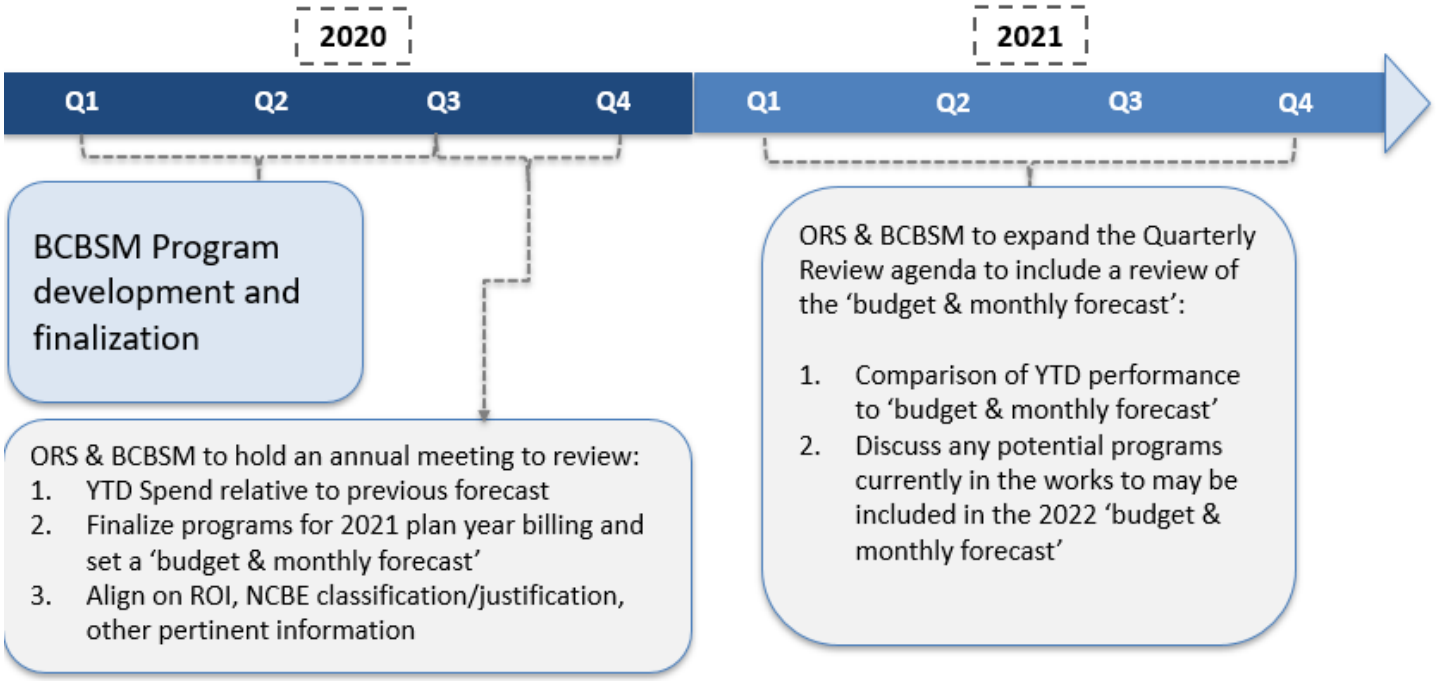

Exhibit D
Service Level Agreements (SLAs) – Non-Medicare Medical Plan
Effective 1/1/20

Service Level Agreements (SLAs) – Non-Medicare Medical Plan
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 has been approved 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 for Plan Sponsor's prior approval. 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 (Standard Contract Terms, Section 39).

Quarterly SLA reports are due 45 Days after the end of each calendar quarter. Annual SLA reports are due 90 days after the close of the plan year. The Contractor must provide the Plan Sponsor with completed SLA tracking tool, provided by Plan Sponsor, self-reporting the Contractor's performance under each SLA for the Plan Sponsor. Supporting documentation must accompany the completed tracking tool. Within 75 Days after the end of each calendar quarter, the Contractor must approve penalty amounts for any applicable penalties to the Plan Sponsor based on the provided documentation.

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 will be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

Plan Sponsor has the right to reallocate the total amount at risk among the various individual guarantees annually. Reallocation cannot increase the annual value of any one component by more than 10% of the original value. Reallocation will not increase the overall aggregate value of the penalties. Any such reallocation must be received by Contractor at least 10 business days prior to the applicable calendar year, otherwise attempted reallocations will be of no effect.

SLA 1 - Eligibility Uploads
Guarantee
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. The SLA report must show weekly activity defined as the number of records uploaded within the above timeframe.

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 the Plan Sponsor. The SLA report must show weekly activity defined as the number of records not accepted and the timeframe for presenting the discrepancy reports to the Plan Sponsor.

The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 2 - Membership Cards
Guarantee
Membership Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. Performance must be substantiated by documentation providing proof of receipt date and mailing date.

Membership Cards must have an accuracy rate of 100.00%. Accuracy must be measured by sampling ID card production to ensure 100.00% accuracy of information.

The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Penalty
The Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 3 - Average Speed of Answer
Guarantee
Contractor must maintain an average speed of answer (ASA) 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 must 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 6 - Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to at least 95.00% 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 7 - Timeliness of Data Transmission to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager
Guarantee
Contractor must deliver Claim data files to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager in an 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 a Saturday, Sunday or State recognized holiday, the data file can be delivered on the next business day without penalty.

Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Non- Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 8 - Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $30,000.00 per quarter not met.

SLA 9 - Non-Financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $30,000.00 per quarter not met.

SLA 10 - Claims Processing Time
Guarantee
95.00% of clean Claims must be processed within 30 calendar Days.
99.50% of clean 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 11 – Members Managed
Guarantee
Contractor guarantees to achieve 2% of Non-Medicare membership managed through the Enhanced Integrated Care Model.

Contractor must report its performance on this SLA on an annual basis, starting in 2021 for 2020 plan year. The SLA will be considered “Met” if a managed rate of 2% or above is achieved.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 12 – High Dollar Claimant Review
Guarantee
Contractor guarantees to achieve 95% of newly identified high dollar members (members with $100,000 or greater spend in the last 12 months) with a case reviewed within 30 days of identification.

Contractor must report its performance on this SLA on an annual basis, starting in 2021 for 2020 plan year. The SLA will be considered “Met” if a rate of 95% or above is achieved.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 13 – Member Satisfaction
Guarantee
Contractor guarantees to achieve 90% of managed members who self-report being satisfied with their Care Management experience.

Contractor must report its performance on this SLA on an annual basis, starting in 2021 for 2020 plan year. The SLA will be considered “Met” if a rate of 90% or above is achieved.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 14 - Clinical Quality Improvements
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 (>9.00%)
- HbA1c control (<8.00%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- Blood Pressure (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 (Non-Medicare only): 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.

Contractor must calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and National Committee on Quality Assurance (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 Non-Medicare penalty for failure to meet this SLA is $50,000.00 for each measure not met per year, for a total potential penalty of $150,000.00 per year.

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 four applicable measures, each measure would be assessed 25.00% of the penalty if not met.

SLA 15 - 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. These process improvement projects will be approved by Plan Sponsor by December 31st.

Contractor must complete up to three process improvement projects developed and approved during the previous Plan Year.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 if the Contractor does not complete the approved project(s). $150,000.00 will be split equally amongst the quality improvement projects selected by Plan Sponsor and assessed for each quality improvement project that is not completed within the agreed upon timeframe.

SLA 16 - Customer Performance Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1.00 to 5.00. The Contractor will be measured using the Plan Sponsor's annual survey (see Exhibit Y) to assess the Contractor's Performance within the following categories:

- Senior Account Manager Performance
- Communications
- Data Reporting
- Customer Service
- Administrative Support

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

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional $75,000.00.

SLA 17 - Member Satisfaction Survey
Guarantee
One random sample Member Satisfaction Survey must be completed annually at no additional cost. The surveys must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for approval of questions and scoring methodology prior to deployment. Plan Sponsor has the authority to request changes and customization to the survey and scoring methodology. The respondent pool must be statistically valid based on the Plan Sponsor's total population (randomly generated sample size sufficient to produce a 95.00% confidence interval with a margin of error of not greater than +/-3.00%). Survey results must be available to the Plan Sponsor by September 30th within the Plan Year unless a different date is agreed upon.

Contractor must achieve a score of 4.00 or higher on a 5.00 point scale (other scoring scales may be used as long as they are equivalent) from 85.00% of the responders.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 18 - Financial Accuracy Rate
Guarantee
Financial Accuracy Rate must be calculated on a monthly basis using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision.

The resultant accuracy rate (as defined as the total dollar value of claims paid, minus 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%; 1.00% error rate.

Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $120,000.00 per year that the SLA is not met, plus $60,000.00 for each 0.50% below the standard.

Exhibit E
Service Level Agreements (SLAs) – Medicare Medical Plan
Effective 1/1/20

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 has been approved 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 for Plan Sponsor's prior approval. 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 (Standard Contract Terms, Section 39).

Quarterly SLA reports are due 45 Days after the end of each calendar quarter. Annual SLA reports are due 90 days after the close of the plan year. The Contractor must provide the Plan Sponsor with completed SLA tracking tool, provided by Plan Sponsor, self-reporting the Contractor's performance under each SLA for the Plan Sponsor, and within 75 Days after the end of each calendar quarter. The Contractor must approve penalty amounts for any applicable penalties to the Plan Sponsor based on the provided documentation. Any metric that is reported must be accompanied by supporting documentation.

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 will be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

Plan Sponsor has the right to reallocate the total amount at risk among the various individual guarantees annually. Reallocation cannot increase the annual value of any one component by more than 10% of the original value. Reallocation will not increase the overall aggregate value of the penalties. Any such reallocation must be received by Contractor at least 10 business days prior to the applicable calendar year, otherwise attempted reallocations will be of no effect.

SLA 1 - Eligibility Uploads
Guarantee
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. The SLA report must show weekly activity defined as the number of records uploaded within the above timeframe.

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 the Plan Sponsor. The SLA report must show weekly activity defined as the number of records not accepted and the timeframe for presenting the discrepancy reports to the Plan Sponsor.

The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 2 - Membership Cards
Guarantee
Membership Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. Performance must be substantiated by documentation providing proof of receipt date and mailing date.

Membership Cards must have an accuracy rate of 100.00%. Accuracy must be measured by sampling ID card production to ensure 100.00% accuracy of information.

The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 3 - Average Speed of Answer
Guarantee
Contractor must maintain an average speed of answer (ASA) 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 must 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 Medicare penalty for failure to meet this SLA is $55,000.00 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 Medicare penalty for failure to meet this SLA is $55,000.00 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 6 - Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to at least 95.00% 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 7 - Timeliness of Data Transmission to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager
Guarantee
Contractor must deliver Claim data files to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager in an 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 a Saturday, Sunday or State recognized holiday, the data file can be delivered on the next business day without penalty.

Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 8 - Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $165,000.00 per quarter not met.

SLA 9 - Non-Financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $165,000.00 per quarter not met.

SLA 10 - Claims Processing Time
Guarantee
95.00% of clean Claims must be processed within 30 calendar Days.
99.50% of clean 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 11 – Members Managed
Guarantee
Contractor guarantees to achieve 2.0% of Medicare membership managed through the Enhanced Integrated Care Model.

This SLA is applicable to be measured on 2020 plan year. Contractor must report its performance on this SLA on an annual basis in 2021 for the 2020 plan year. The SLA will be considered "Met" if a managed rate of 2.0% or above is achieved. A graduated penalty will be applied if the managed rate is below 2.0%. This SLA is not applicable to be measured on 2021 and 2022 plan years and will not be reported on for those years.

Penalty
The Medicare penalty for failure to meet this SLA is $600,000 per year if the Contractor achieves a managed rate of 1.7-1.99%. The penalty is $1,200,000.00 per year if the Contractor achieves a managed rate below 1.7%.

SLA 12 – High Dollar Claimant Review
Guarantee
Contractor guarantees to achieve 95% of newly identified high dollar members (members with $100,000 or greater spend in the last 12 months) with a case reviewed within 30 days of identification.

This SLA is applicable to be measured on 2020 plan year. Contractor must report its performance on this SLA on an annual basis in 2021 for the 2020 plan year. The SLA will be considered "Met" if a rate of 95% or above is achieved. A graduated penalty will be applied if the rate is below 95%. This SLA is not applicable to be measured on 2021 and 2022 plan years and will not be reported on for those years.

Penalty
The Medicare penalty for failure to meet this SLA is $600,000 per year if the Contractor achieves a rate of 92-94% of cases reviewed within 30 days. The penalty is $1,200,000.00 per year if the Contractor achieves a rate below 92% of cases reviewed within 30 days.

SLA 13 – Member Satisfaction
Guarantee
Contractor guarantees to achieve 90% of managed members who self-report being satisfied with their Care Management experience.

This SLA is applicable to be measured on 2020 plan year. Contractor must report its performance on this SLA on an annual basis in 2021 for the 2020 plan year. The SLA will be considered "Met" if a rate of 90% or above is achieved. This SLA is not applicable to be measured on 2021 and 2022 plan years and will not be reported on for those years.

Penalty
The Medicare penalty for failure to meet this SLA is $600,000 per year if the Contractor achieves a member satisfaction rate of 87-89%. The penalty is $1,200,000.00 per year if the Contractor achieves a member satisfaction rate below 87%.

SLA 14 - Clinical Quality Improvements
Guarantee
This SLA is applicable to be measured on 2020 plan year. Contractor must measure and report performance, on an annual basis in 2021 for the 2020 plan year, on the following HEDIS measures following HEDIS methodology and reporting schedule. This SLA is not applicable to be measured on 2021 and 2022 plan years and will not be reported on for those years.

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 (>9.00%)
- HbA1c control (<8.00%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- Blood Pressure (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 Emergency Department 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.

Contractor must calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and National Committee of Quality Assurance (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 Medicare penalty for failure to meet this SLA is $400,000.00 for each measure not met per year, for a total potential penalty of $1,200,000.00 per year.

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 four applicable measures, each measure would be assessed 25.00% of the penalty if not met.

SLA 15 - 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. These process improvement projects will be approved by Plan Sponsor by December 31st.

Contractor must complete up to three process improvement projects developed and approved during the previous Plan Year.

Penalty
The Medicare penalty for failure to meet this SLA is $1,200,000.00 if the Contractor does not complete the approved project(s). $1,200,000.00 will be split equally amongst the quality improvement projects selected by Plan Sponsor and assessed for each quality improvement project that is not completed within the agreed upon timeframe.

SLA 16 - Customer Performance Satisfaction
Guarantee
Plan Sponsor’s satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1.00 to 5.00. The Contractor will be measured using the Plan Sponsor’s annual survey (see Exhibit Y) to assess the Contractor’s Performance within the following categories:

- Senior Account Manager Performance
- Communications
- Data Reporting
- Customer Service
- Administrative Support

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

Penalty
The Medicare penalty for failure to meet this SLA is $1,200,000.00 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional $600,000.00.

SLA 17 - Member Satisfaction Survey
Guarantee
One random sample Member Satisfaction Survey must be completed annually at no additional cost. The surveys must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for approval of questions and scoring methodology prior to deployment. Plan Sponsor has the authority to request changes and customization to the survey and scoring methodology. The respondent pool must be statistically

valid based on the Plan Sponsor's total population (randomly generated sample size sufficient to produce a 95.00% confidence interval with a margin of error of not greater than +/-3.00%). Survey results must be available to the Plan Sponsor by September 30th within the Plan Year unless a different date is agreed upon.

Contractor must achieve a score of 4.00 or higher on a 5.00 point scale (other scoring scales may be used as long as they are equivalent) from 85.00% of the responders.

Penalty
The Medicare penalty for failure to meet this SLA is $1,200,000.00 per year that the SLA is not met.

SLA 18 - Financial Accuracy Rate
Guarantee
Financial Accuracy Rate must be calculated on a monthly basis using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. The resultant accuracy rate (as defined as the total dollar value of claims paid, minus 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%; 1.00% error rate.

Contractor must measure its performance on this SLA on a quarterly basis and report it on an annual basis.

Penalty
The Medicare penalty for failure to meet this SLA is $660,000.00 per year that the SLA is not met, plus $330,000.00 for each 0.50% below the standard.

STATE OF MICHIGAN
ENTERPRISE PROCUREMENT

Department of Technology, Management, and Budget

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

CONTRACT CHANGE NOTICE

Change Notice Number **2**

to

Contract Number **071B7700002**

CONTRACTOR	
	Blue Cross and Blue Shield of Michigan
	600 East Lafayette
	Detroit, MI 48226
	Patricia Soyemi
	313-448-6943
	psoyemi@bcbsm.com
	CV0024314

STATE			
	Program Manager	Danyelle Stoddard	DTMB
		517-284-4576	
		StoddardD1@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

Medical Administration Services for Post-Employment Health Insurance for Michigan Public School Employees Retirement System (MPSERS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2017	December 31, 2020	4 - 1 Year	December 31, 2020

PAYMENT TERMS	DELIVERY TIMEFRAME
NET45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

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

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$1,903,360,149.00	$0.00	$1,903,360,149.00

DESCRIPTION

Effective May 3, 2018, the Contract is amended as follows:

1. Add Enhanced Payment Integrity Services per the attached Change Request 2 (Schedule A - Statement of Work)
2. Add pricing for Enhanced Payment Integrity Services per the attached Change Request 2 (Schedule B - Pricing)
3. Update the Subcontractor table in Schedule A, Section 3.6.2 of Contract per the attached Change Request 2 (Schedule A, Section 4.2 of Change Request 2)
4. Change Program Manager to Danyelle Stoddard, Phone: 517-284-4576 and Email: StoddardD1@michigan.gov (Section 4 of Standard Contract Terms).

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

Contract 071B7700002
Change Request 2
Medical Administration Services for Post-Employment for MPSERS

SCHEDULE A
STATEMENT OF WORK
CONTRACT ACTIVITIES

1. BACKGROUND

This is a Statement of Work (SOW) to amend the Contract for Medical Administration Services for Post-Employment for MPSERS and add Enhanced Payment Integrity Services (avoidances and recoveries).

All other terms/conditions of the Contract remain unchanged.

2. SCOPE

The scope of work for the Contractor includes the primary tasks listed in Contract 071B7700002, all supporting tasks and the following items:

- Pre-pay forensic bill review;
- Prospective clinical editing;
- Provider credit balance recovery;
- Advanced payment analytics.

3. REQUIREMENTS

3.1 Pre-Pay Forensic Bill Review. Contactor will:

1. Review certain types of inpatient claims (in-state and out-of-state) that pay more than a predetermined threshold as defined by Contractor
2. Identify defects and improprieties with a review of claims' itemized bill
3. Utilize expert clinical review and data analytics.

3.2 Prospective Clinical Editing. Contractor will:

1. Apply coding edits to Michigan claims based on nationally recognized coding guidelines
2. Edit claims prior to payment processing as defined by Contractor
3. Refine coding edits over time

3.3 Provider Credit Balance Recovery. Contractor will:

1. Review certain hospital patient accounting systems for possible overpayment due to credit balances.

3.4 Advanced Payment Analytics. Contractor will:

1. Apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities.

3.5 Avoidances and Recoveries. Contractor will:

1. Deliver all avoidances and recoveries to Plan Sponsor within 30 calendar days once recovered in the final review
2. At the State's discretion, a reduced contingency fee (service credit) of no more than 1% per month may be applied if avoidances and recoveries are not delivered within 30 calendar days.

3.6 Enhanced Payment Integrity Services and programs are in addition to those provided within the base administrative fee pursuant to Contract 071B7700002 (including, but not limited to clinical editing, RN reviews, coordination of benefits, data mining and analytics, provider audits, fraud, waste and abuse and overpayment recovery) which will remain in effect and must not be diminished by the addition of the enhanced services listed.

4. Staffing

4.1 Reserved.

4.2 Disclosure of Subcontractors

Legal Business Name	Address / Telephone Number	Services Provided	Complete description of Contract Activities that will be performed/provided by subcontractor	Of the total Contract, the price of the subcontractor's work
Equian, LLC	5975 Castle Creek Parkway Suite 100 Indianapolis, Indiana 46250 Telephone Number Slayton Gorman (615) 784-8639	Pre-Pay Forensic Review Services Advanced Payment Analytics Services	Pre-Pay Forensic Review Services – Equian will review referred inpatient claims for potential billing issues. Once any potential billing issues have been identified, and if claim savings warrant it, Equian will prepare a Forensic Review Report that lists each identified issue and specifies BCBSM's payment liability for all uncontested charges. Equian's Resolution and Appeals staff will address and respond to Provider disputes or formal appeals until Claim Closure. Advanced Payment Analytics (3rd Pass) – Equian will apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities. Equian will identify and validate overpayments through the review and analysis prior to submitting to BCBSM for final review and recovery.	less than 1%
Cotiviti, LLC	115 Perimeter Center Place Suite 700 Atlanta, GA 30346 Telephone Number Dan Grocki (470) 585-2916	Advanced Payment Analytics Services	Advanced Payment Analytics (2nd Pass) – Cotiviti will apply advanced data mining and analytics capabilities to BCBSM claim payment and member eligibility data with the intent of identifying and recovering overpaid medical claims and other claim recovery opportunities. Cotiviti will identify and validate overpayments through the review and analysis prior to submitting to BCBSM for final review and recovery.	less than 1%
CDR Associates, Inc.	307 International Circle Suite 300 Hunt Valley, Maryland 21030 Telephone Number 410-560-6700 x1110	Credit Balance Identification and Recovery Services	Credit Balance Identification and Recovery Services – CDR will review all files and accounts receivable systems of those assigned providers for the purpose of determining whether, and to what extent, credit balance overpayments have been made to such providers. In addition, CDR will research each discovery of overpayments and prepare the necessary documentation for Providers to approve each item, process and refund overpayments to BCBSM.	less than 1%

SCHEDULE B
PRICING

1. Price proposals must include all costs, including but not limited to, any one-time or set-up charges, fees, and potential costs that Contractor may charge the State.

2. Pricing Schedule:

BCBSM will retain the following percentages as administrative compensation of the recoveries or cost avoidance for Pre-pay forensic bill review, Prospective clinical editing, Provider credit balance recovery, and Advanced payment analytics. Administrative compensation retained by BCBSM through the Shared Savings Program will be itemized on Group's invoices, with detail available to the Group in a report entitled Shared Savings Value Report.

First 3 months implemented – 0%
Remainder of 2018 – 25.0%
2019 and thereafter – 27.5%

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

CONTRACT CHANGE NOTICE

Change Notice Number **1**

to

Contract Number **071B7700002**

CONTRACTOR	
	Blue Cross and Blue Shield of Michigan
	600 East Lafayette
	Detroit, MI 48226
	Patricia Soyemi
	313-448-6943
	psoyemi@bcbsm.com
	*******9753

STATE			
	Program Manager	Mark Howard	DTMB
		517-284-4584	
		howardm4@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 284-7021	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

MEDICAL ADMINISTRATION SERVICES FOR POST-EMPLOYMENT HEALTH INSURANCE FOR MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS)

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW
January 1, 2017	December 31, 2020	4 - 1 Year	December 31, 2020

PAYMENT TERMS	DELIVERY TIMEFRAME
Net 45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

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

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$1,903,360,149.00	$0.00	$1,903,360,149.00

DESCRIPTION

Effective April 24, 2017, the Contract is amended as follows:
1) Attached Drug Subsidy Agreement is hereby incorporated into this Contract via CN1, Attachment 1.
2) Schedule B Pricing is updated to add 50% recovery amount for agreement.
3) The Subcontractor table in Schedule A Section 3.6.2 Disclosure of Subcontractors is hereby replaced with the Subcontractor table in CN1, Attachment 1 to incorporate Retiree Drug Subsidy program administration subcontractor.
4) Contract Administrator is changed to Mary Ostrowski (Contract Cover Page and Section 2 & 3 of Standard Contract Terms)

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

Change Notice 1, Attachment 1
Contract 071B7700002

Exhibit A, Section 3.6.2 Subcontractors:

Legal Business Name	Address / Telephone Number	Services Provided	Complete description of Contract Activities that will be performed/provided by subcontractor	Of the total Contract, the price of the subcontractor's work.
Accent	Accent Corporate Headquarters 11808 Miracle Hills Drive Omaha, NE 68154 Mailing Address Accent P.O. Box 543099 Omaha, NE 68154-9896 Telephone Number (800) 747-7243	Accent is responsible for identifying BCBSM MA members who failed to respond to the verification of coverage survey. They also make outbound calls to these member to gather the required information.	Complete the annual verification of coverage campaign.	less than 1%
Alere	Alere Health 3200 Windy Hill Road Suite 300E Atlanta, GA 30339 770-767-4500 800-456-4060	Alere® delivers chronic condition management to BCBSM members. Nurse case managers conduct an engagement call, initial clinical assessment and subsequent calls as needed. Call frequency is determined by the member's need for the intervention. The nurse case managers work with each member to complete a clinical assessment, establish self-management goals and build self-management skills.	Chronic condition management program including option for remote monitoring for members with HF, COPD, CAD and diabetes who are identified and targeted for the program based on a predictive model.	less than 1%
New Directions	8140 Ward Parkway Ste. 500 Kansas City, MO 64114	New Directions would provide: Utilization Management; Autism Management; Member Services; Provider Services; Audit Process; Reporting; Case Management; rTMS Authorization Management; Appeals and Grievances; Quality Assurances.	New Directions will deliver a population management-grounded, data driven behavioral health program to support members in accessing their mental health, substance abuse, autism and rTMS benefits under commercial plans (PPO, Traditional, FEP, and Health Exchange) to produce better health outcomes.	less than 1%
AIM	8600 West Bryne Mawr Ave. Ste. 800 Chicago, IL 60631	Preauthorization services for diagnostics imaging, Echo-cardiology, Sleep Study Therapy and Proton Beam Therapy to provide medical appropriateness preauthorization for services requested	AIM Specialty Health provides preauthorization services for diagnostics imaging, echo-cardiology, sleep study therapy and proton beam therapy.	less than 1%

Legal Business Name	Address / Telephone Number	Services Provided	Complete description of Contract Activities that will be performed/provided by subcontractor	Of the total Contract, the price of the subcontractor's work.
Part D Advisors	17199 N. Laurel Park Drive, Suite 400 Livonia, MI 48152	Retiree Drug Subsidy (RDS) program administration for ongoing RDS applications and to reopen previously reconciled plan years.	Part D Advisors will reopen and redo the final reconciliation process for any and all eligible RDS applications filed by the Office of Retirement Services.	less than 1%
Inovalon	4321 Collington Road, Bowie, Maryland, 20716 301/809-4000	Risk Adjustment - Identification and closure of diagnosis gaps for Medicare Advantage - Submission of risk adjustment information to CMS for Medicare Advantage HEDIS - NCQA certified HEDIS Engine and support for HEDIS submission process as mandated by CMS for Medicare Advantage - NCQA certified HEDIS Engine and support for HEDIS submission as mandated by HHS for Commercial to support NCQA Accreditation	Risk Adjustment - Identify diagnosis gaps - Retrieve and code medical records to close diagnosis gaps - Submit claims and supplemental data to CMS HEDIS - HEDIS Engine - Support HEDIS submission process for Medicare Advantage and Commercial	less than 1%

Retiree Drug Subsidy Agreement

This Retiree Drug Subsidy Agreement ("Agreement") is effective as of mutually signed Change Notice 1 (the "Effective Date") pursuant to Contract Number 071B7700002 and is made between Blue Cross Blue Shield of Michigan ("BCBSM") and State of Michigan ("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 "group health plan," "Part D drug," "qualified retiree prescription drug plan," and "qualifying covered retiree" shall have the meaning as set forth in 42 C.F.R. §423.882.

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

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

D. The term "RDS Program 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.

II. Term and termination

A. Term. The term of this Agreement shall commence on the Effective Date and shall continue through contract expiration date.

B. Termination of Agreement. Termination of this agreement subjected to Contract 071B7700002 Standard Contract Terms, Section 23 (Termination for Cause) and Section 24 (Termination for Convenience).

III. Scope of services

Reopening of Filings

BCBSM or its vendor shall assist Plan Sponsor with reopening of all available years to obtain additional RDS Program funds as permitted by CMS regulations. BCBSM shall be paid 50% 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.

BCBSM or its vendor shall also continue to supply cost reporting for the population with BCBSM Pharmacy coverage under this agreement at no additional charge.

IV. Acknowledgement of purpose of data

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

V. Appeals

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

VI. Retention of records

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

VII. HIPAA compliance

The parties acknowledge and agree that this Agreement involves the use and disclosure of "protected health information," as defined in HIPAA. The parties therefore agree that all uses and disclosures of 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 subject to Contract 071B7700002 Standard Contract Terms, Section 10 (Subcontracting).

D. Entire Agreement. This Agreement is incorporated into the contract subject to Contract 071B7700002 Standard Contract Terms, Section 53 (Entire Contract and Modification).

E. Governing Law. Governing Law will be subject to Contract 071B7700002 Standard Contract Terms, Section 43 (Governing 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 subject to Contract 071B7700002 Standard Contract Terms, Section 2 (Notices):

Contractor:

Patricia Soyemi
Blue Cross Blue Shield of Michigan
600 East Lafayette, 517 J

Detroit, MI 48226

H. Severability. Severability will be subject to Contract 071B7700002 Standard Contract Terms, Section 50 (Severability)

I. Status as Independent Entities. Status as Independent Entities will be subject to Contract 071B7700002 Standard Contract Terms, Section 9 (Independent Contractor)

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. Force Majeure will be subject to Contract 071B7700002 Standard Contract Terms, Section 45 (Force Majeure).

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. Dispute Resolution. Dispute resolution will be subject to Standard Contract Terms, Section 46 (Dispute Resolution)

N. Survival. The provisions of Sections entitled "Term and Termination," "Indemnification," "Limitation of Liability," "Retention of Records," "HIPAA compliance," and "Miscellaneous" will be subject to Contract 071B7700002 Standard Contract Terms, Section 52 (Survival).

IN WITNESS WHEREOF, the parties have executed this Agreement.

Blue Cross Blue Shield of Michigan	State of Michigan
BY:_____	BY: _____
TITLE:_____	TITLE: _____
DATE:_____	DATE: _____

Form No. DTMB-3522 (Rev. 10/2015)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN

DEPARTMENT OF TECHNOLOGY, MANAGEMENT & BUDGET

PROCUREMENT

525 W. ALLEGAN STREET
LANSING, MI 48933

P.O. BOX 30026
LANSING, MI 48909

NOTICE OF CONTRACT NO. 071B7700002

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 East Lafayette, 517 J	**PHONE**	**VENDOR TAX ID # (LAST FOUR DIGITS ONLY)**
Detroit, MI 48226	**313.448.6943**	**9753**

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
PROGRAM MANAGER	DTMB	Mark Howard	517.284.4584	howardm4@michigan.gov
CONTRACT ADMINISTRATOR	DTMB	Michael Kennedy	517.284.6397	Kennedym6@michigan.gov

CONTRACT SUMMARY

DESCRIPTION:
Medical Administration Services for Post-Employment Health Insurance for Michigan Public School Employees Retirement System (MPSERS)

INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
Four Years	January 1, 2017	December 31, 2020	Four, one-year
PAYMENT TERMS	**F.O.B.**	**SHIPPED TO**	
Net 45	N/A	N/A	

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

MINIMUM DELIVERY REQUIREMENTS

N/A

MISCELLANEOUS INFORMATION

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the solicitation #007116B0006528. Orders for delivery will be issued directly by Departments through the issuance of a Purchase Order.

ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION	$1,903,360,149.00

For the Contractor:

9-8-16
Date

Authorized Agent (Print or Type)
Blue Cross Blue Shield of Michigan

For the State:

9-9-16
Date

Tom Falik,
Services Director
State of Michigan

STATE OF MICHIGAN

STANDARD CONTRACT TERMS

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and Blue Cross Blue Shield of Michigan. This Contract is effective on January 1, 2017 ("**Effective Date**"), and unless terminated, expires on Dec. 31, 2020. The Transitional Implementation Period will be the time period prior to Contract Effective Date and the Services Begin Date on January 1, 2017. Contractor must commence performance of all Services to all Members, without interruption, on January 1, 2017.

This Contract may be renewed for up to four additional one-year periods. Renewal must be by written agreement of the parties and will automatically extend the Term of this Contract.

The parties agree as follows:

1. **Duties of Contractor.** Contractor must perform the services and provide the deliverables described in **Exhibit A – Statement of Work** (the "**Contract Activities**"). An obligation to provide delivery of any commodity is considered a service and is a Contract Activity.

   Contractor must furnish all labor, equipment, materials, and supplies necessary for the performance of the Contract Activities, and meet operational standards, unless otherwise specified in Exhibit A.

   Contractor must: (a) perform the Contract Activities in a timely, professional, safe, and workmanlike manner consistent with standards in the trade, profession, or industry; (b) meet or exceed the performance and operational standards, and specifications of the Contract; (c) provide all Contract Activities in good quality, with no material defects; (d) not interfere with the State's operations; (e) obtain and maintain all necessary licenses, permits or other authorizations necessary for the performance of the Contract; (f) cooperate with the State, including the State's quality assurance personnel, and any third party to achieve the objectives of the Contract; (g) return to the State any State-furnished equipment or other resources in the same condition as when provided when no longer required for the Contract; (h) not make any media releases without prior written authorization from the State; (i) assign to the State any claims resulting from state or federal antitrust violations to the extent that those violations concern materials or services supplied by third parties toward fulfillment of the Contract; (j) comply with all State physical and IT security policies and standards which will be made available upon request; and (k) provide the State priority in performance of the Contract except as mandated by federal disaster response requirements. Any breach under this paragraph is considered a material breach.

   Contractor must also be clearly identifiable while on State property by wearing identification issued by the State, and clearly identify themselves whenever making contact with the State.

2. **Notices.** All notices and other communications required or permitted under this Contract must be in writing and will be considered given and received: (a) when verified by written receipt if sent by courier; (b) when actually received if sent by mail without verification of receipt; or (c) when verified by automated receipt or electronic logs if sent by facsimile or email.

If to State:	If to Contractor:
Michael Kennedy 525 West Allegan St. Lansing, MI 48929 kennedym6@michigan.gov (517) 284-6397	Patricia Soyemi (313) 448-6943 psoyemi@bcbsm.com

and Anthony Estell 530 West Allegan St. Lansing, MI 48929 EstellA@michigan.gov (517) 284-4555	

3. **Contract Administrator.** The Contract Administrator for each party is the only person authorized to modify any terms of this Contract, and approve and execute any change under this Contract (each a "**Contract Administrator**"):

State:	Contractor:
Michael Kennedy 525 West Allegan St. Lansing, MI 48929 kennedym6@michigan.gov (517) 284-6397	Patricia Soyemi (313) 448-6943 psoyemi@bcbsm.com

4. **Program Manager.** The Program Manager for each party will monitor and coordinate the day-to-day activities of the Contract (each a "**Program Manager**"):

State:	Contractor:
Mark Howard 530 West Allegan St. Lansing, MI 48929 Howardm4@michigan.gov (517) 284-4584	Patricia Soyemi (313) 448-6943 psoyemi@bcbsm.com

5. **Performance Guarantee**. Contractor must at all times have financial resources sufficient, in the opinion of the State, to ensure performance of the Contract and must provide proof upon request. The State may require a performance bond (as specified in Exhibit A) if, in the opinion of the State, it will ensure performance of the Contract.

6. **Insurance Requirements.** Contractor must maintain the insurances identified below and is responsible for all deductibles. All required insurance must: (a) protect the State from claims that may arise out of, are alleged to arise out of, or result from Contractor's or a subcontractor's performance; (b) be primary and non-contributing to any comparable liability insurance (including self-insurance) carried by the State; and (c) be provided by a company with an A.M. Best rating of "A" or better, and a financial size of VII or better (excluding the Crime (Fidelity) Insurance and Professional Liability (Errors and Omissions) Insurance as the Contractor's coverage is provided by companies who are regulated by the Michigan Department of Insurance and Financial Services).

Required Limits	Additional Requirements
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence Limit $1,000,000 Personal & Advertising Injury Limit $2,000,000 General Aggregate Limit $2,000,000 Products/Completed Operations	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds. The deductible and Self-Insured Retentions are greater than $50,000 but are appropriate for the revenue generated by BCBSM. Policy is issued on Chubb General Liability Form 17-02-3080, Chubb has an A++ XV AM Best Rating.
Umbrella or Excess Liability Insurance	
Minimal Limits:	Contractor must have their policy endorsed to add

$10,000,000 General Aggregate	"the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $1,000,000 Each Accident $1,000,000 Each Employee by Disease $1,000,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate	Contractor must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability. Adding "Additional insured" is NOT AVAILABLE on the Cyber Policy.
Crime (Fidelity) Insurance	
Minimal Limits: $5,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate	The deductible and Self-Insured Retentions are greater than $50,000 but are appropriate for the revenue generated by BCBSM.
Commercial General Liability Insurance	
Minimal Limits: $1,000,000 Each Occurrence Limit $1,000,000 Personal & Advertising Injury Limit $2,000,000 General Aggregate Limit $2,000,000 Products/Completed Operations Deductible Maximum: $50,000 Each Occurrence	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 0.

Umbrella or Excess Liability Insurance	
Minimal Limits: $10,000,000 General Aggregate	Contractor must have their policy endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds.
Automobile Liability Insurance	
Minimal Limits: $1,000,000 Per Occurrence	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) include Hired and Non-Owned Automobile coverage.
Workers' Compensation Insurance	
Minimal Limits: Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Employers Liability Insurance	
Minimal Limits: $1,000,000 Each Accident $1,000,000 Each Employee by Disease $1,000,000 Aggregate Disease	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate	Contractor must have their policy: (1) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds; and (2) cover information security and privacy liability, privacy notification costs, regulatory defense and penalties, and website media content liability.
Crime (Fidelity) Insurance	
Minimal Limits: $5,000,000 Employee Theft Per Loss	Contractor must have their policy: (1) cover forgery and alteration, theft of money and securities, robbery and safe burglary, computer fraud, funds transfer fraud, money order and counterfeit currency, and (2) endorsed to add "the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees, and agents" as Loss Payees.
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate Deductible Maximum: $50,000 Per Loss	

If any of the required policies provide **claims-made** coverage, the Contractor must: (a) provide coverage with a retroactive date before the effective date of the contract or the beginning of Contract Activities; (b) maintain coverage and provide evidence of coverage for at least three years after completion of the Contract Activities; and (c) if coverage is canceled or not renewed, and not replaced with another claims-made policy form with a retroactive date prior to the contract effective date, Contractor must purchase extended reporting coverage for a minimum of three years after completion of work.

Contractor must: (a) provide insurance certificates to the Contract Administrator, containing the agreement or purchase order number, at Contract formation and within 20 calendar days of the expiration date of the applicable policies; (b) require that subcontractors maintain the required insurances contained in this Section; (c) notify the Contract Administrator within five business days if any insurance is cancelled; and (d) waive all rights against the State for damages covered by insurance. Failure to maintain the required insurance does not limit this waiver.

This Section is not intended to and is not be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations under this Contract (including any provisions hereof requiring Contractor to indemnify, defend and hold harmless the State).

7. **MiDEAL Administrative Fee and Reporting.** Contractor must pay an administrative fee of 1% on all MiDEAL payments made to Contractor under the Contract including transactions with MiDEAL members and other states (including governmental subdivisions and authorized entities). Administrative fee payments must be made by check payable to the State of Michigan and mailed to:

Department of Technology, Management and Budget
Financial Services – Cashier Unit
Lewis Cass Building
320 South Walnut St.
P.O. Box 30681
Lansing, MI 48909

Contractor must submit an itemized purchasing activity report, which includes at a minimum, the name of the purchasing entity and the total dollar volume in sales. Reports should be mailed to DTMB-Procurement.

The administrative fee and purchasing activity report are due within 30 calendar days from the last day of each calendar quarter.

8. **Extended Purchasing Program.** Upon written agreement between the State and Contractor, this Contract may be extended to: (a) MiDEAL members, (b) other states (including governmental subdivisions and authorized entities), or (c) State of Michigan employees. MiDEAL members include local units of government, school districts, universities, community colleges, and nonprofit hospitals. A current list of MiDEAL members is available at www.michigan.gov/mideal.

If extended, Contractor must supply all Contract Activities at the established Contract prices and terms, and the State reserves the right to impose an administrative fee and negotiate additional discounts based on any increased volume generated by such extensions.

Contractor must submit invoices to, and receive payment from, extended purchasing program members on a direct and individual basis.

9. **Independent Contractor.** Contractor is an independent contractor and assumes all rights, obligations and liabilities set forth in this Contract. Contractor, its employees, and agents will not be considered employees of the State. No partnership or joint venture relationship is created by virtue of this Contract. Contractor, and not the State, is responsible for the payment of wages, benefits and taxes of Contractor's employees and any subcontractors. Prior performance does not modify Contractor's status as an independent contractor.

10. **Subcontracting.** Contractor may not delegate any of its obligations under the Contract without the prior written approval of the State, except the State agrees that Contractor may use its book-of-business suppliers without further approval. Section 3.6 of the Contract identifies State approved subcontractors. For any change to an already approved subcontractor or an addition to the subcontract list, the Contractor must notify the State at least 90 calendar days before the proposed delegation, and provide to the State any information the State may reasonably request to determine whether the delegation is in its best interest. If approved, Contractor must: (a) be the sole point of contact regarding all contractual matters, including payment and charges for all Contract Activities; (b) make all payments to the subcontractor; and (c) incorporate the terms and conditions contained in this Contract in any subcontract with a subcontractor. Contractor remains responsible for the completion of the Contract Activities, compliance with the terms of this Contract, and the acts and omissions of the subcontractor. The State, in its sole discretion, may require the replacement of any subcontractor.

11. **Staffing.** The State's Contract Administrator may require Contractor to remove or reassign personnel by providing a notice to Contractor.

12. **Background Checks.** Upon request, Contractor must perform background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

13. **Assignment.** Contractor may not assign this Contract to any other party without the prior approval of the State. Upon notice to Contractor, the State, in its sole discretion, may assign in whole or in part, its rights or responsibilities under this Contract to any other party. If the State determines that a novation of the Contract to a third party is necessary, Contractor will agree to the novation and provide all necessary documentation and signatures.

14. **Change of Control.** Contractor will notify, at least 90 calendar days before the effective date, the State of a change in Contractor's organizational structure or ownership unless prohibited by confidentiality terms of any transaction. In the event that a confidentiality agreement prohibits prior notification, the Contractor must notify the State immediately after the confidentiality agreement expires. For purposes of this Contract, a change in control means any of the following: (a) a sale of more than 50% of Contractor's stock; (b) a sale of substantially all of Contractor's assets; (c) a change in a majority of Contractor's board members; (d) consummation of a merger or consolidation of Contractor with any other entity; (e) a change in ownership through a transaction or series of transactions; (f) or the board (or the stockholders) approves a plan of complete liquidation. A change of control does not include any consolidation or merger effected exclusively to change the domicile of Contractor, or any transaction or series of transactions principally for bona fide equity financing purposes.
In the event of a change of control, Contractor must require the successor to assume this Contract and all of its obligations under this Contract.

15. **Ordering.** Contractor is not authorized to begin performance until receipt of authorization as identified in Exhibit A.

16. **Acceptance.** Contract Activities are subject to inspection and testing by the State within 30 calendar days of the State's receipt of them ("**State Review Period**"), unless otherwise provided in Exhibit A. If the Contract Activities are not fully accepted by the State, the State will notify Contractor by the end of the State Review Period that either: (a) the Contract Activities are accepted, but noted deficiencies must be corrected; or (b) the Contract Activities are rejected. If the State finds material deficiencies, it may: (i) reject the Contract Activities without performing any further inspections; (ii) demand performance at no additional cost; or (iii) terminate this Contract in accordance with Section 23., Termination for Cause.

    Within 10 business days, or a mutually agreed upon reasonable timeframe between the State and Contractor, from the date of Contractor's receipt of notification of acceptance with deficiencies or rejection of any Contract Activities, Contractor must cure, at no additional cost, the deficiency and deliver unequivocally acceptable Contract Activities to the State. If acceptance with deficiencies or rejection of the Contract Activities impacts the content or delivery of other non-completed Contract Activities, the parties' respective Program Managers must determine an agreed to number of days for re-submission that minimizes the overall impact to the Contract. However, nothing herein affects, alters, or relieves Contractor of its obligations to correct deficiencies in accordance with the time response standards set forth in this Contract.

    If Contractor is unable or refuses to correct the deficiency within the time response standards set forth in this Contract, the State may cancel the order in whole or in part. The State, or a third party identified by the State, may perform the Contract Activities and recover the difference between the cost to cure and the Contract price plus an additional 10% administrative fee.

17. **Delivery.** Contractor must deliver all Contract Activities F.O.B. destination, within the State premises with transportation and handling charges paid by Contractor, unless otherwise specified in Exhibit A. All containers and packaging becomes the State's exclusive property upon acceptance.

18. **Risk of Loss and Title.** Until final acceptance, title and risk of loss or damage to Contract Activities remains with Contractor. Contractor is responsible for filing, processing, and collecting all damage claims. The State will record and report to Contractor any evidence of visible damage. If the State rejects the Contract Activities, Contractor must remove them from the premises within 10 calendar days after notification of rejection. The risk of loss of rejected or non-conforming Contract Activities remains with Contractor. Rejected Contract Activities

not removed by Contractor within 10 calendar days will be deemed abandoned by Contractor, and the State will have the right to dispose of it as its own property. Contractor must reimburse the State for costs and expenses incurred in storing or effecting removal or disposition of rejected Contract Activities.

19. **Warranty Period**. The warranty period, if applicable, for Contract Activities is a fixed period commencing on the date specified in Exhibit A. If the Contract Activities do not function as warranted during the warranty period the State may return such non-conforming Contract Activities to the Contractor for a full refund..

20. **Terms of Payment.** Invoices must conform to the requirements communicated from time-to-time by the State. All undisputed amounts are payable within 45 days of the State's receipt. Contractor may only charge for Contract Activities performed as specified in Exhibit A. Invoices must include an itemized statement of all charges. The State is exempt from State sales tax for direct purchases and may be exempt from federal excise tax, if Services purchased under this Agreement are for the State's exclusive use. Notwithstanding the foregoing, all prices are inclusive of taxes, except for any tax or surcharge imposed on Claims ("Claims" as defined in Exhibit E) and Contractor is responsible for all sales, use and excise taxes, and any other similar taxes, duties and charges of any kind imposed by any federal, State, or local governmental entity on any amounts payable by the State under this Contract.

    The State has the right to withhold payment of any disputed amounts until the parties agree as to the validity of the disputed amount. The State will notify Contractor of any dispute within a reasonable time. Payment by the State will not constitute a waiver of any rights as to Contractor's continuing obligations, including claims for deficiencies or substandard Contract Activities. Contractor's acceptance of final payment by the State constitutes 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 disputed.

    The State will only disburse payments under this Contract through Electronic Funds Transfer (EFT). Contractor must register with the State at http://www.michigan.gov/cpexpress to receive electronic fund transfer payments. If Contractor does not register, the State is not liable for failure to provide payment.
    Without prejudice to any other right or remedy it may have, the State reserves the right to set off at any time any amount then due and owing to it by Contractor against any amount payable by the State to Contractor under this Contract.

21. **Reserved.**

22. **Stop Work Order.** The State may suspend any or all activities under the Contract at any time. The State will provide Contractor a written stop work order detailing the suspension. Contractor must comply with the stop work order upon receipt. Within 90 calendar days, or any longer period agreed to by Contractor, the State will either: (a) issue a notice authorizing Contractor to resume work, or (b) terminate the Contract or purchase order. The State will not pay for Contract Activities, Contractor's lost profits, or any additional compensation during a stop work period.

23. **Termination for Cause.** The State may terminate this Contract for cause, in whole or in part, if Contractor, as determined by the State: (a) endangers the value, integrity, or security of any location, data, or personnel; (b) becomes insolvent, petitions for bankruptcy court proceedings, or has an involuntary bankruptcy proceeding filed against it by any creditor; (c) engages in any conduct that may expose the State to liability; (d) breaches any of its material duties or obligations; or (e) fails to cure a breach within the time stated in a notice of breach. Any reference to specific breaches being material breaches within this Contract will not be construed to mean that other breaches are not material.

    If the State terminates this Contract under this Section, the State will issue a termination notice specifying whether Contractor must: (a) cease performance immediately, or (b) continue to perform for a specified period. If it is later determined that Contractor was not in breach of the Contract, the termination will be deemed to have been a Termination for Convenience, effective as of the same date, and the rights and obligations of the parties will be limited to those provided in Section 24, Termination for Convenience.

    The State will only pay for amounts due to Contractor for Contract Activities accepted by the State on or before the date of termination, subject to the State's right to set off any amounts owed by the Contractor for the State's reasonable costs in terminating this Contract. The Contractor must pay all reasonable costs incurred by the State in terminating this Contract for cause, including administrative costs, attorneys' fees, court costs, transition costs, and any costs the State incurs to procure the Contract Activities from other sources.

24. **Termination for Convenience.** The State may immediately terminate this Contract in whole or in part without penalty and for any reason, including but not limited to, appropriation or budget shortfalls. The termination notice will specify whether Contractor must: (a) cease performance of the Contract Activities immediately, or (b) continue to perform the Contract Activities in accordance with Section 25., Transition Responsibilities. If the State terminates this Contract for convenience, the State will pay all reasonable costs, as determined by the State, for State approved Transition Responsibilities.

25. **Transition Responsibilities.** Upon termination or expiration of this Contract for any reason, Contractor must, for a period of time specified by the State (not to exceed 180 calendar days), provide all reasonable transition assistance requested by the State, to allow for the expired or terminated portion of the Contract Activities to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Contract Activities to the State or its designees. Such transition assistance may include, but is not limited to: (a) continuing to perform the Contract Activities at the established Contract rates; (b) taking all reasonable and necessary measures to transition performance of the work, including all applicable Contract Activities, training, equipment, software, leases, reports and other documentation, to the State or the State's designee; (c) taking all necessary and appropriate steps, or such other action as the State may direct, to preserve, maintain, protect, or return to the State all materials, data, property, and confidential information provided directly or indirectly to Contractor by any entity, agent, vendor, or employee of the State; (d) transferring title in and delivering to the State, at the State's discretion, all completed or partially completed deliverables prepared under this Contract as of the Contract termination date; and (e) preparing an accurate accounting from which the State and Contractor may reconcile all outstanding accounts (collectively, "**Transition Responsibilities**"). This Contract will automatically be extended through the end of the transition period.

26. **General Indemnification.** Contractor must defend, indemnify and hold the State, its departments, divisions, agencies, offices, commissions, officers, and employees harmless, without limitation, from and against any and all actions, claims, losses, liabilities, damages, costs, attorney fees, and expenses (including those required to establish the right to indemnification), arising out of or relating to: (a) any breach by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable) of any of the promises, agreements, representations, warranties, or insurance requirements contained in this Contract; (b) any infringement, misappropriation, or other violation of any intellectual property right or other right of any third party; (c) any bodily injury, death, or damage to real or tangible personal property occurring wholly or in part due to action or inaction by Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable); and (d) any acts or omissions of Contractor (or any of Contractor's employees, agents, subcontractors, or by anyone else for whose acts any of them may be liable).

    The State will notify Contractor in writing if indemnification is sought; however, failure to do so will not relieve Contractor, except to the extent that Contractor is materially prejudiced. Contractor must, to the satisfaction of the State, demonstrate its financial ability to carry out these obligations.

    The State is entitled to: (i) regular updates on proceeding status; (ii) participate in the defense of the proceeding; (iii) employ its own counsel; and to (iv) retain control of the defense if the State deems necessary. Contractor will not, without the State's written consent (not to be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any claim, action, or proceeding. To the extent that any State employee, official, or law may be involved or challenged, the State may, at its own expense, control the defense of that portion of the claim.

    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. An attorney designated to represent the State may not do so until approved by the Michigan Attorney General and appointed as a Special Assistant Attorney General.

27. **Infringement Remedies.** If, in either party's opinion, any piece of equipment, software, commodity, or service supplied by Contractor or its subcontractors, or its operation, use or reproduction, is likely to become the subject of a copyright, patent, trademark, or trade secret infringement claim, Contractor must, at its expense: (a) procure for the State the right to continue using the equipment, software, commodity, or service, or if this option is not reasonably available to Contractor, (b) replace or modify the same so that it becomes non-infringing; or (c) accept its return by the State with appropriate credits to the State against 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.

28. **Limitation of Liability.** The State is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

29. **Disclosure of Litigation, or Other Proceeding.** Contractor must notify the State within 14 calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Proceeding**") involving Contractor, a subcontractor, or an officer or director of Contractor or subcontractor, that arises during the term of the Contract, including: (a) a criminal Proceeding; (b) a parole or probation Proceeding; (c) a Proceeding under the Sarbanes-Oxley Act; (d) a civil Proceeding involving: (1) a claim that might reasonably be expected to adversely affect Contractor's viability or financial stability; or (2) a governmental or public entity's claim or written allegation of fraud; or (e) a Proceeding involving any license that Contractor is required to possess in order to perform under this Contract.

30. **Reserved.**

31. **State Data.**

a. Ownership. The State's data ("**State Data**," which will be treated by Contractor as Confidential Information) includes: (a) the State's data collected, used, processed, stored, or generated as the result of the Contract Activities; (b) personally identifiable information ("**PII**") collected, used, processed, stored, or generated as the result of the Contract Activities, including, without limitation, any information that identifies an individual, such as an individual's social security number or other government-issued identification number, date of birth, address, telephone number, biometric data, mother's maiden name, email address, credit card information, or an individual's name in combination with any other of the elements here listed; and, (c) personal health information ("**PHI**") collected, used, processed, stored, or generated as the result of the Contract Activities, which is defined under the Health Insurance Portability and Accountability Act (HIPAA) and its related rules and regulations. State Data is and will remain the sole and exclusive property of the State and all right, title, and interest in the same is reserved by the State. This Section survives the termination of this Contract.

b. Contractor Use of State Data. Contractor is provided a limited license to State Data for the sole and exclusive purpose of providing the Contract Activities, including a license to collect, process, store, generate, and display State Data only to the extent necessary in the provision of the Contract Activities. Contractor must: (a) keep and maintain State Data in strict confidence, using such degree of care as is appropriate and consistent with its obligations as further described in this Contract and applicable law to avoid unauthorized access, use, disclosure, or loss; (b) use and disclose State Data solely and exclusively for the purpose of providing the Contract Activities, such use and disclosure being in accordance with this Contract, any applicable Statement of Work, and applicable law; and (c) not use, sell, rent, transfer, distribute, or otherwise disclose or make available State Data for Contractor's own purposes or for the benefit of anyone other than the State without the State's prior written consent. This Section survives the termination of this Contract.

c. Extraction of State Data. Contractor must, within five business days of the State's request, provide the State, without charge and without any conditions or contingencies whatsoever (including but not limited to the payment of any fees due to Contractor), an extract of the State Data in the format specified by the State.

d. Backup and Recovery of State Data. Unless otherwise specified in Exhibit A, Contractor is responsible for maintaining a backup of State Data and for an orderly and timely recovery of such data. Unless otherwise described in Exhibit A, Contractor must maintain a contemporaneous backup of State Data that can be recovered within two hours at any point in time.

e. Loss of Data. In the event of any act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise the security, confidentiality, or integrity of State Data or the physical, technical, administrative, or organizational safeguards put in place by Contractor that relate to the protection of the security, confidentiality, or integrity of State Data, Contractor must, as applicable: (a) notify the State as soon as practicable but no later than 24 hours of becoming aware of such occurrence; (b) cooperate with the State in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the State; (c) in the case of PII or PHI, at the State's sole election, (i) notify the affected individuals who comprise the PII or PHI as soon as practicable but no later than is required to comply with applicable law, or, in the absence of any legally required notification period, within five calendar days of the occurrence; or (ii) reimburse the State for any costs in notifying the affected individuals; (d) in the case of PII, provide third-party credit and identity monitoring services to each of the affected individuals who comprise the PII for the period required to comply with applicable law, or, in

the absence of any legally required monitoring services, for no less than 24 months following the date of notification to such individuals; (e) perform or take any other actions required to comply with applicable law as a result of the occurrence; (f) without limiting Contractor's obligations of indemnification as further described in this Contract, indemnify, defend, and hold harmless the State for any and all claims, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (g) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and, (h) provide to the State a detailed plan within 10 calendar days of the occurrence describing the measures Contractor will undertake to prevent a future occurrence. Notification to affected individuals, as described above, must comply with applicable law, be written in plain language, and contain, at a minimum: name and contact information of Contractor's representative; a description of the nature of the loss; a list of the types of data involved; the known or approximate date of the loss; how such loss may affect the affected individual; what steps Contractor has taken to protect the affected individual; what steps the affected individual can take to protect himself or herself; contact information for major credit card reporting agencies; and, information regarding the credit and identity monitoring services to be provided by Contractor. This Section survives the termination of this Contract.

32. Non-Disclosure of Confidential Information. The parties acknowledge that each party may be exposed to or acquire communication or data of the other party that is confidential, privileged communication not intended to be disclosed to third parties. The provisions of this Section survive the termination of this Contract.

a. Meaning of Confidential Information. For the purposes of this Contract, the term "**Confidential Information**" means all information and documentation of a party that: (a) has been marked "confidential" or with words of similar meaning, at the time of disclosure by such party; (b) if disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning; and, (c) should reasonably be recognized as confidential information of the disclosing party. The term "Confidential Information" does not include any information or documentation that was: (a) subject to disclosure under the Michigan Freedom of Information Act (FOIA); (b) already in the possession of the receiving party without an obligation of confidentiality; (c) developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights; (d) obtained from a source other than the disclosing party without an obligation of confidentiality; or, (e) publicly available when received, or thereafter became publicly available (other than through any unauthorized disclosure by, through, or on behalf of, the receiving party). For purposes of this Contract, in all cases and for all matters, State Data is deemed to be Confidential Information.

b. Obligation of Confidentiality. The parties agree to hold all Confidential Information in strict confidence and not to copy, reproduce, sell, transfer, or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or subcontractors of a party who have a need to know in connection with this Contract or to use such Confidential Information for any purposes whatsoever other than the performance of this Contract except as allowed under HIPPA for health plan administration purposes, or under the Business Associate Addendum. The parties agree to advise and require their respective employees, agents, and subcontractors of their obligations to keep all Confidential Information confidential. Disclosure to 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 responsibilities; 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 or any subcontractor may be required to execute a separate agreement to be bound by the provisions of this Section.

c. Cooperation to Prevent Disclosure of Confidential Information. Each party must use its best efforts to assist the other party in identifying and preventing any unauthorized use or disclosure of any Confidential Information. Without limiting the foregoing, each party must advise the other party immediately in the event either party learns or has reason to believe that any person who has had access to Confidential Information has violated or intends to violate the terms of this Contract and each party will cooperate with the other party in seeking injunctive or other equitable relief against any such person.

d. Remedies for Breach of Obligation of Confidentiality. Each party acknowledges that breach of its obligation of confidentiality may give rise to irreparable injury to the other party, which damage may be inadequately compensable in the form of monetary damages. Accordingly, a party may seek and obtain

injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies which may be available, to include, in the case of the State, at the sole election of the State, the immediate termination, without liability to the State, of this Contract or any Statement of Work corresponding to the breach or threatened breach.

e. Surrender of Confidential Information upon Termination. Upon termination of this Contract or a Statement of Work, in whole or in part, each party must, within five calendar days from the date of termination, return to the other party any and all Confidential Information received from the other party, or created or received by a party on behalf of the other party, which are in such party's possession, custody, or control; provided, however, that Contractor must return State Data to the State following the timeframe and procedure described further in this Contract. Should Contractor or the State determine that the return of any Confidential Information is not feasible, such party must destroy the Confidential Information and must certify the same in writing within five calendar days from the date of termination to the other party or maintain the Confidential Information, as approved by the State, in the same manner under the terms of this Contract.

33. Data Privacy and Information Security

a. Undertaking by Contractor. Without limiting Contractor's obligation of confidentiality as further described, Contractor is responsible for establishing and maintaining a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (a) ensure the security and confidentiality of the State Data; (b) protect against any anticipated threats or hazards to the security or integrity of the State Data; (c) protect against unauthorized disclosure, access to, or use of the State Data; (d) ensure the proper disposal of State Data; and (e) ensure that all employees, agents, and subcontractors of Contractor, if any, comply with all of the foregoing. In no case will the safeguards of Contractor's data privacy and information security program be less stringent than the safeguards used by the State, and Contractor must at all times comply with all applicable State IT policies and standards, which are available to Contractor upon request.

b. Audit by Contractor. No less than annually, Contractor must conduct a comprehensive independent third-party audit of its data privacy and information security program and provide such audit findings to the State.

c. Right of Audit by the State. Without limiting any other audit rights of the State, the State has the right to review Contractor's data privacy and information security program prior to the commencement of Contract Activities and from time to time during the term of this Contract. During the providing of the Contract Activities, on an ongoing basis from time to time and without notice, the State, at its own expense, is entitled to perform, or to have performed, an on-site audit of Contractor's data privacy and information security program. In lieu of an on-site audit, upon request by the State, Contractor agrees to complete, within 45 calendar days of receipt, an audit questionnaire provided by the State regarding Contractor's data privacy and information security program.

d. Audit Findings. Contractor must implement any required safeguards as identified by the State or by any audit of Contractor's data privacy and information security program.

e. State's Right to Termination for Deficiencies. The State reserves the right, at its sole election, to immediately terminate this Contract or a Statement of Work without limitation and without liability if the State determines that Contractor fails or has failed to meet its obligations under this Section.

34. Reserved.

35. Reserved.

36. Records Maintenance, Inspection, Examination, and Audit. The State or its designee may audit Contractor to verify compliance with this Contract. Contractor must retain, and provide to the State or its designee and the auditor general upon request, all financial and accounting records related to the Contract through the term of the Contract and for four years after the latter of termination, expiration, or final payment under this Contract or any extension ("**Audit Period**"). If an audit, litigation, or other action involving the records is initiated before the end of the Audit Period, Contractor must retain the records until all issues are resolved.

Within 10 calendar days of providing notice, the State and its authorized representatives or designees have the right to enter and inspect Contractor's premises or any other places where Contract Activities are being performed, and examine, copy, and audit all records related to this Contract. Contractor must cooperate and provide reasonable assistance. If any financial errors are revealed, the amount in error must be reflected as a credit or debit on subsequent invoices until the amount is paid or refunded. Any remaining balance at the end of the Contract must be paid or refunded within 45 calendar days.

This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

37. **Warranties and Representations.** Contractor represents and warrants: (a) Contractor is the owner or licensee of any Contract Activities that it licenses, sells, or develops and Contractor has the rights necessary to convey title, ownership rights, or licensed use; (b) all Contract Activities are delivered free from any security interest, lien, or encumbrance and will continue in that respect; (c) the Contract Activities will not infringe the patent, trademark, copyright, trade secret, or other proprietary rights of any third party; (d) Contractor must assign or otherwise transfer to the State or its designee any manufacturer's warranty for the Contract Activities; (e) the Contract Activities are merchantable and fit for the specific purposes identified in the Contract; (f) the Contract signatory has the authority to enter into this Contract; (g) all information furnished by Contractor in connection with the Contract fairly and accurately represents Contractor's business, properties, finances, and operations as of the dates covered by the information, and Contractor will inform the State of any material adverse changes; and (h) all information furnished and representations made in connection with the award of this Contract is true, accurate, and complete, and contains no false statements or omits any fact that would make the information misleading. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 23., Termination for Cause.

38. **Conflicts and Ethics.** Contractor will uphold high ethical standards and is prohibited from: (a) holding or acquiring an interest that would conflict with this Contract; (b) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract; (c) attempting to influence or appearing to influence any State employee by the direct or indirect offer of anything of value; or (d) paying or agreeing to pay any person, other than employees and consultants working for Contractor, any consideration contingent upon the award of the Contract. Contractor must immediately notify the State of any violation or potential violation of these standards. This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

39. **Compliance with Laws.** Contractor must comply with all federal, state and local laws, rules and regulations.

40. **Reserved.**

41. **Nondiscrimination.** Under the Elliott-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*., Contractor and its subcontractors agree not to discriminate against an employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, or a matter directly or indirectly related to employment, because of race, color, religion, national origin, age, sex, height, weight, marital status, or mental or physical disability. Breach of this covenant is a material breach of this Contract.

42. **Unfair Labor Practice.** Under MCL 423.324, the State may void any Contract with a Contractor or subcontractor who appears on the Unfair Labor Practice register compiled under MCL 423.322.

43. **Governing Law.** This Contract is governed, construed, and enforced in accordance with Michigan law, excluding choice-of-law principles, and all claims relating to or arising out of this Contract are governed by Michigan law, excluding choice-of-law principles. Any dispute arising from this Contract must be resolved in Michigan Court of Claims. Contractor consents to venue in Ingham County, and waives any objections, such as lack of personal jurisdiction or *forum non conveniens*. Contractor must appoint agents in Michigan to receive service of process.

44. **Non-Exclusivity.** Nothing contained in this Contract is intended nor will be construed as creating any requirements contract with Contractor. This Contract does not restrict the State or its agencies from acquiring similar, equal, or like Contract Activities from other sources.

45. **Force Majeure.** Neither party will be in breach of this Contract because of any failure arising from any disaster or acts of god that are beyond their control and without their fault or negligence. Each party will use commercially reasonable efforts to resume performance. Contractor will not be relieved of a breach or delay caused by its subcontractors. If immediate performance is necessary to ensure public health and safety, the State may immediately contract with a third party.

46. **Dispute Resolution.** The parties will endeavor to resolve any Contract dispute in accordance with this provision. The dispute will be referred to the parties' respective Contract Administrators or Program Managers. Such referral must include a description of the issues and all supporting documentation. The parties must submit the dispute to a senior executive if unable to resolve the dispute within 15 business days. The parties will continue performing while a dispute is being resolved, unless the dispute precludes performance. A dispute involving payment does not preclude performance.

    Litigation to resolve the dispute will not be instituted until after the dispute has been elevated to the parties' senior executive and either concludes that resolution is unlikely, or fails to respond within 15 business days. The parties are not prohibited from instituting formal proceedings: (a) to avoid the expiration of statute of limitations period; (b) to preserve a superior position with respect to creditors; or (c) where a party makes a determination that a temporary restraining order or other injunctive relief is the only adequate remedy. This Section does not limit the State's right to terminate the Contract.

47. **Media Releases.** News releases (including promotional literature and commercial advertisements) pertaining to the Contract or project to which it relates must not be made without prior written State approval, and then only in accordance with the explicit written instructions of the State.

48. **Website Incorporation.** The State is not bound by any content on Contractor's website unless expressly incorporated directly into this Contract.

49. **Order of Precedence.** In the event of a conflict between the terms and conditions of the Contract, the exhibits, a purchase order, or an amendment, the order of precedence is: (a) the purchase order; (b) the amendment; (c) Exhibit A; (d) any other exhibits; and (e) the Contract.

50. **Severability.** If any part of this Contract is held invalid or unenforceable, by any court of competent jurisdiction, that part will be deemed deleted from this Contract and the severed part will be replaced by agreed upon language that achieves the same or similar objectives. The remaining Contract will continue in full force and effect.

51. **Waiver.** Failure to enforce any provision of this Contract will not constitute a waiver.

52. **Survival.** The provisions of this Contract that impose continuing obligations, including warranties and representations, termination, transition, insurance coverage, indemnification, and confidentiality, will survive the expiration or termination of this Contract.

53. **Entire Contract and Modification.** This Contract is the entire agreement and replaces all previous agreements between the parties for the Contract Activities. This Contract may not be amended except by signed agreement between the parties (a "**Contract Change Notice**").

STATE OF MICHIGAN

Contract No. 071B7700002
Administration Services for Post-Employment Health Insurance for Michigan Public School Employees Retirement System (MPSERS) – Department of Technology, Management and Budget – Office of Retirement Services (ORS)

EXHIBIT A
STATEMENT OF WORK
CONTRACT ACTIVITIES

Project Identification
This is a Contract for administration of post-employment health coverage (hospital and medical) for the Medicare-Eligible Members and non-Medicare Eligible Members, including Retirees, beneficiaries, COBRA participants, and their Dependents of the Michigan Public School Employees Retirement System (MPSERS), administered by the Office of Retirement Services (ORS). The current plan is Self-Insured, including the Medicare Advantage (MA) plan.

No payment will be made to the Contractor during the Transitional Implementation Period. The Transitional Implementation Period means the period of time prior to the Contract Begin or Effective Date and Services are commenced on January 1, 2017. Contractor must commence performance of all Services to all Members, without interruption, on January 1, 2017.

Background
ORS administers the MPSERS Plan which provides post-employment health coverage to Non-Medicare Eligible and Medicare-Eligible Members, including Retirees, beneficiaries and their Dependents enrolled in the health plan. 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 197,000 Members in the MPSERS health plans. Approximately 20% of the Members are not Medicare-Eligible and 80% are Medicare-Eligible. The self-funded portion of the Plan does not include participants in the HMOs, in which there are currently approximately 28,700 Members.

There are currently approximately 158,000 Members enrolled in the MA Plan, 39,000 members enrolled in the Non-Medicare PPO and approximately 28,700 Members enrolled in the HMOs. In any given month, there are between 400-500 Members transitioning from the Non-Medicare PPO Plan into the Plan Sponsor's MA Plan.

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

Plan Sponsor acknowledges that final enrollment in Contractor's MA 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 MA plan; and (3) and being approved by CMS.
See Exhibit D for claim cost and enrollment data for Plan Sponsor.

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.

All words capitalized in this document indicate a defined word. Please refer to Exhibit B for all definitions.

1.0a General Requirements
For all Services/Deliverables to be provided by Contractor (and its subcontractors, if any) under the Contract, the State must not be obligated to pay any amounts in addition to the charges specified in the Contract. Services considered within the scope of this Contract include, but are not limited to, the following:

A. Provide a fully functional medical Plan for Members which encompasses and manages the needs of an older, retired population.

B. Provide Services in the administration of Enrollment, Claims Processing, and Member Support, including review and administration of Grievances and Appeals.

C. Provide Medical Management Services to ensure a high quality of care at the lowest possible cost.

D. Collaborates with the Plans Sponsor to provide plan updates and services to ensure the future success and ability of the Plan to continue to offer competitive health care coverage.

E. Provide 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.

G. Ensure Transparency and Pass-Through Pricing for all Services provided.

H. Fully implement the Plan Sponsor's custom plan design.

I. Adhere to medical policy review approval process and do not modify coverage without written approval from the Plan Sponsor.

J. Adhere to any program related to compliance with government initiatives such as Health Care Reform and administration of an EGWP.

K. Monitor, review and implement all legislation and guidance that applies to this Contract.

L. Reserved.

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:

M. Plan Design

a. Contractor must administer hospital and medical coverage at the direction of the Plan Sponsor.

b. The Contractor must duplicate the current Plan Design for Plan Sponsor. Refer to Section 1.0c for the Non-Medicare Plan Design and Section 1.0d for the Medicare Plan Design.

c. The Plan Design is subject to change throughout the duration of this Contract. The Contractor must implement Plan changes as requested by the Plan Sponsor by their effective date at no additional cost to the Plan Sponsor. Contractor must not expand or reduce coverage for Members without the Plan Sponsor's written approval. This includes, but is not limited to: reducing member access to providers, expanding coverage to include new medical technology, reimbursement of additional provider-types, new locations in which covered services can be provided, and expanding diagnostic criteria for bone and stem cell transplants.

N. Member Support

a. Contractor must provide a Customer Service call center, where it will maintain staff dedicated to supporting the needs of the Plan Sponsor's Members. The State prefers that the call center is located in Michigan. The Contractor's call center must be available to receive inbound calls Monday through Friday from 8:30 AM to 5:00 PM Eastern Standard Daylight Time.

b. The Contractor must notify the Plan Sponsor of any known or suspected system issues that may impact operations or service to Members.

c. Contractor must provide phone, secure email/messaging, and written correspondence options for customer contacts. Contractor must provide a phone service system, for both Members and

Providers that includes (at minimum) the following components:

i. The system must be toll-free
ii. An IVR system
iii. Methods for logging calls, recording call data and content; the recorded call must be attached to the customer account
iv. Methods to report metrics, standards and ad hoc report generation.
v. Methods to monitor calls for quality

d. Secure email/Message Service: Contractor must provide a secure email/messaging service, for both Members and Providers, which include (at minimum) the following components:
    i. Methods for receiving and transmitting messages
    ii. Methods for routing messages to properly trained responders
    iii. Methods for logging messages, recording message data and content; the message must be attached to the customer account
    iv. Methods to report metrics, standards and ad hoc report generation
    v. Methods to monitor messaging for quality

e. Contractor must provide written correspondence services, for both Members and Providers, which include (at minimum) the following components:
    i. Methods for storing, tracking and routing correspondence to properly trained responders
    ii. Methods for logging correspondences, recording correspondence data and content; it is highly preferred that the correspondence be attached to the customer account.
    iii. Methods to report metrics, standards and ad hoc report generation
    iv. Methods to monitor responses for quality

f. If the Contractor provides chat services, the Contractor must include all the following:
    i. Methods for storing, tracking and routing chats to properly trained responders
    ii. Methods for logging chats, recording chat data and content; the recorded call must be attached to the customer account
    iii. Methods to report metrics, standards and ad hoc report generation
    iv. Methods to monitor chats for quality

g. A single front-end toll-free telephone number with touch-tone routing (if necessary) for Customer Service staff to respond to Member requests and/or questions.

h. A voice response system with a user-friendly menu.

i. Separate, toll-free numbers for Members and Providers.

j. An advanced telephone system that provides the Plan Sponsor with management tracking and reporting capabilities, including a speech analytic tool.

k. 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:
    i. Capabilities to provide Members with information specific to their own Claims and enrollment
    ii. Ability to list Providers based on accessibility to Member's home address
    iii. Capabilities to answer Member questions about the Plan
    iv. Capability to provide quality-of-care information about Providers
    v. Contractor must be able to provide Members access to designated electronic Plan-specific documents on the Contractor's Plan-specific website

l. A Customer Service system scalable to future demand, as will be defined by Contractor and Plan Sponsor during the Implementation Period.

m. Contractor must have the capabilities of addressing special needs of Members, including Text Telephone (TTY) or relay services for the hearing impaired.

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

o. Information on how to access Customer Services must be clearly communicated in all Plan specific booklets, claim kits/post-enrollment, newsletters and other Member Materials.

p. For those issues not resolved immediately, Contractor must contact Members about their issues within seven Days of receipt of member contact. This response must either resolve the outstanding issue(s) or inform the Member as to when resolution can be expected.
    i. Written Member inquiries must be responded to in writing.

O. Member Communication Materials and Meetings

a. Member Communication Materials:
    i. All communication materials must be approved by the Plan Sponsor in advance of distribution. This applies to all information developed, provided, and/or distributed by Contractor to Members about the Plan—including those placed on the Contractor's Plan Sponsor-specific website. Contractor must provide a communication plan, no later than November 1st each year, which must include the description of the communication, the due date to the Plan Sponsor for prior approval, and the final targeted publication date.
    ii. Contractor must prepare and distribute these materials, at its own cost. This includes planned member communications and ad hoc communications where desired by the Plan Sponsor.
        1. All communications must be customizable to better address the specific needs of the Plan Sponsor and its members. This includes co-branding materials with the name of the Contractor and the Plan Sponsor, where desired by the Plan Sponsor.

b. Contractor must provide quarterly submission to the Member newsletter published and distributed by the Plan Sponsor's Medicare Health Plan informing membership of current events, health and wellness, and any plan updates.

c. Member Communication Meetings:
The Contractor must provide speakers at meetings designated by the Plan Sponsor at no additional charge to the Plan Sponsor. Meeting requests may vary from year-to-year, but will include up to 10 day-long sessions out-of-state (primarily Florida and Arizona, but could include other U.S. states, as directed by the Plan Sponsor, based on the Member's geographic location) and up to 13 day-long sessions in Michigan, of which three may be in the Upper Peninsula. All meetings will require the combined participation of the Contractor, the Plan Sponsor, the Health Plan Contractor, the PBM Contractor, the Vision Plan Contractor, and HMO Contractors as deemed appropriate by the Plan Sponsor. Any travel and accommodations and meals expenses for State employees, and/or other Plan Sponsor representatives, must be covered by the Contractor. Each Contractor will be responsible for their own travel arrangements, but the planning and organizing of these meetings is the responsibility of the Medicare Health Plan provider. Associated cost for these meetings is to be shared equally with the other Contractors.

d. In addition to the Plan Sponsor's' designated meetings, the Contractor may receive requests for speakers from the Member support organizations. A reasonable effort must be made to accommodate requests for in-state meetings at no charge to the retiree support organizations or the Plan Sponsor.

e. Contractor must provide publications.

f. Contractor must provide 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.

g. Contractor is expected to coordinate messaging with ORS, CMS and with other carriers such that members are not confused by multiple messages from different sources.

P. Enrollment and Eligibility

a. 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. Enrollment information for Members will be transferred to Contractor from Plan Sponsor by electronic medium including all necessary information with respect to current enrollees at a date to be determined by Plan Sponsor. Payment of Administration Fee is predicated on the enrollment records of the Plan Sponsor.

b. Contractor must comply with all applicable requirements of HIPAA, as amended (see Exhibit F, Business Associate Addendum).

c. Contractor must have the ability to store Member information. Any changes, additions or terminations of Member enrollment information or changes or additions to Member demographic information must originate from the Plan Sponsor, unless otherwise specifically agreed upon. Any exceptions to this process must be agreed upon by the Plan Sponsor prior to any change in process. Contractor must not make any changes to Member information that would lead to Contractor and Plan Sponsor having different information for the same Member.

iii. The Contractor must provide the Plan Sponsor with all enrollment and eligibility information about the Plan Sponsor's members received from affiliate sources such that the Plan Sponsor remains the enrollment and eligibility system of record. Information must be provided in a method determined by Plan Sponsor.

d. Contractor must support Plan Sponsor in confirming Member Eligibility. This includes, but is not limited to:

i. Contractor must conduct an annual Verification of Coverage campaign, as outlined in Exhibits G1 and G2. This campaign is essential to meeting Plan Sponsor's statutory obligation for Coordination of Benefits.
ii. Contractor must perform all dependent eligibility verifications listed on Exhibit H.
iii. Contractor must conduct additional eligibility verifications as mutually agreed upon by the Contractor and the Plan Sponsor.

e. Contractor must have the capability to accept electronic data transfer on a weekly basis, more frequently if necessary, from the Plan Sponsor, in a HIPAA compliant 834 format, inclusive of all fields contained in Exhibit F and which is provided through the State of Michigan's data exchange gateway. Contractor must work with Plan Sponsor in the implementation of this data transfer.

f. Contractor is responsible for any changes, and any associated costs therein, to their systems or processes required to support the receipt and processing of Plan Sponsor's enrollment files. Contractor must work with Plan Sponsor to develop a timeline for implementation and testing of any system changes. Contractor is expected to maintain a testing environment for such purpose.

g. Contractor must have validation edits in place to ensure, for each data load, that all fields are properly populated and readable.

h. Upon written notification from Plan Sponsor, Member Enrollment updates must be completed in real-time.

i. Contractor must provide to the Plan Sponsor, by means of a secured Internet portal, access to the system used to maintain Enrollment. The Plan Sponsor requires that all access be established using unique usernames and passwords (i.e., no shared or generic passwords).

j. Contractor must provide to Providers, by means of a secured Internet portal, access to Eligibility.

k. Communication involving any identifiable Member information must be transmitted to the State

through a secure channel defined by the Plan Sponsor.

l. Contractor must produce and issue membership cards to Members as needed and are subject to Plan Sponsor's approval of the card template. Plan Sponsor will need at least five days for approval.

Q. Technology and Systems

a. Contractor must keep duplicate or back-up computer data files maintained in connection with the plans in a place of safekeeping complying with all HIPAA Standards. All computer data files of the Plan Sponsor, as maintained by Contractor, must at all times remain the property of the State notwithstanding the fact that such records may be stored upon or within one or more computer or data retention systems owned, operated or leased by Contractor. The State, or its representatives, must, at all reasonable times, have access to the records. To the extent that any such records are to be maintained upon a computer system or any other data retention system which is not owned by the Contractor, the Contractor must provide the State with assurances from the owner of such computer facilities, satisfactory to the State, of continued availability and security of such records at all times.

b. Contractor must maintain and keep a documented disaster recovery plan that will be made available to the State or Plan Sponsor upon request. Contractor must provide proof and the results of an annual disaster recovery exercise is conducted annually.

c. Contractor must provide the State access to all back-up source materials, reports, books, records, computer programs and all other information and documentation relating to each plan, as reasonably required so that the State and/or its designated officers, agents and accounts, can conduct a financial examination and/or audit of the plans.

d. The State's data needs to be kept within the continental U.S. A. boundaries.

e. Duplicate copies of State data must be kept off-site from the primary processing site, and at a location that is at least 500 miles from the primary data repository location, following same encryption in transit and at rest requirements.

f. **SSAE No.16**

a. Contractor must have either a Type II Statement on Standards for Attestation Engagements (SSAE) No. 16, conducted annually specific to the State of Michigan.

b. Contractor must supply Plan Sponsor with an annual copy of the results of this audit, within 45 days of completion of the report.

c. Contractor must also provide to Plan Sponsor additional information pertaining to internal controls, upon request.

d. 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.

e. If Contractor's current SSAE-16 or SAS-70 has qualifications, the Contractor must provide the Plan Sponsor with the corrective action plan and provide regular updates until issues have been corrected.

R. Financial Administration

a. 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.

b. 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.

Contractor must electronically transmit a signed, written statement which certifies that the wire request correctly and completely reflects Plan Sponsor's financial obligation for the time period defined.

c. Contractor must prepare and distribute to Providers Internal Revenue Service Forms 1099, as well as any other State and federal forms required by law.

d. All interest accrued from account(s) used to pay Eligible Claims, including all revenue, must accrue to the Plan Sponsor.

e. 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 of discovery. Any payment—in part or in full—beyond 30 Days is subject to the actuarially determined interest rate, compounded, which is currently 8%.

f. If necessary, the Contractor and the State will meet to review each audit report 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 and the State will develop, agree upon and monitor an action plan to address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

g. 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.

h. 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.

i. 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.

S. Data

a. Contractor must agree to work with the Plan Sponsor-chosen data management contractor (hereafter referred to as the "data contractor") in a manner inclusive of, but not limited to, the following:
    i. Contractor must provide the data contractor claims data as described in Exhibits J1, J2, and J3. This information is to be provided to the data contractor monthly and by a date no later than the 15th Day from the last day of the reporting month. Data must be securely maintained for the duration of this Contract.
    ii. Upon termination or expiration of the Contract, Contractor must deliver all data to the data contractor within five Days of a request for the same.
    iii. Contractor is responsible for all expenses, including the cost of any subcontractors, related to producing the data and providing it to the data contractor. This includes any costs associated with resubmissions and processing costs incurred by the data contractor due to the transmittal of incomplete, inaccurate, or unreadable data files belonging to the Plan Sponsor.
    iv. Contractor is responsible to work with the data contractor, including developing any process improvement procedures needed, to correct all issues that impede or prevent accurate data reporting from the database.

b. If the Plan Sponsor adds additional contractors, the Contractor must provide data feeds to these contractors without additional costs.

T. Service Level Agreements (SLAs) – Medicare, Non-Medicare Medical and Pharmacy

a. See Exhibit D for Medicare SLAs.
b. See Exhibit E for Non-Medicare SLAs.

U. **Contractual Provisions**

a. Covenant of Good Faith: Each party must act reasonably and in good faith. Unless stated otherwise in the Contract, the parties must 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.

V. Credits

a. Contractor must agree to provide Plan Sponsor with a $50,000.00 competitive development fund per year that can be used for a variety of services during the term of the Contract. Plan Sponsor can utilize this pool to offset any expenses related to, but not limited to: clinical programs, member mailings, communications, market checks, ongoing plan management, auditor fees and consulting fees. The Contractor must not need to evaluate the client's use of these fees as long as the fees are used in support of Plan Sponsor's healthcare benefit.

The process for requesting payment will be to contract the SAM and ask for the Credit. Payment should be expected by the second billing invoice received by the Plan Sponsor expected within 30 days of the request from the Plan Sponsor.

1.0b Medical Plan General Requirements

A. Claims Processing

a. Contractor must administer claims in conformity with Plan Design as described in Section1.0a A.

b. Contractor must only pay Eligible Claims for Eligible Members. If a claim payment for an ineligible member is made, the Contractor must reimburse the Plan Sponsor. If a paid claim or a member is later determined to be ineligible and can be identified, the Contractor must recover such payments from participants or reimburse Plan Sponsor for such payments from Contractor's own funds.

c. Contractor must only charge against the Plan Sponsor's account Claim payments authorized under the Plan Sponsor's Plan Design.

d. Contractor must undertake responsibility for providing Organization Determinations, including full and fair review of Claims Appeals by Members, in compliance with CMS requirements. For the Non-Medicare members, Contractor's Claims Appeals process must be the Plan Sponsor's Claims Appeals process, included as Exhibit N Contractor's Claims Appeals reporting must comply with Plan Sponsor's Claims Appeals reporting requirements.

e. Contractor must adjudicate Eligible Claims so as to reflect the status of Members' cost share amounts pursuant to the Plan, as of the commencement of its administration. The Contractor must be able to provide Members with an Explanation of Benefit that accurately reflects the approved listed items in a format that is easily understood by members.

f. Contractor must maintain a claims processing department that can image and scan paper claims, process high volume and complex claims, adjudicate coordination of benefits, process out of country claims, handle recoveries, and have staff to handle claims that require manual intervention.

g. 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 sufficient information to link Claims to Eligibility.

h. Contractor must maintain confidentiality of all data collected by the Contractor, according to all applicable laws, rules and regulations.

i. Contractor must capture and store all Claim data elements involved in the processing or payment

of Claims.

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

k. The Contractor's system, processes, subcontractors, and partners must comply with HIPAA. Contractor must provide Plan Sponsor with an annual attestation that it meets this requirement.

l. Contractor must comply with the statutory mandate for Coordination of Benefits (COB).

m. Contractor must be able to process Direct Member Reimbursement Claims.

n. Contractor must have processes in place to prevent, detect, and correct non-compliance with billing requirements.

o. Contractor must have a process in place to detect, prevent, and correct fraud, waste, and abuse. Where fraud and abuse is discovered, Contractor must attempt to make recoveries. Contractor's employees and Members must be made aware of how to report suspected fraud, waste, and abuse.

p. Contractor must have procedures for handling overpayments and recoveries through multiple channels, including but not limited to - providers, members, Claims, Servicing, Coordination of Benefits & Recoveries COBR, Corporate & Financial Investigations (CFI), Health Care Value (HCV), and Subrogation.

q. If there are administrative changes in the Contractor's systems, processes, or procedures that impact the Plan Sponsor or Members, the Contractor must notify the Plan Sponsor as soon as possible and provide written notification explaining the change, the impact to the Plan Sponsor and/or to Members and the related timeline, in writing, 60 days prior to the change (or as soon as the Contractor is aware).

r. If the Contractor receives rebates on any prescription drug, the Contractor must Pass Through the rebates to the Plan Sponsor.

s. Contractor must file, collect, and redistribute any class action lawsuit settlements on Plan Sponsor's behalf.

B. Provider Network

a. Contractor must manage and maintain a Provider Network for the Plan Sponsor and Members, including, but not limited to:

i. Contractor must have and use a process to credential, monitor, and re-credential Network Providers.

ii. Contractor must be able to add Providers to the Provider Network. The Contractor must notify the Plan Sponsor, in writing, of the removal of large health systems.

iii. Contractor must maintain a network of Providers in areas where Members reside. For Non-Medicare, the Contractor's network must provide one or more medical network Providers located within a convenient distance of Member residences, provided there is a medical Provider available, for at least 95.00% of all Members. Otherwise the standard must be the nearest available medical Provider. Convenient distances for purposes of this Contract are defined in chart below. For Medicare, the Contractor's network must follow CMS's provider and facility network adequacy criteria.

Provider Type	Urban Members (> 3,000 population per square mile)	Suburban Members (1,000 – 3,000 population per square mile)	Rural Members (< 1,000 population per square mile)
Internal Medicine	2 Providers within 5 miles	2 Providers within 10 miles	2 Providers within 20 miles
Family Practice	2 Providers within 5 miles	2 Providers within 10 miles	2 Providers within 20 miles
Ob-Gyn	2 Providers within 5 miles	2 Providers within 10 miles	2 Providers within 20 miles
Cardiology	1 Provider within 10 miles	1 Provider within 15 miles	2 Providers within 20 miles
Laboratory Drawing Stations	1 Provider within 10 miles	1 Provider within 15 miles	2 Providers within 20 miles
Other Specialties	1 Provider within 10 miles	1 Provider within 15 miles	2 Providers within 20 miles

b. Contractor must provide a GEO Access report for its Medicare and non-Medicare provider networks, identifying the percentage of Members who meet the access standard based on their home address ZIP Code.

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

d. The Provider Network must be designed to direct Members to the Provider.
   i. Contractor's program should encourage the use of primary care physicians to eliminate unnecessary use of high-cost specialists.
   ii. The Provider Network should address the needs which are specific to an older, retired population.
   iii. The Contractor must be able to implement, at a minimum, the concepts of a Patient-Centered Medical Home.
   iv. Contractor must have the ability to provide Members with a transparency or cost calculator tool.

e. Contractor must provide full 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.

f. Contractor must have the ability to implement narrow networks with various out-of-pocket requirements.

g. Contractor must commit to soliciting Provider access in any area where the access standard is not currently being met.

C. Utilization and Medical Management

Contractor must ensure that its Medical management programs address the needs of an older, retired population. The program must include, but not be limited to, the below requirements:

a. Contractor must utilize effective Medical Management programs that ensure quality of care to Members and control costs. Medical Management programs must address the continuum of Member health status, ranging from healthy population initiatives (wellness) through acute care management (utilization management, discharge planning, care transitions) through chronic care management (disease management) and Case Management for high cost cases with strategies designed to promote the most cost effective use of health care resources. The predictive modeling capabilities must include, but not limited to: the ingestion of behavioral health, lab values, prescription drug claims, Medical claims, and Gaps in care.

   The current program offerings are detailed below. If the Contractor makes any major improvements to their medical management programs, significantly modifies the current programs, or develops any new programs, Contractor will offer the updated programs as part of the all-inclusive administrative fee in an effort to provide the most cost effective use of health care resources.

Medicare Plan

Programs include:

- 24 Hour Nurse Line—Toll-free access to an experienced team of registered nurses 24 hours a day, seven days a week.
- Engagement Center—Specially-trained, experienced staff help members understand and enroll in wellness and care management programs.

Case Management (includes high-cost claim management) - A voluntary, member-centric and integrated program that helps members coordinate their care and deal with complex health issues. This program is for members with high-cost chronic and acute conditions, as well as those who are at high risk for incurring high costs in the future. The overall goal for the program is to develop cost-effective and efficient ways of coordinating health care services to improve the member's quality of life through collaboration with the member, family and the treating physician. Case managers arrange appropriate services and care settings, assist in the evaluation of services, encourage communication among health care providers, and provide education for complicated health care needs.

Complex care management (Blue Care Connect) - an integrated care management program designed to provide extra support to members with complex care needs. The program offers resources to improve self-management of multiple and complex conditions, and making decisions about care needs. The program also helps reduce the need for hospital stays and emergency room visits. A dedicated care manager will work with members to provide help managing conditions, comprehensive home assessments, home visits as needed and other support. Through personal, one-on-one interaction with a care manager, members will receive assistance with care coordination, information about their condition, information on Contractors' doctors and hospitals, community resource referrals, medical supply delivery coordination and end-of-life support. The care manager will remain with the member until the member has met their care goals.

Chronic Condition Management - is for members identified with coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, or heart failure (HF). This vendor-managed (Alere) program offers support and assistance to members to maintain, restore or improve health through technology-enabled, evidence-based solutions and management. Members are offered the option for remote monitoring if their condition permits or telephonic-only intervention.

Care Transition to Home - is a short-term program (six weeks or less) for members who have recently been hospitalized and are at risk of a readmission within 30 days. The program goal is to minimize future adverse medical events that occur soon after discharge by educating and empowering members to become active managers in the maintenance of their health. Each engaged case contributes to the reduced likelihood of readmission potential and provides a solid return on the investment through benefit cost reduction.

Tobacco Cessation Coaching is a telephone-based smoking cessation program designed to support members in their efforts to stop smoking. Members have access to counseling by specially trained health coaches. The goals of the program are to improve the quality of life for members and reduce costs and hospital utilization for conditions associated with cigarette smoking. This program is opt-in only and voluntary.

Care Transition to Home Onsite: is a program is delivered to Medicare Advantage members in selected hospitals in the state of Michigan. Initial member engagement is conducted through a face to face interaction while the member is still in the hospital. The Members receive education, support and resources to assist with the transition from the acute setting to home. Care managers address, medication compliance, gaps in care and facilitate physician follow up within seven days of discharge to decrease the potential for readmissions. This program is currently available within 13 Southeast Michigan facilities.

Gaps in Care: Within each programs, care managers identify gaps in care and implement specific interventions to close gaps such as educating members on the gap in care, ensuring that members have a primary care physician, scheduling appointments with the primary care physicians, and

sending physicians a fax including the members' gaps in care.

Blue365® and Healthy Blue Xtras[SM]—Offers discounts to members for health-related products and services needed to support a healthy, balanced lifestyle.

The Contractor uses a predictive model that helps them find the right program for the right person at the right time. Predictive modeling identifies potential participants for chronic condition management, case management and care transition (discharge planning) programs. This analysis uses inpatient and outpatient facility, professional, vision, pharmacy, external pharmacy claims data and membership data for all members on a rolling monthly basis and provides members with a risk score that estimates the probability that he or she will incur high health care costs in the coming year. After a risk score has been assigned, the Contractor integrates the score with internal precertification and pre-notification data, health assessment data, biometric screening results, and other known data (e.g., number of chronic conditions, number of admissions) to target members for outreach. The Contractor is in the process of enhancing the predictive model for their Care Transition program to include gaps in care, medication adherence and physician attribution.

Non-Medicare Plan
The Contractor provides MPSERS with the following programs:
Engagement Center—Specially-trained, experienced staff help members understand and enroll in health and wellness programs.
Online Wellness Program—Online, interactive platform, available through a partnership with WebMD® Health Services, that creates a seamless member experience and offers innovative capabilities, flexibility and technological functionality. The platform includes interactive online resources including a health assessment, Digital Health Assistant[SM], integrated apps, message boards, trackers, videos, tools and other health information such as preventive reminders.
24 Hour Nurse Line—Toll-free access to an experienced team of registered nurses 24 hours a day, seven days a week.
Case Management (includes high-cost claim management)—A voluntary, member-centric and integrated program that helps members coordinate their care and deal with complex health issues.
Complex Chronic Condition Management—Targets high-risk members who have multiple complex medical issues and psycho-social needs that impact their ability to manage their chronic conditions. Focuses on the five most costly conditions: heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes and asthma. Case managers identify gaps in care and implement specific interventions to close gaps, such as educating members on gaps, ensuring members have a primary care physician, scheduling appointments with the physicians, and providing physicians with gaps information for their patients.
Care Transition to Home—A short-term program (six weeks or less) for members who have recently been hospitalized and are at risk of a readmission within 30 days. The program goal is to minimize future adverse medical events that occur soon after discharge by educating and empowering members to become active managers in the maintenance of their health.
Win by Losing—Provides members with a toolkit that includes templates for tracking food intake and activity, health coaching videos, an eating plan and healthy recipes.
Blue365® and Healthy Blue Xtras[SM]—Offers discounts to members for health-related products and services needed to support a healthy, balanced lifestyle.
Predictive Modeling
The Contractor uses a predictive model that helps find the right program for the right person at the right time. Predictive modeling identifies potential participants for disease management, case management and care transition (discharge planning) programs. This analysis includes a variety of data including laboratory data, pharmacy claims, biometrics, health assessment data, gaps in care and utilization management data. The Contractor has the capability of integrating additional types of data, as required by MPSERS.

b. Medical Management programs must include, but not be limited to:
    i. Wellness/Care Management
        1. Contractor must provide programs that address the concept of the compression of morbidity.

           Care Management Programs - In each telephone-based program, members work with a designated nurse case manager who helps manage and support the member throughout the program. Nurses use evidence-based techniques, such

as motivational interviewing and cognitive behavioral coaching, and collaborate with internal resources, such as other care management staff, to help the members reach their health goals, change lifestyle behaviors and reduce health risks. Nurses will also coordinate with external resources, such as a member's treating physician, to ensure continuity of care and maximize program effectiveness for integration purposes.

Wellness Programs – The Contractor's Health & Wellness programs include an integrated online wellness platform powered by WebMD® Health Services. It features a health assessment, a Digital Health Assistant, online trackers and message boards, and interactive online tools, articles and videos.

Educational Resources - All telephone-based program participants receive resources throughout the program, including educational materials on topics related to their specific health concerns. Members who participate in Digital Health Assistant programs receive a personalized online plan to help them achieve goals they've set and stay on track.

2. Contractor must be able to support Plan Sponsor's existing wellness program structure, as well as plan an active role in supporting and advising on future enhancements to the same. Elements of such programs must include, but not be limited to:
    a. Health assessments focused on an older, retired population with the ability to measure functional status and utilize a predictive modeling tool.
    b. A strategy to administer different plan design provisions depending on whether a Member has completed a health assessment.
    c. Member communication.
    d. Member education and support concerning lifestyle/health risks, health management resources.

ii. Utilization Management

1. Contractor must provide a program to certify and monitor the appropriateness and duration of inpatient care and specified outpatient Services. Utilization management must address high frequency imaging procedures, admission, concurrent review and discharge planning, retrospective review when the process is started after discharge, and any other care to home transitional programs. Utilization management decisions must be communicated to Members and Providers, which includes information about the Appeals process.

   The Contractor's Precertification program ensures that health care services (including inpatient and outpatient services) are rendered in the appropriate setting. Utilization decisions are communicated to members and providers. Precertification services provide authorizations for admissions to:
   - Michigan and out-of-State skilled nursing facilities, rehabilitation facilities and long-term acute care facility admissions
   - Out-of-state acute hospitals

   Precertification reviews include the use of evidence-based guidelines such as InterQual and physician consultant reviews to determine medical necessity of the admission and continued stay. A precertification authorization number is assigned when the level of care is medically appropriate given the patient's condition and the service(s) being rendered. Members that may benefit from Case Management are referred. Michigan hospitals submit a pre-notification for admission and based on targeting may receive a clinical review.

iii. Chronic Care/ Disease management

1. Contractor must follow HEDIS measurement processes.

2. Contractor must offer a Disease Management program that Plan Sponsor may elect to participate in. This program must include, but not limited to, the following conditions: Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Diabetes, Heart Failure, Cancer, and Hypertension.

   The Contractor offers a voluntary disease management program, which manages the five most costly conditions—heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes and asthma. The program manages hypertension as a comorbidity. Additionally, the cancer component is addressed in BCBSM's Case Management program.

   In addition to telephone-based programs, members have access to Digital Health Assistant programs through BCBSM's partnership with WebMD. Digital Health Assistant topics include several that are related to condition management such as nutrition, exercise and weight loss. Members also have access to a variety of health content, as well as Message Board Exchanges, related to conditions including CAD, COPD, diabetes, heart failure, cancer and hypertension.

3. Contractor must have a process to identify, notify, and enroll individuals into the Disease Management program.

iv. Case Management: Contractor must provide a program that:

1. Has predictive modeling trigger to identify Members that are at risk for high-cost care.

   Case Management and Care Transition to Home (discharge planning) programs use predictive model triggers to identify members who are at risk for high-cost care, as well as use. Members are assigned risk scores and are priority ranked. The case management predictive model processes smaller volumes of referrals with high case management potential to create a more efficient and effective nurse outreach process. The Case Management predictive model is triggered by:
   - Risk score in top 10% of the population
   - Multiple ER visits that did not result in a hospital admission
   - Health Assessment

   Case Management trigger diagnoses include:
   - AIDS/HIV
   - Amyotrophic lateral sclerosis (ALS)
   - Aplasitc anemia
   - Brain aneurysm
   - Brain injury
   - Burns
   - Cystic fibrosis
   - Chronic obstructive pulmonary disease (COPD)
   - Congestive heart failure
   - Diabetes
   - Emphysema
   - Hemophilia
   - High-risk pregnancy
   - High-risk neonates
   - Infectious disease
   - Malignancies (breast, brain, lung, colon, prostate, etc.)
   - Multiple sclerosis
   - Paraplegia
   - Quadriplegia
   - Spinal cord injuries
   - Stroke
   - Transplants/rejections

- Trauma/injuries

The customized predictive model for the Care Transition to Home program ranks members based on their risk of readmission in the next 30 days. The predictive model is run daily as new prenotifications (hospital admission notifications) are added to the system. The predictive model aims to concentrate intervention efforts toward the highest risk population.

Data from pre-notifications is used to supplement the claims history that might be lagging due to payment processes. The predictive model includes information about the member, the hospital to which they were admitted, and past medical and pharmacy claims history.

2. Monitors high-cost Claimants on an individual basis (>$50,000.00).

3. Provides support to Members under treatment, their families, and Providers in order to facilitate the use of medically appropriate services and facilities at a lowest net cost setting.

4. Has the ability to use prescription drug data from Plan Sponsor's PBM to help identify Members at risk for high-cost care.

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5. Routinely evaluate members for depression using a validated age appropriate screening tool.

c. Contractor must provide to Members, at a minimum, the following:
   i. Transplant Centers of Excellence
   ii. Cardiac Centers of Excellence
   iii. Nurse Line, with clinical resources
   iv. Oncology Center of Excellence

d. Contractor must have a gaps in care process that compares clinical metrics to evidence based medicine best practice across a multitude of conditions. The Contractor must include this gaps in care information in their predictive modeling, provider relations and member education/Disease Management process.

e. Contractor must offer Plan Sponsor support for, and advice on, Medical Policy. This includes, but is not limited to, the following:
   i. Identifying and notifying Plan Sponsor, in writing, of new and emerging technological developments in the treatment and diagnosis of medical conditions.
   ii. Providing cost benefit analyses of these emerging technologies.
   iii. 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.

f. Contractor must monitor and manage Members on Specialty Drugs when paid through the medical plan. Contractor must monitor and manage Members on Specialty Drugs including, but is not limited to, the following:
   i. 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.
   ii. Working with the Plan Sponsor and its PBM to ensure compliance with Prior Authorization/ Step Therapy requirements for Specialty Drugs.
   iii. Working with Plan Sponsor and its PBM to make sure that Members who are prescribed Specialty Drugs are included in the Contractor's other Medical Management Programs.

g. Contractor must demonstrate quality assurance and a Quality Management program directed toward improving patient outcomes and the quality of care provided to Members that uses Claims data, including prescription drug data from Plan Sponsor's PBM, and that integrates all of the Medical Management program components and provides a framework for monitoring program effectiveness.
    i. Members must be issued written adverse benefit determinations in accordance with CMS regulations.
    ii. Contractor must have formal processes and structures in place to measure and improve clinical and service quality for both healthcare service delivery and administrative performance.

D. Audit

a. The Contractor must pass through to Plan Sponsor 100% recovery of medical audit recoveries and overpayments.

b. The Contractor must allow Plan Sponsor the right to audit all aspects of the medical program managed by the Contractor including, but not limited to: financial terms, service agreements, administration, and guarantees at no cost to the Plan Sponsor. The review of all aspects of the medical program may include, but not limited to: paid claims, the claim processing system, rebate agreements on drugs covered under the medical plan, performance guarantees, pricing guarantees, CMS payment reconciliations, onsite assessments, operational assessments, clinical assessments and customer service call monitoring for both the non-Medicare and Medicare plans, if applicable. Audits will be conducted by a firm selected by Plan Sponsor. The Contractor cannot charge Plan Sponsor or audit firm for audit, for any data required for audit, or for any audits requested by the Plan Sponsor.

c. There are no limitations on the number of claims to be audited and the Contractor must not charge the Plan Sponsor for any audits, including, but not limited to: onsite pre-implementation audit, annual claims audit, annual benefit audit, etc.

d. Contractor must provide written confirmation acknowledging the Contractor's approval of the timeline for the claims audit five days after the audit kickoff meeting.

e. Contractor must provide requested data elements required to complete a benefit and claims audit 30 days from receipt of the data request by the Plan Sponsor's auditor.

f. Contractor must provide their responses to the claims that require review within 30 days of receipt of claim inquires and/or exceptions from the Plan Sponsor's auditor.

g. Contractor must provide their formal response to the audit findings within 30 days of receipt of the audit report.

h. Contractor must allow full onsite audit-ability.

i. Contractor must not offset any audit recovery overpayments by any potential underpayments identified by the audit.

j. Contractor must allow Plan Sponsor, or Plan Sponsor's consultant, the right to review the internal testing completed for Plan Sponsor's non-Medicare and Medicare Plan, if applicable, prior to the effective date of the plan on an annual basis.

k. Contractor must allow Plan Sponsor, or Plan Sponsor's consultant, the right to create and submit test claims for Plan Sponsor's non-Medicare and Medicare plan, without limitations on the number of test claims, as part of a pre or post implementation audit, on an annual basis.

l. Contractor must provide 40 claims per plan design that would typically be tested in advance of a new client's effective date, to ensure the plan is set up accurately.

m. Contractor and/or subcontractor must allow plan sponsor to audit the clinical programs in place.

n. Contractor and/or subcontractor must allow plan sponsor to audit customer service calls.

1.0c Non-Medicare Medical Plan

A. The Contractor must duplicate the current Plan Design for Plan Sponsor.

1.0d Medicare Medical Plan

A. The Contractor must duplicate the current Plan Design for Plan Sponsor.

B. Medicare Supplemental

a. Contractor must be able to transition the MA plan to a Medicare Supplemental plan within 90 days from Plan Sponsor's written notification.

C. Medicare Advantage

a. Contractor must provide comprehensive administration of an MA Plan.

b. Contractor must monitor MA costs and revenue streams and provide supporting analytics to Plan Sponsor or its designee(s) as requested by Plan Sponsor in order to determine if Plan Sponsor should continue offering a MA plan. Contractor must also show a qualitative comparison between MA and Medicare Supplemental that emphasizes both the member benefits of a MA plan compared to a Medicare Supplemental plan and the total cost of the different options to Plan Sponsor. Upon Plan Sponsor's request, must be prepared to present the information at the Plan Sponsor's location.

c. Contractor must administer Plan Sponsor's MA plan for as long as the Plan Sponsor determines to offer an MA plan to its Members.

In the event the Plan Sponsor determines to terminate the plan offering, the Contractor will implement a transition strategy that avoids harm to Members.

d. Contractor must have a Revenue Management program that optimizes CMS revenue with 100.00% pass through of all revenue, including CMS revenue, to Plan Sponsor.

e. If Plan Sponsor elects a MA Plan, and the CMS Star rating in the second and/or subsequent years of the Contract is less than that disclosed in the Contractor's proposal, Contractor must reimburse Plan Sponsor 50% of the difference between the CMS Star bonus payments that would have been received if they had maintained the originally disclosed CMS Star rating and the CMS Star bonus payments that they actually received.

f. All CMS Revenue, including CMS Star bonus payments, is subject to Transparency and full Pass-Through provisions. Contractor must credit all CMS revenue to Plan Sponsor's account within 30 days of Contractor's receipt.

g. Contractor must provide ongoing run-out support of the MA plan, in the case that Plan Sponsor decides to discontinue the MA plan.

h. Contractor must transfer all out-of-pocket accumulators when a Member becomes eligible for the MA plan.

i. Contractor must provide, annually, their plan to maximize CMS Revenue Management and CMS Star rating.

j. Plan Sponsor will notify Contractor of any Member that will be enrolled in Contractor's MA Plan through a group enrollment process utilizing electronic procedures and formats for the transfer of enrollment data.

i. Contractor must advise eligible Members that Plan Sponsor intends to enroll them into the Contractor's MA plan through an automatic enrollment process unless the Member

affirmatively opts out of such enrollment. Contractor must ensure that all such Members will be provided enrollment information at least 21 days prior to the effective date of the Member'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 Contractor must comply with CMS requirements.

ii. Contractor must submit the enrollment data received from Plan Sponsor (subject Section 1.0aD) to CMS for enrollment or dis-enrollment in the Plan within the time frame specified by CMS. Upon receipt of confirmation of acceptance, denial or rejection of an individual from CMS, Contractor must load the accepted Members into the Plan within three business days and report the rejected or denied members back to the Plan Sponsor within two business days for correction or other action. Plan Sponsor will provide Contractor with any corrections to the rejected or denied members within 14 days of Plan Sponsor's receipt of the report from Contractor.

k. Plan Sponsor acknowledges that each month Contractor receives CMS capitated payments for Members enrolled in Contractor's MA plan. Any payments received by Contractor on behalf of Plan Sponsor's Members are subject to the Contract's requirements for full Pass-Through Pricing and Transparency. Contractor must apply all CMS revenue to the Plan Sponsor within 30 days of Contractor's receipt.

l. Credit Memo. Contractor must issue to the Plan Sponsor, on a monthly basis, a Credit Memo reflecting the CMS Subsidy received by Contractor for Members enrolled in MA plan. The credit amount will be applied on the last invoice of the month, but can only be applied to invoices for MA Claims provided under this Contract.

m. Contractor must reconcile any terminations (including retroactive terminations made by CMS) at least once each year. 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 Contractor and the Provider.

n. If the Contract terminates, Plan Sponsor will pay Contractor for the cost of any 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 Contractor will not receive any new CMS capitated payments during such run-out period. Any payments received by Contractor 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. Contractor must continue to do run-out activities. Contractor must continue to submit Claims files to Plan Sponsor and their data contractor during the 12 month run-out period.

o. Member Communications. All Member communication materials are subject to the terms and requirements of the Contract, Section 1.0a C., 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 will negotiate in good faith to reach a mutually acceptable resolution. Plan Sponsor acknowledges that CMS mandates that Contractor send Member communications by certain dates and that Contractor will be constrained to send CMS model language if an agreement cannot be reached. Contractor must be willing to take full advantage of the waivers allowed for under the Medicare Managed Care Manual Chapter 9 - Employer/Union Sponsored Group Health Plans. As set forth under the CMS Contract, the Parties agree that with respect to the MA plan, the Contractor will not be subject to the information requirements set forth in 42 CFR § 423.48 and the prior review and approval of marketing materials and enrollment forms requirements by CMS set forth in 42 CFR §423.2260 .

p. Opt-Out Notices. Pursuant to the foregoing, the Contractor must identify new Eligible Participants and mail the Opt-Out Notices to those Eligible Participants. If an Eligible Participants chooses to opt-out, such Eligible Participant will contact Plan Sponsor (or if the Contractor is notified, the Contractor must provide to Plan Sponsor) and Plan Sponsor will processes the Opt-Out request and promptly update the eligibility file. Each Party will comply with the Opt-Out Notice Requirements applicable to the Opt-Out Notice functions each are

providing. Further, due to the fact that the Contractor has delegated certain Opt-Out Notice functions to Plan Sponsor, Plan Sponsor will provide to the Contractor documentation of its compliance with applicable Opt-Out Notice Requirements upon request by the Contractor or CMS.

q. Retroactive Disenrollment. If CMS determines that a Member was not eligible for Contractor's MA plan and requires that Contractor retroactively disenroll such Member, Contractor must re-process Claims as if Original Medicare were in place and Member will pay the appropriate cost share per the Plan Design in effect during that time period and Plan Sponsor will pay applicable Claims costs.

r. Contractor, or its subcontractor, must submit to CMS the enrollment data transfers that it receives from Plan Sponsor for verification and final enrollment in Contractor's MA plan. CMS will review such enrollment data and determine if a Member will be enrolled in the Contractor's MA plan.

s. The Contractor's MA plan must 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.

t. Claims Processing. Processing and payment of Claims is subject to the terms and requirements set forth in Section 1.0 b. A. of the Contract provided that such terms and requirements do not conflict with CMS requirements.

u. Required Disclosures. At the time of enrollment, and at least annually thereafter, and in compliance with the timeframes as set forth by CMS, Contractor must disclose the following to Members:
    i. Service area. Contractor's service area and any enrollment continuation area and any out-of-area coverage provided under the plan.

    ii. Benefits. An evidence of coverage document and summary of benefits offered under Contractor's MA 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:
        1. The benefits offered under Original Medicare, and
        2. The availability of the Medicare hospice option and any approved hospices in the service area, including those that Contractor owns, controls, or has a financial interest in, if any.

    iii. Emergency coverage. Contractor's MA plan must cover emergencies in accordance with 42 CFR 422.113 and discloses to Members 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.

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

    v. Grievance and appeals procedures. Contractor must provide to Members all grievance and appeals rights and procedures that include:
        1. Timeframe for requests for service. When a party has made a request for a service, Contractor must notify the Member of its determination as expeditiously as the Member's health condition requires, but no later than 14 calendar days after the date Contractor receives the request for a standard determination.

Contractor may extend the timeframe by up to 14 calendar days if the Member requests the extension or if the Contractor justifies a need for additional information and how the delay is in the interest of the Member (for example, the receipt of additional medical evidence from non-contracted providers may change Contractor's decision to deny). When Contractor extends the timeframe, it must notify the Member in writing of the reasons for the delay, and inform the Member of the right to file an expedited grievance if he or she disagrees with Contractor's decision to grant an extension.

2. Timeframe for requests for payment. Contractor must process requests for payment according to the "prompt payment" provisions set forth in 42 CFR 422.520.

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

4. Written notice for denials. If a Member requests Contractor to provide an explanation of a Practitioner's denial of an item or service, in whole or in part, Contractor must give the Member a written notice.

5. Form and content of notice. The notice of any denial under paragraph 4 of this section must:
    a. Use approved notice language in a readable and understandable form;
    b. State the specific reasons for the denial;
    c. Inform the Member of his or her right to reconsideration;
    d. For service denials, describe both the standard and expedited reconsideration processes, including the Member's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and
    e. For payment denials, describe the standard reconsideration process and the rest of the appeal process; and
    f. Comply with any other notice requirements specified by CMS.

vi. Effect of failure to provide timely notice. If Contractor fails to provide the Member with timely notice of Contractor's determination as specified in this section, this failure itself constitutes an adverse Contractor determination and may be appealed.

vii. Quality assurance program. The Contractor must provide a quality assurance program required under 42 CFR 422.152.

viii. Disenrollment rights and responsibilities. Contractor must provide all disenrollment rights and responsibilities to Members as defined by CMS.

v. Disclosures upon request. Upon the request of a Member eligible to elect Contractor's MA plan, Contractor must provide to the Member the following information:
    i. Benefits under original Medicare, including covered services, Member cost-sharing, such as deductibles, coinsurance, and copayment amounts and any Member liability for balance billing.

    ii. Contractor's procedures to control utilization of services and expenditures.

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

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

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

w. Changes in Contractor's MA Plan Rules. If changes are made to the rules for Contractor's MA plan, Contractor must:
   i. For changes that take effect on January 1, notify all Members at least 15 Days before the beginning of the Annual Coordinated Election Period defined in section 1851(e)(3)(B) of the Act.
   ii. For all other changes, notify all Members at least 30 days before the intended effective date of the changes.

x. Required disenrollment. Contractor must disenroll Members under the following circumstances:
   i. The Member loses entitlement to Medicare Part A or Part B benefits.
   ii. Death of the Member.
   iii. The Plan Sponsor terminates the Contract with Contractor.
   iv. CMS terminates its contract with Contractor.

y. Notice. Before disenrollment, Contactor must provide the Member with notice of disenrollment in accordance with CMS Enrollment Guidance.

z. Plan Coordination
   i. The Contractor must produce a quarterly Member newsletter informing membership of current events, health and wellness topics, and plan changes. The Plan Sponsor's newsletter must be under the MPSERS logo and must have sections devoted to the Health Plan, Dental Plan, Vision Plan, and the plan administered by the Pharmacy Benefit Manager as well as items of general interest.
      1. Non-Medicare Health Plan, Dental Plan, Vision Plan, and Pharmacy Benefit Manager contractors will contribute articles to each quarterly newsletter. Contractor must elicit, review/edit, and include these articles in the final newsletter.

      2. Draft newsletter must be submitted to Plan Sponsor for review, edit, and ultimate approval. Newsletter timeline and review process must be submitted to Plan Sponsor prior to the development of the newsletter. This will include time for Plan Sponsor to review of each draft version and provide approval prior to finalization of newsletter.

      3. Medicare Contractor will be responsible for all aspects of planning, organizing, and conducting the Member Communication Meetings (reference Section1.0a C.), including coordinating with the Non-Medicare plan contractor, the Dental Plan contractor, the Vision Plan contractor, and the Pharmacy Benefit Manager, and if requested by the Plan Sponsor, HMOs, notices, facilities, and travel arrangements. The costs of the meetings are to be shared equally amongst the contractors.

   ii. Contractor must coordinate with Plan Sponsor's Non-Medicare contractor to ensure CMS-compliant enrollment for Members aging into its Medicare product.

   iii. Contractor must perform Medicare Part B Enrollment Services and Social Security Disability Advocacy Services for members. These services must be performed by Contractor outreach based upon surveys and claims analysis, and must also be performed upon Plan Sponsor request for selected members. These services must be billed on a per-success basis with a focus on transitioning appropriate members into the Medicare plan.

1.1 Transition

A. Contractor must carry out this project under the direction and control of the Plan Sponsor; all transition and implementation plans for use during the Implementation Period are subject to the approval of the Plan

Sponsor and the Program Manager (PM).

B. There must be continuous liaising between the Plan Sponsor and Contractor during the Implementation Period and over the course of this Contract. The PM and Plan Sponsor will meet with the Contractor's Senior Account Manager (SAM) for initial review and updated status of the Contractor's work plan periodically during the Implementation Period. 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 Contractor must submit a final implementation plan to PM and Plan Sponsor 90 days before Contract Effective Date, including Contractor's project plan management approach and detailed explanation of any identifying methods, tools, and processes, intended for oversight and completion of the implementation for January 1, 2017. The PM will provide final approval of implementation plan within 14 Days after submission.

D. Contractor must accommodate a pre- or post- implementation audit at the Contractor's expense, providing a fund in order to verify the Contractor's readiness to administer the Plan Sponsor program. The pre-implementation audit must be completed before the program effective date and the post-implementation audit must be conducted at a mutually agreed upon timeframe post effective date. These audits may include, but not be limited to: ID card production and turnaround time, eligibility, claims processing, customer service, plan design, drug coverage and clinical utilization management program set-up, and overall pricing. The review must be conducted by an audit firm selected by Plan Sponsor and would include test claims developed independently by the audit firm to represent Plan Sponsor' unique requirements.

1.2 Contract Activities That Will Include IT Related Services
The links below provide information on the State's Enterprise Information Technology (IT) policies, standards and procedures which includes security policy and procedures, eMichigan web development, and the State Unified Information Technology Environment (SUITE).

Contractors are advised that the State has methods, policies, standards and procedures that have been developed over the years. Contractors are expected to provide proposals that conform to State IT policies and standards. All services and products provided as a result of this Contract must comply with all applicable State IT policies and standards. Contractor is required to review all applicable links provided below and state compliance in their response.

All software and hardware items provided by the Contractor must run on and be compatible with the DTMB Standard IT Environment. Additionally, the State must be able to maintain software and other items produced as the result of the Contract.

It is recognized that technology changes rapidly. The Contractor may request, in writing, a change in the standard environment, providing justification for the requested change and all costs associated with any change. The State's Project Manager must approve any changes, in writing, and DTMB, before work may proceed based on the changed environment.

Enterprise IT Policies, Standards and Procedures (PSP):
http://michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html

The State's security environment includes:

- DTMB Single Login.
- DTMB provided SQL security database.
- Secured Socket Layers.
- SecureID (State Security Standard for external network access and high risk Web systems)

DTMB requires that its single - login security environment be used for all new client-server software development. Where software is being converted from an existing package, or a client-server application is being purchased, the security mechanism must be approved in writing by the State's Program Manager and DTMB Office of Enterprise Security.

Look and Feel Standard
All software items provided by the Contractor must be ADA complaint and adhere to the Look and Feel Standards www.michigan.gov/somlookandfeelstandards.

SUITE:
Includes standards for project management, systems engineering, and associated forms and templates – must be followed: http://www.michigan.gov/suite

2.0 Acceptance

2.1 Acceptance, Inspection and Testing
The State will use the following criteria to determine acceptance of the Contract Activities: see Standard Contract Terms, Section 16.

3.0 Staffing

3.1 Contractor Representative
The Contractor must appoint at least one Senior Account Manager (SAM) for the Medicare Medical, Non-Medicare Medical or both and at least one Senior Account Manager for the Pharmacy Benefits, specifically assigned to State of Michigan accounts, that will respond to State inquiries regarding the Contract Activities, answering questions related to ordering and delivery, etc. (the "Contractor Representative").

The Contractor must notify the Contract Administrator at least 30 calendar days before removing or assigning a new Contractor Representative.

3.2 Contractor Representative Phone Number
The Contractor must specify its phone number for the State to make contact with the Contractor Representative. The Contractor Representative must be available for calls during the hours of Monday – Friday 8:00 am to 5:00 pm EST.

3.3 Work Hours
The Contractor must provide Contract Activities during the State's normal working hours Monday – Friday 7:00 a.m. to 6:00 p.m. EST, and possible night and weekend hours depending on the requirements of the project.

3.4 Key Personnel
The Contractor must appoint the Key Personnel (as noted below) who will be directly responsible for the day-to-day operations of the Contract ("Key Personnel"). Key Personnel must be specifically assigned to the State account, be knowledgeable on the Contractual requirements, and respond to State inquires within one business day.

3.4a Key Personnel – Non-Medicare Contractor

A. The Contractor must provide an account team responsible for, at a minimum, the following functions:
    a. Executive management
    b. Senior Account Management
    c. Banking/Financial Management
    d. Member communications
    e. Claims processing
    f. Enrollment and eligibility
    g. Customer service
    h. Data/Reporting
    i. Medical Management and Medical Policy
    j. Project management

B. The Contractor must appoint three individuals who will be directly responsible for the day-to-day operations of the Contract ("Key Personnel"). Key Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 24 hours. Contractor must have assigned not less than the following Key Personnel:
    a. One Senior Account Manager (SAM) solely dedicated to the Plan Sponsor whose role and responsibilities must include:
        i. The SAM must be located onsite at Plan Sponsor's State of Michigan office.

        ii. Authority to make day-to-day decisions regarding service issues on a daily basis. The Contractor must also provide escalation procedures and contact information for issues which need to be escalated above the SAM.

iii. Ability within the Contractor's organization to obtain and leverage the use of Contractor's resources, both direct and indirect, as are necessary including, but not limited to the following:
    1. Timely issue resolution
    2. Consultative Services
    3. Timeliness of reporting and annual reviews
    4. Frequency of meetings/plan updates
    5. Cultivates multi-level client relationships
    6. Manages contract renewal activities
    7. Understands primary business objectives
    8. Maintains consistent and regular communications
    9. Prepares and presents regular performance reviews, including identification of cost drivers, recommendations for cost savings opportunities, utilization & cost reports, and vendor industry news
    10. Maintains a complete understanding of Contract terms, including, but not limited to, the monitoring and reporting of performance guarantees

iv. Designating one back-up to the SAM, whose role and responsibilities must 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.

b. One dedicated Enrollment & Customer Service Specialist (CSS):
    i. Contractor must provide at least one experienced enrollment and customer service specialist to work onsite at Plan Sponsor's Lansing, MI office.
    ii. This person is responsible for addressing enrollment and customer service issues and is an employee of the Contractor.
    iii. The CSS must have the authority within the Contractor's organization to obtain and leverage the use of all Contractor's resources, both direct and indirect, as necessary included but not limited to the following:
        1. Day-to-day issues
        2. Member correspondence and escalations
        3. Claims, eligibility, and overrides
        4. Member materials
        5. Call Center/Mail service escalation point of contact
        6. Understand benefit dynamics
        7. Manual enrollments
        8. Contractual reports
        9. Operational questions/projects
        10. Participate in member and retiree organization meetings

c. One Implementation Project Plan Manager: Contractor must provide at least an experienced project plan manager to manage the project implementation during the Implementation Period, in accordance with Section 1.1.

d. Other Key Staff: These positions are also considered Key Personnel for purposes of this Contract, are expected to be onsite to the Plan Sponsor, and must work under the direction of the Plan Sponsor. Plan Sponsor must be involved in the selection of those occupying these positions and any matters related to ensuring retention. Contractor must take into consideration, at a minimum, compensation, benefits, and leave in order to ensure placement and retention of qualified individuals. These positions must be contracted through a third party agency. The budget for these positions must 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 must report to the Plan Sponsor by January 31 of the following year the budgeted amount and the actual amount spent for these positions. If Contractor spends less money than originally budgeted, the amount of budget not spent for each plan year must be returned to the Plan Sponsor within 60 days.

e. The job responsibilities are subject to change based on evolving business needs through mutual agreement of Contractor and Plan Sponsor.

3.4b Key Personnel – Medicare Contractor

A. The Contractor must provide an account team responsible for, at a minimum, the following functions:
   a. Executive management
   b. Senior Account Management
   c. Banking/Financial Management
   d. Member communications
   e. Claims processing
   f. Enrollment and eligibility
   g. Customer service
   h. Data/Reporting
   i. Medical Management and Medical Policy
   j. Project management

B. The Contractor must appoint three individuals who will be directly responsible for the day-to-day operations of the Contract ("Key Personnel"). Key Personnel must be specifically assigned to the State account, be knowledgeable on the contractual requirements, and respond to State inquires within 24 hours. Contractor must have assigned not less than the following Key Personnel:
   a. One SAM solely dedicated to the Plan Sponsor whose role and responsibilities must include:
      i. The SAM must be located onsite at Plan Sponsor's State of Michigan office.

      ii. Authority to make day-to-day decisions regarding service issues on a daily basis. The Contractor must also provide escalation procedures and contact information for issues which need to be escalated above the SAM.

      iii. Ability within the Contractor's organization to obtain and leverage the use of Contractor's resources, both direct and indirect, as are necessary included, but not limited to the following:
         1. Timely issue resolution
         2. Consultative Services
         3. Timeliness of reporting and annual reviews
         4. Frequency of meetings/plan updates
         5. Cultivates multi-level client relationships
         6. Manages contract renewal activities
         7. Understands primary business objectives
         8. Maintains consistent and regular communications
         9. Prepares and presents regular performance reviews, including identification of cost drivers, recommendations for cost savings opportunities, utilization and cost reports, and vendor industry news
         10. Maintains a complete understanding of Contract terms, including, but not limited to, the monitoring and reporting of performance guarantees

      iv. Designating one back-up to the SAM, whose role and responsibilities must 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.

   b. One dedicated Enrollment and Customer Service Specialist (CSS):
      i. Contractor must provide at least one experienced enrollment and customer service specialist to work onsite at Plan Sponsor's Lansing office.
      ii. The CSS is responsible for addressing enrollment and customer service issues and is an employee of the Contractor.

iii. The CSS must have the authority within the Contractor's organization to obtain and leverage the use of all Contractor's resources, both direct and indirect, as necessary included but not limited to the following:
    1. Day-to-day issues
    2. Member correspondence and escalations
    3. Claims, Eligibility, Overrides, PAs
    4. Member Materials
    5. Call Center/Mail Service Escalation Point of Contact
    6. Understand benefit dynamics
    7. Manual enrollments
    8. Contractual reports
    9. Operational questions/projects
    10. Participate in member and retiree organization meetings

c. One Implementation Project Plan Manager: Contractor must provide at least an experienced project plan manager to manage the project implementation during the Implementation Period, in accordance with Section1.1.

d. Other Key Staff: These positions are also considered Key Personnel for purposes of this Contract, are expected to be onsite to the Plan Sponsor, and must work under the direction of the Plan Sponsor. Plan Sponsor must be involved in the selection of those occupying these positions and any matters related to ensuring retention. Contractor must take into consideration, at a minimum, compensation, benefits, and leave in order to ensure placement and retention of qualified individuals. These positions must be contracted through a third party agency. The budget for these positions must 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 must report to the Plan Sponsor by January 31 of the following year the budgeted amount and the actual amount spent for these positions. If Contractor spends less money than originally budgeted, the amount of budget not spent for each plan year must be returned to the Plan Sponsor within 60 days.

e. Requirements and job responsibilities are subject to change based on evolving business needs through mutual agreement of Contractor and Plan Sponsor.

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 PM, as designated by the State) on a reasonably frequent basis (as determined or scheduled by Plan Sponsor or PM, as designated by the State).

The State has 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, introduce the individual to the State's Project Manager, and 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. The State may require a 30-calendar day training period for replacement personnel.

Contractor will not remove any Key Personnel from their assigned roles on this 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**"). An Unauthorized Removal 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. Any Unauthorized Removal may be considered by the State to be a material breach of this Contract, in respect of which the State may elect to terminate this Contract for cause under Termination for Cause in the Standard Terms.

It is further acknowledged that an Unauthorized Removal will interfere with the timely and proper completion of this Contract, to the loss and damage of the State, and that it would be impracticable and extremely difficult to fix the actual damage sustained by the State as a result of any Unauthorized Removal. Therefore,

Contractor and the State agree that in the case of any Unauthorized Removal in respect of which the State does not elect to exercise its rights under Termination for Cause, Contractor will issue to the State the corresponding credits set forth below (each, an "Unauthorized Removal Credit"):

(i) For the Unauthorized Removal of any Key Personnel designated in the applicable Statement of Work, the credit amount will be $25,000.00 per individual if Contractor identifies a replacement approved by the State and assigns the replacement to shadow the Key Personnel who is leaving for a period of at least 30 calendar days before the Key Personnel's removal.

(ii) If Contractor fails to assign a replacement to shadow the removed Key Personnel for at least 30 calendar days, in addition to the $25,000.00 credit specified above, Contractor will credit the State $833.33 per calendar day for each day of the 30 calendar-day shadow period that the replacement Key Personnel does not shadow the removed Key Personnel, up to $25,000.00 maximum per individual. The total Unauthorized Removal Credits that may be assessed per Unauthorized Removal and failure to provide 30 calendar days of shadowing will not exceed $50,000.00 per individual.

Contractor acknowledges and agrees that each of the Unauthorized Removal Credits assessed above: (i) is a reasonable estimate of and compensation for the anticipated or actual harm to the State that may arise from the Unauthorized Removal, which would be impossible or very difficult to accurately estimate; and (ii) may, at the State's option, be credited or set off against any fees or other charges payable to Contractor under this Contract.

3.5 Organizational Chart
The Contractor must provide an overall organizational chart that details staff members, by name and title, and subcontractors (if applicable).

3.6 Disclosure of Subcontractors
1. If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

- The legal business name; address; telephone number; a description of subcontractor's organization and the services it will provide; and information concerning subcontractor's ability to provide the Contract Activities.
- The relationship of the subcontractor to the Contractor.
- Whether the Contractor has a previous working experience with the subcontractor. If yes, provide the details of that previous relationship.
- A complete description of the Contract Activities that will be performed or provided by the subcontractor.
- Of the total Contract, the price of the subcontractor's work.

2. Subcontractors

Legal Business Name	**Address / Telephone Number**	**Services Provided**	**Complete description of Contract Activities that will be performed/provided by subcontractor**	**Of the total Contract, the price of the subcontractor' s work.**
Accent (MPSERS)	Accent Corporate Headquarters 11808 Miracle Hills Drive Omaha, NE 68154 Mailing Address Accent P.O. Box 543099 Omaha, NE 68154-9896 Telephone Number 800/747-7243	Accent is responsible for identifying BCBSM MA members who failed to respond to the verification of coverage survey. THey also make outbound calls to these member to gather the required information.	Complete the annual verification of coverage campaign.	less than 1%
Alere (BCBSM Book of Business)	Alere Health 3200 Windy Hill Road Suite 300E Atlanta, GA 30339 770/767-4500 800/456-4060	Alere® delivers chronic condition management to BCBSM members. Nurse case managers conduct an engagement call, initial clinical assessment and subsequent calls as needed. Call frequency is determined by the member's need for the intervention. The nurse case managers work with each member to complete a clinical assessment, establish self-management goals and build self-management skills.	Chronic condition management program including option for remote monitoring for members with HF, COPD, CAD and diabetes who are identified and targeted for the program based on a predictive model.	less than 1%
New Directions (BCBSM Book of Business)	8140 Ward Parkway Ste. 500 Kansas City, MO 64114 816/237-2300	New Directions would provide: Utilization Management; Autism Management; Member Services; Provider Services; Audit Process; Reporting; Case Management; rTMS Authorization Management; Appeals and Grievances; Quality Assurances.	New Directions will deliver a population management-grounded, data driven behavioral health program to support members in accessing their mental health, substance abuse, autism and rTMS benefits under commercial plans (PPO, Traditional, FEP, and Health Exchange) to produce better health outcomes.	less than 1%

Legal Business Name	Address / Telephone Number	Services Provided	Complete description of Contract Activities that will be performed/provided by subcontractor	Of the total Contract, the price of the subcontractor's work.
AIM (BCBSM Book of Business)	8600 West Bryne Mawr Ave. Ste. 800 Chicago, IL 60631 773/243-0500	Preauthorization services for diagnostics imaging, Echo-cardiology, Sleep Study Therapy and Proton Beam Therapy to provide medical appropriateness preauthorization for services requested	AIM Specialty Health provides preauthorization services for diagnostics imaging, echo-cardiology, sleep study therapy and proton beam therapy.	less than 1%
Inovalon (BCBSM Book of Business)	4321 Collington Road, Bowie, Maryland, 20716 301/809-4000	Risk Adjustment - Identification and closure of diagnosis gaps for Medicare Advantage - Submission of risk adjustment information to CMS for Medicare Advantage HEDIS - NCQA certified HEDIS Engine and support for HEDIS submission process as mandated by CMS for Medicare Advantage - NCQA certified HEDIS Engine and support for HEDIS submission as mandated by HHS for Commercial to support NCQA Accreditation	Risk Adjustment - Identify diagnosis gaps - Retrieve and code medical records to close diagnosis gaps - Submit claims and supplemental data to CMS HEDIS - HEDIS Engine - Support HEDIS submission process for Medicare Advantage and Commercial	less than 1%
SSDC (MPSERS)	28125 Cabot Dr # 201, Novi, MI 48377 248/344-4444	Identification of members under age 65 that might qualify for Medicare due to a disability	SSDC has over 35 years experience helping individuals win Social Security Disability Insurance (SSDI) awards We are the premier Medicare Controllership & Compliance partner to Fortune 500 and large public employers and municipalities We have helped more than 100,000 disabled individuals obtain SSDI benefits and our Medicare coordination services impact nearly 4 million plan participants annually	less than 1%

Legal Business Name	Address / Telephone Number	Services Provided	Complete description of Contract Activities that will be performed/provided by subcontractor	Of the total Contract, the price of the subcontractor's work.
Quest Diagnostics (BCBSM Book of Business)	4444 Giddings Road Auburn Hills, MI 48326 866/697-8378	Laboratory Services	Leading world provider of diagnostic testing	less than 1%
Scantron (MPSERS and BCBSM Book of Business)	1313 Lone Oak Road, Eagan, MN 55121 714/437-4285	Medicare Advantage Health Assessment. Mail, tabulate, assess, follow up and report results	Send out Health Assessments to Medicare members and include an insert to MPSER specific members	less than 1%
Web MD (BCBSM Book of Business)	111 8th Ave New York, NY, 10111 212/624-3700	Online Health platform	Our vendor partner WebMD® provides an online health platform, online health assessment, Digital Health Assistant℠ programs, mobile applications, online health content, incentive management tracking, text messaging and wellness challenges. WebMD also administers the Lifestyle and Tobacco Cessation coaching programs, as well as, the worksite health screening program which is subcontracted through their vendor partner Summit Health ® .	less than 1%

4.0 Project Management

4.1 Meetings

All agendas and meeting materials created by Contractor for meetings as required below must be provided to Plan Sponsor at least five days prior to the meeting. The Contractor must attend the following meetings:

Non-Medicare Medical

A. Biweekly work plan meeting. This meeting is onsite at the Plan Sponsor office. The purpose is to review operational concerns and provide status on ongoing projects. The Plan Sponsor must create work plan agenda, facilitate the meeting, and maintain notes.

B. Quarterly and Annual Performance Review meeting. This meeting will be held onsite at Plan Sponsor's location, unless otherwise specified by Plan Sponsor. The purpose of this meeting will be to walk-through the Quarterly and Annual Review Report (see Section 4.3C and Section 4.3D). The Contractor must create the agenda, facilitate the meeting, and maintain notes. This meeting must be held in person.

C. Quarterly and Annual Financial Review meeting. This meeting will be held in person and at the Plan Sponsor's location, unless otherwise specified by the Plan Sponsor. The purpose of this meeting will be to discuss the Contractor's Service Level Agreement report outcomes and Quarterly/Annual Financial Report (see Section 4.3A and Section 4.3B). The Contractor must create the agenda, facilitate the meeting, and maintain notes.

D. Annual Strategic Planning meeting. This meeting will be held in person at the Plan Sponsor's location,

unless otherwise specified by the Plan Sponsor. The purpose of this meeting will be to review industry trends and recommend plan changes to assist the Plan Sponsor in meeting its cost goals. The Contractor must create the agenda, facilitate the meeting, and maintain notes. This meeting will include, but is not limited to:

a. Data analysis with commensurate recommendations and cost-coverage analysis in support of Plan modifications.
b. Review of changes in the market, identification of emerging trends, and recommenced course of action for each trend identified.

E. Annual Site Visit. This meeting is onsite at the Contractor's facility. Contractor must host up to six representatives from the Plan Sponsor for a site visit to tour the facility and meet with Contractor's staff. Contractor must create the agenda and facilitate the tour. Tour must include, but is not limited to:

a. Call Center
b. Claims Processing Center
c. Mail Processing
d. Enrollment Processing
e. Any travel and accommodations and meal expenses for State employees, and/or other Plan Sponsor Representatives, must be covered by the Contractor.

F. Additional meetings may be requested by the Plan Sponsor on an as-needed basis at Plan Sponsor's sole discretion. Plan Sponsor will determine the location of these meetings. Contractor must make the account team and all necessary subject matter experts available for these meetings.

G. Contractor must provide representation, and may be required to participate in, all Michigan Public School Employees Retirement System board and committee meetings.

Medicare Medical

A. Biweekly work plan meeting. This meeting is onsite at the Plan Sponsor office. The purpose is to review operational concerns and provide status on ongoing projects. The Plan Sponsor must create work plan agenda, facilitate the meeting, and maintain notes.

B. Quarterly and Annual Performance Review meeting. This meeting will be held onsite at Plan Sponsor's location, unless otherwise specified by Plan Sponsor. The purpose of this meeting will be to walk-through the Quarterly and Annual Review Report (see Section 4.3J and Section 4.3K). The Contractor must create the agenda, facilitate the meeting, and maintain notes. This meeting must be held in person.

C. Quarterly and Annual Financial Review meeting. This meeting will be held in person and at the Plan Sponsor's location, unless otherwise specified by the Plan Sponsor. The purpose of this meeting will be to discuss the Contractor's Service Level Agreement report outcomes and Quarterly/Annual Financial Report (see Section 4.3H and Section 4.3I). The Contractor must create the agenda, facilitate the meeting, and maintain notes.

D. Annual Strategic Planning meeting. This meeting will be held in person at the Plan Sponsor's location, unless otherwise specified by the Plan Sponsor. The purpose of this meeting will be to review industry trends and recommend plan changes to assist the Plan Sponsor in meeting its cost goals. The Contractor must create the agenda, facilitate the meeting, and maintain notes. This meeting will include, but is not limited to:

a. Data analysis with commensurate recommendations and cost-coverage analysis in support of Plan modifications.
b. Review of changes in the market, identification of emerging trends, and recommenced course of action for each trend identified.

E. Annual CMS Call Letter Analysis meeting. This meeting will be held in person and at the Plan Sponsor's location, unless otherwise specified by the Plan Sponsor. The purpose of this meeting will be to discuss the CMS call letter and its impact on Plan Sponsor's plan. Contractor must provide a CMS Call Letter Analysis (see Section 4.3Ld). The Contractor must create the agenda, facilitate the meeting, and maintain notes.

F. Annual Site Visit. This meeting is onsite at the Contractor's facility. Contractor must host up to six representatives from the Plan Sponsor for a site visit to tour the facility and meet with Contractor's staff. Contractor must create the agenda and facilitate the tour. Tour must include, but is not limited to:

a. Call Center

b. Claims Processing center
c. Mail Processing
d. Enrollment Processing

Any travel, accommodations, and meal expenses for State employees, and/or other Plan Sponsor Representatives, must be covered by the Contractor.

G. Additional meetings may be requested by the Plan Sponsor on an as-needed basis at Plan Sponsor's sole discretion. Plan Sponsor will determine the location of these meetings. Contractor must make account team and all necessary subject matter experts available for these meetings.

Contractor must provide representation, and may be required to participate in, all Michigan Public School Employees Retirement System board and committee meetings.

4.2 Reporting

Contractor must provide analysis and reports, in a format as determined by the Plan Sponsor.

Non-Medicare Medical

A. Quarterly Financial Report that includes, but is not limited to, the following:
- a. Claim Payments
- b. Administration Fees
- c. Non-claims related benefit costs
- d. Capitated arrangements

B. Annual Financial Report that includes, but is not limited to, the following:
- a. Annualized version of Quarterly Financial Reporting package
- b. Class action recoveries
- c. Prescription drug rebates

C. Quarterly Performance Review Reports for the Quarterly Performance Review meetings (Section 4.2B) with Plan Sponsor, that includes, but is not limited to, the following:
- a. Contractor's comprehensive review of the cost and utilization experience of the Plan
  - i. Trend analysis
  - ii. Comparison to benchmarks
  - iii. Opportunity analysis for low performing areas
- b. Summary of work and activity for Medical Management Programs
  - i. Number of members targeted, reached, and engaged for programs
  - ii. Performance comparison to annual goals
  - iii. Planned improvements to programs
- c. Customer Service Update
  - i. Call Center Activity Summary
    1. Number of inquiries
    2. Summary of call issues
    3. Description of top complaints
  - ii. Inquiry, Grievances and Appeals Summary
    1. Inquiry analysis that details the number, type, date of receipt and date of resolution of Inquiries by month.
    2. Grievance analysis that details the number, type, timeliness, and additional action taken regarding grievances that have been submitted by mail, telephone, or internet by month received.
    3. Appeals analysis that details the number, type, timeliness, and outcomes of Appeals that have been submitted by mail, telephone, or internet by month received.

D. Annual Performance Review Report package that includes, but is not limited to, the following:
- a. Annualized version of Quarterly Performance Review package
- b. Meeting reports detailing the date, location, attendance, sponsoring organization and contact person
- c. COB Activity and Savings Report

E. Monthly dashboard to summarize enrollment activity
- a. Number of new members enrolled in plan

b. Enrollment trend for current plan year compared to prior plan year

F. The Contractor must provide an ad hoc reporting tool that Plan Sponsor can use to directly access utilization and other Plan-specific data. This includes training for a limited number of Plan Sponsor representatives.

G. Contractor must perform ad hoc reporting upon the request and specification of the Plan Sponsor including:
- a. Follow up reporting on reports listed above where additional information and analysis is required.
- b. Strategic Initiative analysis related to Plan performance and improvement opportunities.
- c. Reports requested by Plan Sponsor that provide further information and analysis to Services not encompassed by specified reports above.

Medicare Medical

H. Quarterly Financial Report that includes, but is not limited to, the following:
- a. Claim Payments
- b. Administration Fees
- c. Non-claims related benefit costs
- d. Capitated arrangements
- e. Social Security and Disability advocacy work
- f. Medicare enrollment advocacy

I. Annual Financial Report that includes, but is not limited to, the following:
- a. Annualized version of Quarterly Financial Reporting package
- b. Class action recoveries
- c. Prescription drug rebates

J. Quarterly Performance Review Reports for the Quarterly Performance Review meetings (Section 4.2I) with Plan Sponsor, that includes, but is not limited to, the following:
- a. Contractor's comprehensive review of the cost and utilization experience of the Plan
  - i. Trend analysis
  - ii. Comparison to benchmarks
  - iii. Opportunity analysis for low performing areas
- b. Summary of work and activity for Medical Management Programs
  - i. Number of members targeted, reached, and engaged for programs
  - ii. Performance comparison to annual goals
  - iii. Planned improvements to programs
- c. Customer Service Update
  - i. Call Center Activity Summary
    1. Number of inquiries
    2. Summary of call issues
    3. Description of top complaints
  - ii. Inquiry, Grievances and Appeals Summary
    1. Inquiry analysis that details the number, type, date of receipt and date of resolution of Inquiries by month.
    2. Grievance analysis that details the number, type, timeliness, and additional action taken regarding grievances that have been submitted by mail, telephone, or internet by month received.
    3. Appeals analysis that details the number, type, timeliness, and outcomes of Appeals that have been submitted by mail, telephone, or internet by month received.

K. Annual Performance Review Report package that includes, but is not limited to, the following:
- a. Annualized version of Quarterly Performance Review package
- b. Member Meeting reports detailing the date, location, attendance, sponsoring organization and contact person.
- c. COB Activity and Savings Report
- d. Summary of CMS Revenue:
  - i. Savings compared to Original Medicare
  - ii. Savings compared to alternative (Medicare Supplemental, if we are in MA)

L. MA Specific Reports that are received from CMS must also be made available to the Plan Sponsor. In

situations where reports received from CMS contain members not under the purview of the Plan Sponsor, the Contractor must remove all members not enrolled in the Plan Sponsor's plan before sending the report to the Plan Sponsor. Reports include, but are not limited to:

a. Monthly Medicare Advantage Membership Report (CMS report)
b. Weekly Disenrollment Report
    i. Disenrollments from Transaction Reply Report (CMS Report)
    ii. Enrollment Rejections Report
        1. Members that fail the BEQ
        2. Members in RFI Final Denied Status
    iii. Any other member disenrollment from Plan Sponsor's plan that did not originate from Plan Sponsor
c. Monthly CMS Subsidy Detail Report
d. Annual CMS Call Letter Analysis
    i. Annual CMS Subsidy Projections
    ii. Projected plan cost on a net and pmpm basis

M. Monthly dashboard to summarize enrollment activity

a. Number of new members enrolled in plan
b. Number of Medicare Age-ins enrolled in plan
c. Number of CMS disenrollments by reason code
d. Number of CMS rejected enrollments
e. Top five disenrollment reason codes
f. Enrollment trend for current plan year compared to prior plan year

N. The Contractor must provide an ad hoc reporting tool that Plan Sponsor can use to directly access utilization and other Plan-specific data. This includes training for a limited number of Plan Sponsor representatives.

O. Contractor must perform ad hoc reporting upon the request and specification of the Plan Sponsor including:

a. Follow up reporting on reports listed above where additional information and analysis is required.
b. Strategic Initiative analysis related to Plan performance and improvement opportunities.
c. Reports requested by Plan Sponsor that provide further information and analysis to Services not encompassed by specified reports above.

5.0 Ordering

5.1 Authorizing Document

The appropriate authorizing document for the Contract will be Blanket Purchase Order/Contract and Program Manager approval.

6.0 Invoice and Payment

6.1 Invoice Requirements

1. All invoices submitted to the State must include: (a) date; (b) purchase order; (c) quantity; (d) description of the Contract Activities; (e) itemized by product line (Medicare medical, Non-Medicare medical, Medicare pharmacy, etc.); (f) unit price; (g) shipping cost (if any); and (h) total price. Also include: billing period, product claims were paid for, detailed description of charges (no generic "other charges/fees"), and contract number. Overtime, holiday pay, and travel expenses will not be paid.

2. The making of final payment by the State to Contractor must 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 the Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard.

3. The Contractor must allow for the Plan Sponsor to submit payment for claims and administrative invoices, within 10 business days.

4. The Contractor must invoice the Plan Sponsor for prescription claims on a weekly basis.

6.2 Payment Methods

The State will make payment for Contract Activities via electronic funds transfer (EFT).

7.0 Additional Requirements

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

2. Plan Sponsor acknowledges that final enrollment in Contractor's MA 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 MA plan; and (3) and being approved by CMS.

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

4. The cost of any Claims will be paid from such CMS capitated payments. If the cost of Claims exceeds the CMS capitated payment, Plan Sponsor will pay Contractor any such amount pursuant to the invoicing terms of the Contract, Section 6.1.

5. The Plan Sponsor attests that it has in place eligibility requirements and policies and procedures to manage and process reinstatement requests in accordance with CMS guidance.

6. The Plan Sponsor attests that it has in place eligibility requirements and policies and procedures to manage and process reinstatement requests in accordance with CMS guidance.

7. Contractor must work in partnership and collaboration with ORS, Centers for Medicare and Medicaid Services (CMS), and all other Contractors, including Plan Sponsor's Medicare Medical, Non-Medicare Medical, Pharmacy Benefits Managers, Dental, Vision, HMO partners, Data Management Vendor, and Healthcare Actuarial and Consulting Vendors. This partnership and collaboration must relate to member servicing, communications, data analysis, reporting, transitioning members amongst different lines of business, strategic initiatives, plan design changes, and other areas as needed for the clarity of members and administration from Plan Sponsor.

8. The Contractor agrees to commit to a maximum of 10 business day turnaround for Contract reviews during negotiations (e.g., Notice of Deficiencies, Clarification Requests and Negotiations.

Exhibit B
Definitions

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

Appeal means any of the procedures that deal with the review of adverse Organization Determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Average Wholesale Price (AWP) means the actual package size of the legend drug dispensed as set forth in the most current pricing list in Medi-Span's Prescription Pricing Guide (with supplements). Contractor must use a single nationally recognized reporting service of pharmaceutical prices for Plan Sponsor and such source will be mutually agreed upon by Contractor and Plan Sponsor. Contractor must use the manufacturer's full actual 11-digit NDC to determine AWP for the actual package size on the date the drug is dispensed for all legend drugs dispensed through retail pharmacies, mail service pharmacies and specialty pharmacies. Repackaging which has the effect of inflating AWP is explicitly prohibited. "Price shopping", meaning the Contractor's use of multiple AWP reporting services in order to select the most advantageous AWP price as a means to inflate discount calculations, is prohibited.

Brand Name Drug means a legend drug with a proprietary name assigned to it by the manufacturer and distributor and so indicated by Medi-Span (or mutually agreed upon nationally recognized publication if unavailable). Brand Drugs include Single-Source Brand Drugs and Multi-Source Brand Drugs.

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) means any day other than a Saturday, Sunday or State-recognized legal holiday from 8:00am EST through 5:00pm EST unless otherwise stated.

Case Management means a Medical Management program that identifies potentially high cost claimants and provides a nurse manager to the Member and his/her Provider to identify cost effective treatment alternatives. A high cost claimant is defined as a Member who has incurred medical Claims at or above $50,000 annually.

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.

Claimant means a Member who demands payment of Covered Services.

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

CMS Revenue means any monies received—from CMS—by Contractor on behalf of Plan Sponsor's Members or Claims.

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—excluding penalties—that a Member is required to pay in a Plan Year.

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

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

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 Covered Products and Services 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 coverage under the Plan Sponsor's Plan and is identified by the Plan Sponsor to the Contractor.

Direct Member Reimbursement (DMR) means a request for reimbursement of one or more Covered Products and/or Services submitted for payment by a Member.

Discount Credit is a payment by the Contractor to the Plan Sponsor to offset both implementation and ongoing expenses.

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

Dispensing Fee means an amount paid to a pharmacy for providing professional services necessary to dispense a Covered Product to a Member.

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

DME means Durable Medical Equipment.

Eligibility means the status of an individual with respect to their coverage under the Plan as determined by Plan Sponsor.

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.

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

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.

Generic Drug or Generic Pharmaceutical means a legend drug that is identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. Generic Drugs include all products involved in patent litigation, Single-Source Generic Drugs, Multi-Source Generic Drugs, House Generics, and Generic drugs that may only be available in a limited supply.

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

Fully Insured means a plan where an entity contracts with another organization to assume financial responsibility for the group's member claims and for all incurred administrative costs.

Grievance means any complaint or dispute, other than one involving an Organization Determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item or service. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame

Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on dimensions of care and service

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.

House Generic means those Brand Drugs submitted with DAW 5 code in place of their generic equivalent(s) and for which, therefore, pharmacies are reimbursed at Generic Drug rates, including MAC, as applicable, for these drugs (*e.g.*, Amoxil v. Amoxicillin).

Implementation Period means the period of time between when Contractor is selected and Services are commenced on January 1, 2017.

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

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

Inquiry means any oral or written request to the Contractor, one of its subcontractors, or received by Plan Sponsor and forwarded on to Contractor, that does not involve a request for Organization Determination/exception request.

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

Maximum Allowable Costs (MAC) means and refers to, any Covered Product as defined, the MAC price reimbursed to the Participating Pharmacy, as established by the Contractor. The Contractor must establish MAC prices in order to: (i) enable the Contractor to generate cost-effective and marketing competitive prices, and (ii) decrease such prices as Covered Product prices decrease in the market place. Accordingly, the Contractor must establish such prices, and thereafter adjust such prices, to provide the Plan Sponsor with prices accurately reflecting Contractor's acquisition and/or reimbursement costs. The Contractor represents that it currently has only one proprietary MAC list used to reimburse all retail, Mail Order and Specialty Pharmacies and to invoice all clients (other than those few clients who may have created certain customized changes to the Contractor's MAC list). Should the Contractor in the future establish multiple MAC lists as alternative proprietary MAC lists for Participating Pharmacies, the Contractor must provide to the Plan Sponsor the lowest MAC price for each Covered Product on any of its MAC lists. The Contractor also represents that it currently reviews adjustments to its proprietary MAC list at least weekly, and that it will continue to do so, using Pass-Through Pricing as defined herein as a basis for its adjustments. The Contractor must pass-through to the Plan Sponsor all financial benefits obtained from all pharmaceutical manufacturers, wholesalers, and any other sources, and all amounts paid to Participating Pharmacies, without any markup.

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 Provider programs that address the continuum of Member health status ranging from healthy population initiatives (wellness) through acute care management (utilization management, discharge planning, care transitions) through chronic care management (disease management) and Case Management for high cost cases with strategies designed to promote the most cost effective use of health care resources.

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-Eligible Member means a Member who is eligible, as determined by CMS, for Medicare Parts A, B & D benefits.

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

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.

Non-Medicare Member means a Member who is not a Medicare-Eligible Member.

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

Organization Determination means any decision made by the Contractor on behalf of the Plan regarding payment or benefits to which a Member believes he or she is entitled.

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.

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.

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 MA 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.

Rebate(s) mean all drug company revenues associated with other pharmaceutical manufacturer or third-party payments, including, but not limited to: base, formulary, incentive and market share rebates, payments related to administrative fees, data fees, aggregate utilization rebates (e.g., "book of business"), purchase discounts, educational payments, information sales, specialty rebates and all other revenues from pharmaceutical manufacturers or other third-parties.

Retiree 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 MA Members and the corresponding CMS revenue is received by the Plan Sponsor. This includes, but is not limited to, risk-based adjusted payments, as well as CMS payments based on Contractor's star rating.

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.

Specialty Drugs means Covered Products and biologicals used in the treatment of complex clinical conditions such as cancer, HIV/AIDS, organ transplant, Gaucher's disease and hemophilia. These agents require special handling and/or close supervision or clinical management. Plan Sponsor must approve any Covered Products on the Contractor's specialty list.

Speed of Answer 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.

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. TPA 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 that enables 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 and satisfied all Pass-Through Pricing requirements.

Usual and Customary Price (**U&C)** means the retail price, including any minimum price, charged by a Non-Participating Pharmacy or a Participating Pharmacy for a Covered Product in a cash or uninsured transaction on the

date the pharmaceutical is dispensed. It also includes non-funded prescription discount programs managed or promoted by the pharmacy.

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.

EXHIBIT C
PRICING

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

2. **The Contract will be for a four-year period with service commencing January 1, 2017, and ending December 31, 2020. The price for each year is firm for the period January 1 of that year through December 31 of that year. Prices are a flat monthly fee for all services specified by this Contract. Fees are a uniform Individual Fee.**

3. **Medicare Eligibles**
   1. **Pricing is for each product: Medicare Advantage Plan and Medicare Supplemental Plan. Basic services are included as a whole and optional services should be specified separately.**

   2. **Alternative risk-sharing arrangements are included at the end of this Exhibit.**

Per Month Administration Fee 2017

Medicare Advantage	Individual Fee
Basic Services	$60.50
Optional – Disease Management	Included in base fee
Optional – Nurse Line	Included in base fee
Optional – Wellness Programs	Included in base fee
Optional – Please Specify	$0.00
Total	$60.50

Medicare Supplemental	Individual Fee
Basic Services	$19.98
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Total	$19.98

Medicare Part P Enrollment Services/Social Security Disability Advocacy Services (see requirement 1.0d C dd iii)	Per Success Fee
Basic Services	

Per Month Administration Fee 2018

Medicare Advantage	Individual Fee

Basic Services	$60.50
Optional – Disease Management	Included in base fee
Optional – Nurse Line	Included in base fee
Optional – Wellness Programs	Included in base fee
Optional – Please Specify	$0.00
Total	$60.50

Medicare Supplemental	Individual Fee
Basic Services	$19.98
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Total	$19.98

Per Month Administration Fee 2019

Medicare Advantage	Individual Fee
Basic Services	$61.71
Optional – Disease Management	Included in base fee
Optional – Nurse Line	Included in base fee
Optional – Wellness Programs	Included in base fee
Optional – Please Specify	$0.00
Total	$61.71

Medicare Supplemental	Individual Fee
Basic Services	$20.68
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00

Optional – Please Specify	$0.00
Total	$20.68

Per Month Administration Fee 2020

Medicare Advantage	Individual Fee
Basic Services	$62.94
Optional – Disease Management	Included in base fee
Optional – Nurse Line	Included in base fee
Optional – Wellness Programs	Included in base fee
Optional – Please Specify	$0.00
Total	$62.94

Medicare Supplemental	Individual Fee
Basic Services	$21.40
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Optional – Please Specify	$0.00
Total	$21.40

Insured Pricing

1. **Plan Sponsor is also requesting an insured quote for the Medicare products.**

   An insured Medicare Advantage quote would be more costly for MPSERS due to premium taxes and risk charges. Therefore, Contractor is not proposing a fully insured Medicare Advantage option. An insured quote for a Medicare Supplemental plan is provided below.

2. **Description of the methodology, including all of the formulas, calculations and any guaranteed maximums used to develop renewal rates for 2018, 2019 and 2020.**

   Medicare Advantage:
   A fully insured Medicare Advantage quote is not provided; therefore, BCBSM is not providing a Medicare Advantage renewal rating methodology.

   Medicare Supplemental:
   The 2017 Medicare Supplemental premium rate was calculated as the sum of the projected claim costs, projected administrative expenses, risk charges and applicable state and federal taxes and fees. To project claims costs for the MPSERS population in a Medicare Supplemental product, Contractor relied on its Individual Medigap Plan C experience made up of approximately 180,000 members. This

experience was adjusted for demographic differences for the MPSERS population and the MSPERS 2016 benefit design.

The 2018 Medicare Supplemental renewal rate would need to be determined before credible Medicare Supplemental experience is available for MPSERS. Therefore, the 2018 renewal rate would be calculated using the same methodology that was used to develop the 2017 initial rate, but may include an additional adjustment based on early 2017 MPSERS experience if warranted. The 2019+ renewal rate development would be based off of MPSERS Medicare Supplement claims experience. No guaranteed maximums would be used in the renewal rate development for any year.

Given that the 2014 Medicare Advantage experience provided was not used in the Medicare Supplemental rating methodology, the illustrative renewal rate calculation is not applicable.

Product/Population	Insured Rate 2017
Medicare Advantage	
Individual Rate Only	N/A
Medicare Supplemental	
Individual Rate Only	$146.89

4. Non-Medicare Eligibles

Per Month Administration Fee 2017

Non-Medicare	Individual Fee
Basic Services	$30.29
Optional – Disease Management	$1.77
Optional – Nurse Line	$0.14
Optional – Wellness Programs	$0.94
Total	$33.14

Per Month Administration Fee 2018

Non-Medicare	Individual Fee
Basic Services	$30.29
Optional – Disease Management	$1.77
Optional – Nurse Line	$0.14
Optional – Wellness Programs	$0.94
Total	$33.14

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Per Month Administration Fee 2019

Non-Medicare	Individual Fee
Basic Services	$30.90
Optional – Disease Management	$1.81
Optional – Nurse Line	$0.14
Optional – Wellness Programs	$0.96
Optional – Please Specify	$0.00
Total	$33.81

Per Month Administration Fee 2020

Non-Medicare	Individual Fee
Basic Services	$31.52
Optional – Disease Management	$1.85
Optional – Nurse Line	$0.14
Optional – Wellness Programs	$0.98
Optional – Please Specify	$0.00
Total	$34.49

Exhibit D
Service Level Agreements (SLAs) – Non-Medicare Medical Plan

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 has been approved 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 for Plan Sponsor's prior approval. 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 (Standard Contract Terms, Section 39).

Quarterly SLA reports are due 45 Days after the end of each calendar quarter. Annual SLA reports are due 90 days after the close of the plan year. The Contractor must provide the Plan Sponsor with completed SLA tracking tool, provided by Plan Sponsor, self-reporting the Contractor's performance under each SLA for the Plan Sponsor. Supporting documentation must accompany the completed tracking tool. Within 75 Days after the end of each calendar quarter, the Contractor must approve penalty amounts for any applicable penalties to the Plan Sponsor based on the provided documentation.

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 will be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

Plan Sponsor has the right to reallocate the total amount at risk among the various individual guarantees annually. Reallocation cannot increase the annual value of any one component by more than 10% of the original value. Reallocation will not increase the overall aggregate value of the penalties. Any such reallocation must be received by Contractor at least 10 business days prior to the applicable calendar year, otherwise attempted reallocations will be of no effect.

SLA 1 - Eligibility Uploads
Guarantee
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 SLA report must show weekly activity defined as the number of records uploaded within the above timeframe.

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 the Plan Sponsor. The SLA report must show weekly activity defined as the number of records not accepted and the timeframe for presenting the discrepancy reports to the Plan Sponsor.

The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 2 - Membership Cards
Guarantee
Membership Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. Performance must be substantiated by documentation providing proof of receipt date and mailing date.

Membership Cards must have an accuracy rate of 100.00%. Accuracy must be measured by sampling ID card production to ensure 100.00% accuracy of information.

The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 3 - Average Speed of Answer
Guarantee
Contractor must maintain an average speed of answer (ASA) 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 must 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 6 - Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to at least 95.00% 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 7 - Timeliness of Data Transmission to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager
Guarantee
Contractor must deliver Claim data files to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager in an 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 a Saturday, Sunday or State recognized holiday, the data file can be delivered on the next business day without penalty.

Penalty
The Non- Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 8 - Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $30,000.00 per quarter not met.

SLA 9 - Non-Financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $30,000.00 per quarter not met.

SLA 10 - Claims Processing Time
Guarantee
95.00% of clean Claims must be processed within 30 calendar Days.
99.50% of clean 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 Non-Medicare penalty for failure to meet this SLA is $10,000.00 for each month that the SLA is not met.

SLA 11 - Care Transition to Home 30-Day Readmissions
Guarantee
Contractor must 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:

- remain at or below the established threshold;
- achieve a 2.00% improvement from the previous year's rate if performance is more than 2.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 2.00% 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 Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 12 - Disease Management Hospital Admissions
Guarantee
Contractor must achieve one of the following for the annual combined rate of acute hospital inpatient admissions per 1000.00 members enrolled in the Disease Management Program with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Asthma and Diabetes, excluding admissions for trauma and maternity:

- remain at or below the established threshold;
- achieve a 5.00% reduction from the previous year's rate if performance is more than 5.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 5.00% 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 Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 13 - Disease Management Emergency Room Visits
Guarantee
Contractor must achieve one of the following for the annual combined number of Emergency Room visits per1000.00 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:

- remain at or below the established threshold;
- achieve a 2.00% improvement from the previous year's rate if performance is more than 2.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 2.00% 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 Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 14 - Clinical Quality Improvements
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 (>9.00%)
- HbA1c control (<8.00%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- Blood Pressure (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 (Non-Medicare only): 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.

Contractor must calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and National Committee on Quality Assurance (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 Non-Medicare penalty for failure to meet this SLA is $50,000.00 for each measure not met per year, for a total potential penalty of $150,000.00 per year.

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 four applicable measures, each measure would be assessed 25.00% of the penalty if not met.

SLA 15 - 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. These process improvement projects will be approved by Plan Sponsor by December 31st.

Contractor must complete up to three process improvement projects developed and approved during the previous Plan Year.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 if the Contractor does not complete the approved project(s). $150,000.00 will be split equally amongst the quality improvement projects selected by Plan Sponsor and assessed for each quality improvement project that is not completed within the agreed upon timeframe.

SLA 16 - Customer Performance Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1.00 to 5.00. The Contractor will be measured using the Plan Sponsor's annual survey (see Exhibit Y) to assess the Contractor's Performance within the following categories:

- Senior Account Manager Performance
- Communications
- Data Reporting
- Clinical Management
- Customer Service
- 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 Non-Medicare penalty for failure to meet this SLA is $150,000.00 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional $75,000.00.

SLA 17 - Member Satisfaction Survey
Guarantee
One random sample Member Satisfaction Survey must be completed annually at no additional cost. The surveys must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for approval of questions and scoring methodology prior to deployment. Plan Sponsor has the authority to request changes and customization to the survey and scoring methodology. The respondent pool must be statistically valid based on the Plan Sponsor's total population (randomly generated sample size sufficient to produce a 95.00% confidence interval with a margin of error of not greater than +/-3.00%). Survey results must be available to the Plan Sponsor by September 30th within the Plan Year unless a different date is agreed upon.

Contractor must achieve a score of 4.00 or higher on a 5.00 point scale (other scoring scales may be used as long as they are equivalent) from 85.00% of the responders.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $150,000.00 per year that the SLA is not met.

SLA 18 - Financial Accuracy Rate
Guarantee
Financial Accuracy Rate must be calculated on a monthly basis using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. The resultant accuracy rate (as defined as the total dollar value of claims paid, minus 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%; 1.00% error rate.

Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $120,000.00 per year that the SLA is not met, plus $60,000.00 for each 0.50% below the standard.

SLA 19 – Implementation Project Plan, Timeliness, and Accuracy
Guarantee
Contractor must provide to Plan Sponsor, for review and approval, an initial Project Plan which highlights tasks and interdependencies, critical dates, as well as roles and responsibilities (“Project Plan”). After initial baseline, the Project Plan must be updated as needed with Contractor, providing Project Plan updates, which reflect any changes or updates, to Plan Sponsor for review and approval. Plan Sponsor will select up to five specific tasks listed on the Project Plan, after the establishment of the initial base line Project Plan, to be met on time as documented within the Project Plan and with 100.00% accuracy. Should Contractor fail to meet the critical dates outlined in the Project Plan and/or 100.00% accuracy of each item and as selected by the Plan Sponsor for penalty.

Penalty
The Non-Medicare penalty for failure to meet this SLA is $500,000.00.

SLA 20 – Implementation Project Plan Meeting
Guarantee
Plan Sponsor may assess a penalty, if, within 45 days after the Effective Date, Plan Sponsor’s benefit / implementation staff, who are active members of the implementation team, do not rate Contractor’s implementation performance an average of 3.00 or better on a scale of 1.00 to 5.00 (5.00 being the best).

Penalty
The Non-Medicare penalty for failure to meet this SLA is $500,000.00.

Exhibit E
Service Level Agreements (SLAs) – Medicare Medical Plan

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 has been approved 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 for Plan Sponsor's prior approval. 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 (Standard Contract Terms, Section 39).

Quarterly SLA reports are due 45 Days after the end of each calendar quarter. Annual SLA reports are due 90 days after the close of the plan year. The Contractor must provide the Plan Sponsor with completed SLA tracking tool, provided by Plan Sponsor, self-reporting the Contractor's performance under each SLA for the Plan Sponsor, and within 75 Days after the end of each calendar quarter. The Contractor must approve penalty amounts for any applicable penalties to the Plan Sponsor based on the provided documentation. Any metric that is reported must be accompanied by supporting documentation.

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 will be assessed more than one penalty for the month, quarter, or year in which performance was assessed.

Plan Sponsor has the right to reallocate the total amount at risk among the various individual guarantees annually. Reallocation cannot increase the annual value of any one component by more than 10% of the original value. Reallocation will not increase the overall aggregate value of the penalties. Any such reallocation must be received by Contractor at least 10 business days prior to the applicable calendar year, otherwise attempted reallocations will be of no effect.

SLA 1 - Eligibility Uploads
Guarantee
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 SLA report must show weekly activity defined as the number of records uploaded within the above timeframe.

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 the Plan Sponsor. The SLA report must show weekly activity defined as the number of records not accepted and the timeframe for presenting the discrepancy reports to the Plan Sponsor.

The Contractor must measure its performance on this SLA on a monthly basis and report on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 2 - Membership Cards
Guarantee
Membership Cards for all new Contract Holders must be mailed within 10 Days of Contractor loading eligibility record. Performance must be substantiated by documentation providing proof of receipt date and mailing date.

Membership Cards must have an accuracy rate of 100.00%. Accuracy must be measured by sampling ID card production to ensure 100.00% accuracy of information.

The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 3 - Average Speed of Answer
Guarantee
Contractor must maintain an average speed of answer (ASA) 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 must 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 Medicare penalty for failure to meet this SLA is $55,000.00 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 Medicare penalty for failure to meet this SLA is $55,000.00 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 6 - Customer Service Response Time to Written Inquiries
Guarantee
The Contractor must respond to at least 95.00% 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 7 - Timeliness of Data Transmission to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager
Guarantee
Contractor must deliver Claim data files to Plan Sponsor's Data Contractor and Pharmacy Benefits Manager in an 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 a Saturday, Sunday or State recognized holiday, the data file can be delivered on the next business day without penalty.

Penalty
The Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 8 - Financial Error Rate
Guarantee
The financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Penalty
The Medicare penalty for failure to meet this SLA is $165,000.00 per quarter not met.

SLA 9 - Non-Financial Error Rate
Guarantee
The non-financial error rate must be calculated on a monthly basis by using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. 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%; 97.00% accuracy rate.

Contractor must measure quarterly and report its performance on this SLA on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $165,000.00 per quarter not met.

SLA 10 - Claims Processing Time
Guarantee
95.00% of clean Claims must be processed within 30 calendar Days.
99.50% of clean 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 Medicare penalty for failure to meet this SLA is $55,000.00 for each month that the SLA is not met.

SLA 11 - Care Transition to Home 30-Day Readmissions
Guarantee
Contractor must 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:

- remain at or below the established threshold;
- achieve a 2.00% improvement from the previous year's rate if performance is more than 2.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 2.00% 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 Medicare penalty for failure to meet this SLA is $1,200,000.00 per year that the SLA is not met.

SLA 12 - Disease Management Hospital Admissions
Guarantee
Contractor must achieve one of the following for the annual combined rate of acute hospital inpatient admissions per 1000.00 members enrolled in the Disease Management Program with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Asthma and Diabetes, excluding admissions for trauma and maternity:

- remain at or below the established threshold;
- achieve a 5.00% reduction from the previous year's rate if performance is more than 5.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 5.00% 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 Medicare penalty for failure to meet this SLA is $1,200,000.00 per year that the SLA is not met.

SLA 13 - Disease Management Emergency Room Visits
Guarantee
Contractor must achieve one of the following for the annual combined number of Emergency Room visits per1000.00 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:

- remain at or below the established threshold;
- achieve a 2.00% improvement from the previous year's rate if performance is more than 2.00% above (worse than) the target; or
- Improve performance back toward the established threshold if performance is less than 2.00% 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 Medicare penalty for failure to meet this SLA is $1,200,000.00 per year that the SLA is not met.

SLA 14 - Clinical Quality Improvements
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 (>9.00%)
- HbA1c control (<8.00%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- Blood Pressure (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 Emergency Department 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.

Contractor must calculate and report the results of each measure annually by July 31st. Reports will compare current performance to the previous year and National Committee of Quality Assurance (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 Medicare penalty for failure to meet this SLA is $400,000.00 for each measure not met per year, for a total potential penalty of $1,200,000.00 per year.

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 four applicable measures, each measure would be assessed 25.00% of the penalty if not met.

SLA 15 - 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. These process improvement projects will be approved by Plan Sponsor by December 31st.

Contractor must complete up to three process improvement projects developed and approved during the previous Plan Year.

Penalty
The Medicare penalty for failure to meet this SLA is $1,200,000.00 if the Contractor does not complete the approved project(s). $1,200,000.00 will be split equally amongst the quality improvement projects selected by Plan Sponsor and assessed for each quality improvement project that is not completed within the agreed upon timeframe.

SLA 16 - Customer Performance Satisfaction
Guarantee
Plan Sponsor's satisfaction with Contractor performance must be rated an average of 4.00 or above on a scale of 1.00 to 5.00. The Contractor will be measured using the Plan Sponsor's annual survey (see Exhibit Y) to assess the Contractor's Performance within the following categories:

- Senior Account Manager Performance
- Communications
- Data Reporting
- Clinical Management
- Customer Service
- 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 Medicare penalty for failure to meet this SLA is $1,200,000.00 for an overall score less than 4.00. Failure to score at least 3.50 will result in an additional $600,000.00.

SLA 17 - Member Satisfaction Survey
Guarantee
One random sample Member Satisfaction Survey must be completed annually at no additional cost. The surveys must be completed within each Plan Year for the Plan Year. The survey instrument must be presented to the Plan Sponsor for approval of questions and scoring methodology prior to deployment. Plan Sponsor has the authority to request changes and customization to the survey and scoring methodology. The respondent pool must be statistically valid based on the Plan Sponsor's total population (randomly generated sample size sufficient to produce a 95.00% confidence interval with a margin of error of not greater than +/-3.00%). Survey results must be available to the Plan Sponsor by September 30th within the Plan Year unless a different date is agreed upon.

Contractor must achieve a score of 4.00 or higher on a 5.00 point scale (other scoring scales may be used as long as they are equivalent) from 85.00% of the responders.

Penalty
The Medicare penalty for failure to meet this SLA is $1,200,000.00 per year that the SLA is not met.

SLA 18 - Financial Accuracy Rate
Guarantee
Financial Accuracy Rate must be calculated on a monthly basis using a statistically significant sampling method to produce at least 95.00% confidence in the results and +/- 3.00% precision. The resultant accuracy rate (as defined as the total dollar value of claims paid, minus 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%; 1.00% error rate.

Contractor must measure its performance on this SLA on a quarterly basis and report it on a quarterly basis.

Penalty
The Medicare penalty for failure to meet this SLA is $660,000.00 per year that the SLA is not met, plus $330,000.00 for each 0.50% below the standard.

SLA 19 – Implementation Project Plan, Timeliness, and Accuracy
Guarantee
Contractor must provide to Plan Sponsor, for review and approval, an initial Project Plan which highlights tasks and interdependencies, critical dates, as well as roles and responsibilities (“Project Plan”). After initial baseline, the Project Plan must be updated as needed with Contractor, providing Project Plan updates, which reflect any changes or updates, to Plan Sponsor for review and approval. Plan Sponsor will select up to five specific tasks listed on the Project Plan, after the establishment of the initial base line Project Plan, to be met on time as documented within the Project Plan and with 100.00% accuracy. Should Contractor fail to meet the critical dates outlined in the Project Plan and/or 100.00% accuracy of each item and as selected by the Plan Sponsor for penalty.

Penalty
The Medicare penalty for failure to meet this SLA is $500,000.00.

SLA 20 – Implementation Project Plan Meeting
Guarantee
Plan Sponsor may assess a penalty, if, within 45 days after the Effective Date, Plan Sponsor’s benefit / implementation staff, who are active members of the implementation team, do not rate Contractor’s implementation performance an average of 3.00 or better on a scale of 1.00 to 5.00 (5.00 being the best).

Penalty
The Medicare penalty for failure to meet this SLA is $500,000.00.