STATE OF MICHIGAN
ENTERPRISE PROCUREMENT

Department of Technology, Management, and Budget
320 S. Walnut Street 2nd Floor Lansing, MI 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **4**
to
Contract Number **190000000755**

CONTRACTOR	
	BLUE CROSS BLUE SHIELD OF MICHIGAN
	600 E Lafayette 517 J
	Detroit MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024315

STATE			
	Program Manager	Bethany Beauchine	MCSC
		800-505-5011	
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	Contract Administrator	Mary Ostrowski	DTMB
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CONTRACT SUMMARY			
Behavorial Health and Substance Use Disorder Benefits (BH/SUD) for State Health Plan PPO			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE**
July 25, 2019	December 31, 2022	5 - 1 Year	December 31, 2024
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
NET 45		N/A	
ALTERNATE PAYMENT OPTIONS		**EXTENDED PURCHASING**	
☐ P-Card ☒ Direct Voucher (PRC) ☐ Other		☐ Yes ☒ No	
MINIMUM DELIVERY REQUIREMENTS			
N/A			

DESCRIPTION OF CHANGE NOTICE				
OPTION	**LENGTH OF OPTION**	**EXTENSION**	**LENGTH OF EXTENSION**	**REVISED EXP. DATE**
☒	3 Years	☐		December 31, 2027
CURRENT VALUE	**VALUE OF CHANGE NOTICE**	**ESTIMATED AGGREGATE CONTRACT VALUE**		
$125,000,000.00	$174,200,000.00	$299,200,000.00		

DESCRIPTION

Effective January 1, 2025, this Contract is exercising the remaining 3 Option Years and is increased by $174,200,000. The revised contract expiration date is December 31, 2027. In addition, the updates in Change Notice 4, Attachment 1 are incorporated.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement Services approval, and State Administrative Board approval on December 3, 2024.

Change Notice 4, Attachment 1
Contract No. 190000000755

1.) **Schedule A, Section 3.4 Key Personnel tabl**e is updated and replaced with the table below to which updates the assigned Clinical Expert:

1. Name	*3. Position*	4. Role(s) / Responsibilities	5. Direct/ Subcontract / Contract	6. FT/ PT/ T	8. % of Work Time	9. Physical Location
Arva Overton	SAM	Responsible for overseeing all aspects of the Plan Sponsor's contract; functioning as the single point of accountability to ensure the group's servicing expectations are met.	Direct	F T	100%	Detroit, MI
Sydney Lipsey	Back-Up SAM	Back up SAM in servicing Plan Sponsor when needed	Direct	F T	25 – 50% - allocated accordingly	Detroit, MI
Holly Blundo	Data/Eligibility Specialist	Process member eligibility updates from the weekly 834-member eligibility files along with completing enrollment updates	Direct	F T	75%	Detroit, MI
Dr. Kumar, MD	Clinical Expert	Peer reviews, case rounds, interface with BCBSM Medical Director	Subcontractor	F T	20%	Minneapolis, MN

2.) **Schedule A, Section 1.J Performance Guarantees /Service Level Agreements (SLAs):**

- **SLA #1A &1B** is updated and replaced with SLA #1A &1B, which updates reporting format to be mutually agreed upon in 1B.
- **SLA #11** is updated and replaced with SLA#11 below, which removes reference to monthly.

SLA #1A & 1B: Eligibility Files
Guarantee
A.)The Contractor must upload and accurately process eligibility files (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) within one business day of receiving them from the State. B.)Discrepancies must be reported in a mutually agreed upon format within two business days after the eligibility files have been uploaded. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit

The credit for failure to meet the requirement for the Eligibility Upload SLA (#1A) is 2% of the monthly administrative fees for each month missed. The credit for failure to meet the requirement for the Discrepancy Reporting SLA (#1B) is 2% of the monthly administrative fees for each month missed.

SLA #11: Network Accessibility
Guarantee
97% of provider appointments must be offered within the following timeframes: • Immediate for Emergency (Life-threatening) • 6 hours for Emergency (Non-Life-threatening) • 48 hours for urgent • 10 calendar days for routine The Contractor must measure and report their performance on this SLA on an annual basis.
Credit
The credit for failure to meet this requirement (SLA #11) is 4% of the annual administrative fees.

3.) **Schedule B, Pricing** is updated and replaced with the attached Schedule B which incorporates pricing for the remaining 3 Option Years.

4.) **Schedule C, Plan Design and Claim Payment Rules** is updated and replaced with the attached Schedule C to comply with the Mental Health Parity and Addiction Equity Act.

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE B
PRICING

1. The pricing table below reflects pricing with ABA fee rolled into the Administrative Fee.
2. Reserved.
3. Reserved.
4. Pricing 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.
5. The Contractor must provide Pass-Through Pricing to Plan Sponsor. The 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.
6. Reserved.
7. The Base Contract pricing reflects a 39-month period with service commencing October 1, 2019 and ending December 31, 2022.

Self-Insured Pricing (1)						
	Base Contract Term FY2020-2022 (39 Months)	Option Year 1: CY2023	Option Year 2: CY2024	Option Year 3: CY2025	Option Year 4: CY2026	Option Year 5: CY2027
Administrative Fee (Per Contract Per Month Administration Fee)	$1.77	$1.77	$1.77	$1.82	$1.82	$1.82
Implementation Credit	$200,000.00					
Prompt Payment	None					
Notes: (1) The State of Michigan does not guarantee a minimum or maximum volume of services, claims and conversions.						

STATE OF MICHIGAN

Contract No. 190000000755

Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE C

PLAN DESIGN AND CLAIMS PAYMENT RULES

State Health Plan PPO Active Employee Plan Design

Your behavioral health/substance use disorder benefits, A–Z

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions. Mental health and substance use disorder treatment provided by nonparticipating providers are covered. Members seeking services from these providers are responsible for the out-of-network deductible and coinsurance, plus the difference between the charge and the Blue Cross approved amount.

Ambulance	**Covered 90% after deductible (No network required)**

You are covered for ambulance services to transport you to the nearest medical facility capable of treating your condition for behavioral health or substance use disorders. To be covered, the services must be medically necessary.

Autism spectrum disorders Applied Behavioral Analysis (ABA) (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for ABA services administered by a licensed clinician, such as a board-certified behavior analyst, working in association with a paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician. Your benefit covers autism spectrum disorders to treat ABA.

Consultations – hospital (inpatient)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Medical consultations are payable when a physician requires assistance in diagnosing or treating a condition relating to behavioral health or substance use disorder. Hospital outpatient consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Electroconvulsive Therapy (ECT)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for medically necessary ECT treatment including anesthesia services for this benefit. Anesthesia services for ECT are covered at 90% after deductible.

Emergency care	**$200 copay for emergency room (waived if admitted to the same hospital)**

Your benefit plan covers emergency care for behavioral health and substance use disorder diagnoses. Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

Halfway house	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Halfway houses provide substance-free residences for those in recovery from alcohol and substance use. Prior authorization is required.

Hospital care – inpatient behavioral health (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for behavioral health care services that require a hospital stay. Your benefit allows for 365 days per year.

Hospital care – inpatient substance use disorder (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for inpatient substance use disorder services as well as sub-acute detoxification services.

Hospital care – outpatient office visit (physician services)	**In-network – $20 copay**	**Out-of-network – Covered 80% after deductible**

Your benefit covers office visits rendered in an outpatient hospital setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Outpatient office visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Intensive Outpatient Program (IOP) – behavioral health	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for IOP mental health services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Intensive Outpatient Program (IOP) – substance use disorder	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for IOP substance use disorder services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Neuropsychological testing – inpatient	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Neuropsychological testing – outpatient or office	**Covered 90% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Office visits and office consultations	**In-network – Covered $20 copay**	**Out-of-network – Covered 80% after deductible**

Your benefit covers office visits and office consultations when rendered in an office setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – behavioral health (no authorization required)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

You are covered for individual, conjoint, family or group psychotherapy and crisis intervention services. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – substance use disorder (no authorization required)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Services include office based opioid treatment and methadone maintenance. Outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Partial Hospitalization Program (PHP) – behavioral health (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

PHP is a comprehensive care given for a minimum of 6 hours per day, 5 days a week. Treatment may include counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. PHP services are often provided in lieu of inpatient behavioral health for non-acute conditions. Two PHP days equal one inpatient day.

Partial Hospitalization Program (PHP) – substance use disorder (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Program offered at least five hours of therapy a day, up to seven days a week. Two PHP days equal one inpatient day.

Physical, occupational, and speech therapy	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for behavioral health and substance use disorder treatment.

Psychological testing – inpatient	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Your benefit covers medically necessary psychological testing from behavioral health providers.

Psychological testing – outpatient or office	Covered 90% after deductible

Your benefit covers medically necessary psychological testing from behavioral health providers.

Residential mental health treatment (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Not covered

A specialized form of inpatient care. It includes supervision and monitoring within a non-hospital setting.

Residential substance use disorder treatment (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Acute care services provided in a structured full day setting when patient is ambulatory and does not require medical hospitalization. Residential services may include 24-hour supervision, counseling, detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan.

Rural health clinic	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Your benefit covers visits rendered at a rural health clinic relating to behavioral health. Services rendered at a rural health clinic relating to a medical are covered under the State's medical plan.

Telehealth – Blue Cross online tool (online visits)	In-network – $0 copay	Out-of-network – Not covered

You have access to online behavioral health and substance use disorder powered by Virtual Care, available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	In-network – $20 copay	Out-of-network – Covered 80% after deductible

You have access to online behavioral health and substance use disorder using your provider's online tool.

Transcranial magnetic stimulation (TMS) (Requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

TMS is a treatment technique that uses a magnetic field to influence brain activity. It can treat depression, obsessive-compulsive disorder and other brain-related conditions. A prior authorization is required for in-network, out-of-network and non-participating providers.

Benefit summary

	In network	Out of network
Cost share		
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family
Deductible	$400 per member $800 per family	$800 per member $1,600 per family
Coinsurance	10% (where applicable)	20% for most services
Fixed dollar copay	$0 copay for online visits/ telehealth (Blue Cross Online Tool), $20 copay for online telehealth visits (Provider's tool)	Note: Fixed dollar copays do not apply out of network. See appropriate section below for out of network coverage.
Emergency Care		
Ambulance – medically necessary ambulance charges	Covered 90% after deductible	
Emergency room	$200 copay (waived if admitted to the same hospital)	
Hospital care (Inpatient)		
Hospital care – behavioral health (Requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Hospital care – substance use disorder (Requires authorization)		
Consultations		
Neuropsychological testing		
Psychological testing		
Behavioral health		
Autism spectrum disorders – ABA (Requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Electro-Convulsive Therapy (ECT)		
Intensive outpatient program (IOP)		
Neuropsychological testing – outpatient	Covered 90% after deductible	

	In network	Out of network
Outpatient behavioral health	Covered 90% after deductible	Covered 80% after deductible
Partial Hospitalization Program (PHP) (Requires authorization)		
Psychological testing – outpatient	Covered 90% after deductible	
Residential Mental Health treatment (Requires authorization)	Covered 90% after deductible	Not covered
Telehealth (Online visits) – Blue Cross Online Tool	$0 copay	Not covered
Telehealth (Online visits) – Provider's Tool	$20 copay	Covered 80% after deductible
Substance use disorder		
Intensive Outpatient Program (IOP)	Covered 90% after deductible	Covered 80% after deductible
Outpatient care – substance use disorder (Includes office based opioid treatment and methadone maintenance)		
Partial Hospitalization Program (PHP) (Requires authorization)		
Residential Substance Use Disorder treatment (Requires authorization)		

What is not covered

The following behavioral health services aren't covered under the State Health Plan:

- Art therapy
- Biofeedback
- Claims deem fraudulent which, through the exercise of due diligence by contractor could have been prevented
- Completion on any insurance form
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance use disorder
- Hypnotherapy
- Marital counseling
- Medical services or drugs not administered for BH/SU treatment
- Music therapy
- Phone consultations or therapeutic phone questions
- Psychodrama
- Recreation therapy
- Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide
- Services received at private residences (except for autism spectrum disorder to treat ABA)
- Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member
- Services provided while the member is not covered for this benefit
- Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days.

The facility is not primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance use disorder treatment

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Ambulatory Detoxification is non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of the client’s needs and motivation toward continuing participation in the treatment process.

Ambulatory surgery facility is a separate outpatient facility that is not part of a hospital, where surgery is performed, and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Appeal is a complaint made if a member disagrees with a decision to deny a request for health care services or payment for services already received, or to stop services that are being received.

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved amount is the Blue Cross maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved Autism Evaluation Center (AAEC) is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

Approved facility is a hospital that provides medical and other services, such as skilled nursing care or physical therapy, and has been approved as a provider by Blue Cross. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by either the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a facility that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by Blue Cross or an affiliate of Blue Cross.

Autism Spectrum Disorders (ASD) are disorders that are defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the Blue Cross allowed amount is $70, the provider may bill you for the remaining $30. A Blue Cross PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan (Blue Cross) is a nonprofit, independent company. Blue Cross is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Clinical trial is a study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- Phase I – A study conducted on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition
- Phase II – A study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment
- Phase III – A study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Coinsurance is a member's out-of-pocket percentage of the Blue Cross allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

Confinement is a medically necessary inpatient stay that is due to injury or illness.

Coordination of benefits is a program that coordinates your health benefits when you have coverage under more than one group health plan.

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

Covered services are services, treatments or supplies identified as payable under the SHP PPO. Covered services must be medically necessary to be payable, unless otherwise specified.

Crisis Stabilization Bed (CARES Unit) is an inpatient crisis intervention service that provides intensive short-term rapid assessment, stabilization, and disposition management for children under the age of 18 experiencing an acute behavioral health crisis who can be stabilized or discharged within 72 hours. The CARES Unit is designed to provide diversion from inpatient care for those children/adolescents who are in psychiatric crisis and who can be rapidly stabilized. Referrals will come primarily from local Emergency Mobile Psychiatric Services (EMPS) and affiliated Hospital Emergency Departments.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

Deductible is the specified amount you pay each calendar year for services before your plan begins to pay.

Designated cancer center is a site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility is a facility that Blue Cross determines to be qualified to perform a specific organ and bone marrow transplant.

Detoxification is an immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs.

Diabetes - Self management See the document entitled, 'State Health Plan PPO - Preventive services for active employees' located at bcbsm.com/som for benefit details.

Durable medical equipment (DME) is equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Electro Convulsive Therapy (ECT) is brain stimulation techniques such as electroconvulsive therapy (ECT) can be used to treat major depression that hasn't responded to standard treatments.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions

- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied
- Application of butterfly suture
- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

End Stage Renal Disease is permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Excluded services are health care services for which your health plan does not pay or cover.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Blue Cross makes this determination based on a review of established criteria, such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross and Blue Shield Association or other local or national bodies

Extended Day Treatment (EDT) is a community-based program for children and their families that offers a structured, intensive, therapeutic milieu with group, family and individual therapy services. Services are typically after school for several days per week and the program can last up to six months. EDT provides a broad range of treatment services and psycho-social interventions.

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

Grievance is a complaint that does not involve coverage or payment disputes. For example, a complaint regarding one of our network providers or a complaint concerning the quality of care is considered a grievance. This type of complaint does not involve a request for an initial determination or an appeal.

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

Hospital is a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Independent physical therapist is a licensed physical therapist that is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office separate from a hospital or freestanding outpatient physical therapy facility with the equipment necessary to provide adequately physician-prescribed physical therapy.

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

Intensive Outpatient Services (IOP) is an integrated program of outpatient psychiatric services that are designed for more intensive treatment than routine outpatient psychiatric services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance use disorder, or an outpatient psychiatric clinic for children.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person expects that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity for payment of hospital services requires that all of the following conditions are met:

- The covered service is for the treatment, diagnosis of the symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
  - *Appropriate* means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for services even when they are medically necessary. These limited situations are:

- When you do not inform the hospital that you are a Blue Cross member at the time of admission or within 30 days after you have been discharged.
- When you fail to provide the hospital with information that identifies your coverage.

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that the covered service is:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medication Assisted Treatment (MAT) is an approach to treating both opioid and alcohol substance use disorders. The FDA has approved several different medications to treat Opioid Use and Alcohol Use

Disorders. These medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused substance. Research has shown that when provided at the proper dose, MAT medications used have no negative effects on a person's intelligence, mental capability, physical functioning, or employability.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in Blue Cross membership records.

Methadone Maintenance is treatment where the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder.

Network is a group of doctors, hospitals, DME and other health care providers contracted with Blue Cross to provide services to members. Members typically pay less for using a network provider.

Nonparticipating providers are providers that have not signed participation agreements with Blue Cross agreeing to accept the Blue Cross payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross-approved amount as payment in full on a per claim basis.

Observation consists of services up to 48 hours at a hospital to assess whether further inpatient services or community-based services might be needed; usually following a visit to the Emergency Room.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Out-of-network refers to services not rendered by a Blue Cross PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the Blue Cross PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved Blue Cross amount.

Outpatient Services (for behavioral health and substance use disorder) includes behavioral health evaluation and treatment services such as individual, group, family therapy, medication management, Autism Spectrum Disorder services, psychological and developmental testing, consultation, and case management that are provided to people who have a primary behavioral health diagnosis. Services may be provided in a freestanding clinic, hospital outpatient clinic, or by a group practice or solo practitioner who is a licensed behavioral health professional.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet

your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

Partial Hospitalization Program (PHP) is a program used to treat mental health and/or substance use disorders. In partial hospitalization, the member continues to live at home, but commutes to a hospital-based or clinic-based program several days per week.

Participating providers are providers who have signed agreements with Blue Cross to accept the Blue Cross-approved amount for covered services as payment in full.

Patient is the subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per claim is a provider's acceptance of the Blue Cross-approved amount as payment in full for a specific claim or procedure.

Physical therapy is treatment intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Physician or professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD), or a fully licensed psychologist.

Provider is a person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychiatric Hospitalization consists of services where a member stays overnight at a hospital (inpatient) either at a general hospital, psychiatric hospital, or freestanding detox service in the case of a substance use disorder.

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-Blue Cross PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Residential Mental Health Treatment Program is a specialized form of inpatient care in a participating psychiatric residential treatment facility (PRTF) that typically includes 24-hour supervision and monitoring within a non-hospital setting, often aimed at providing an intensive therapeutic environment and treatment for members with mental health issues.

Residential Substance Use Disorder Treatment Program is a community based (non-hospital) facility that provides medical and other services specifically for substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in this type of a program is sometimes called intermediate care and may include subacute detoxification early in the treatment course.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

Skilled nursing facility is a facility that provides short or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty hospital is a hospital, such as a children's hospital or a chronic disease hospital that provides care for a specific disease or population.

Speech therapy is active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem cells are primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the SHP PPO.

State Health Plan PPO Non-Medicare Retiree Plan Design

Your Behavioral Health/Substance Use Disorder Benefits, A–Z

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions. Mental health and substance use disorder treatment provided by nonparticipating providers are covered. Members seeking services from these providers are responsible for the out-of-network deductible and coinsurance, plus the difference between the charge and the Blue Cross-approved amount.

	In-network	Out-of-network
Ambulance	**Covered 90% after deductible (No network required)**	

You are covered for ambulance services to transport you to the nearest medical facility capable of treating your condition for behavioral health or substance use disorders. To be covered, the services must be medically necessary.

Autism spectrum disorders Applied Behavioral Analysis (ABA) (Requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for ABA services administered by a licensed clinician, such as a board-certified behavior analyst, working in association with a paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician. Your benefit covers autism spectrum disorders to treat ABA.

Consultations – hospital (inpatient)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Medical consultations are payable when a physician requires assistance in diagnosing or treating a condition relating to behavioral health or substance use disorder.

Electroconvulsive Therapy (ECT)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for medically necessary ECT treatment including anesthesia services for this benefit. Anesthesia services for ECT are covered at 90% after deductible.

Emergency care	**$200 copay for emergency room (waived if admitted to the same hospital)**

Your benefit plan covers emergency care for behavioral health and substance use disorder diagnoses. Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

Halfway house	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Halfway houses provide substance-free residences for those in recovery from alcohol and substance use. Prior authorization is required.

Hospital care – inpatient behavioral health (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for behavioral health care services that require a hospital stay. Your benefit allows for unlimited days.

Hospital care – inpatient substance use disorder (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for inpatient substance use disorder services as well as sub-acute detoxification services.

Hospital care – outpatient office visit (physician services)	**In-network – $20 copay**	**Out-of-network – Covered 80% after deductible**

Your benefit covers office visits rendered in an outpatient hospital setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Outpatient office visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Intensive Outpatient Program (IOP) – behavioral health	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for IOP mental health services provided on an outpatient basis. These services involve frequent visits (usually 3 to 5 days per week) and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Intensive Outpatient Program (IOP) – substance use disorder	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for IOP substance use disorder services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Neuropsychological testing – inpatient	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Neuropsychological testing – outpatient or office	**Covered 90% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Office visits and office consultations	**In-network – Covered $20 copay**	**Out-of-network – Covered 80% after deductible**

Your benefit covers office visits and office consultations when rendered in an office setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – behavioral health (no authorization required)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for individual, conjoint, family or group psychotherapy and crisis intervention services. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – substance use disorder (no authorization required)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Services include office based opioid treatment and methadone maintenance. Outpatient visits rendered by your primary care provider will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Partial Hospitalization Program (PHP) – behavioral health (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

PHP is a comprehensive care given for a minimum of 6 hours per day, 5 days a week. Treatment may include counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. PHP services are often provided in lieu of inpatient behavioral health for non-acute conditions. Two PHP days equal one inpatient day.

Partial Hospitalization Program (PHP) – substance use disorder (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Program offered at least five hours of therapy a day, up to seven days a week. Two PHP days equal one inpatient day.

Physical, occupational, and speech therapy	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for behavioral health and substance use disorder treatment.

Psychological testing – inpatient	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Your benefit covers medically necessary psychological testing from behavioral health providers.

Psychological testing – outpatient or office	**Covered 90% after deductible**

Your benefit covers medically necessary psychological testing from behavioral health providers.

Residential mental health treatment (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Not covered**

A specialized form of inpatient care. It includes supervision and monitoring within a non-hospital setting.

Residential substance use disorder treatment (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Acute care services provided in a structured full day setting when patient is ambulatory and does not require medical hospitalization. Residential services may include 24-hour supervision, counseling, detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan.

Rural health clinic	**In-network - Covered** **$20 copay**	**Out-of-network – Covered** **80% after deductible**

Your benefit covers visits rendered at a rural health clinic relating to behavioral health. Services rendered at a rural health clinic relating to a medical are covered under the State's medical plan.

Telehealth – Blue Cross online tool (online visits)	**In-network – Covered** **$0 copay**	**Out-of-network –** **Not covered**

You have access to online behavioral health and substance use disorder powered by Virtual Care, available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	**In-network – Covered** **$20 copay**	**Out-of-network – Covered** **80% after deductible**

You have access to online behavioral health and substance use disorder using your provider's online tool.

Transcranial magnetic stimulation (TMS) (requires authorization)	**In-network – Covered** **90% after deductible**	**Out-of-network – Covered** **80% after deductible**

TMS is a treatment technique that uses a magnetic field to influence brain activity. It can treat depression, obsessive-compulsive disorder and other brain-related conditions. A prior authorization is required for in-network, out-of-network and non-participating providers.

	In network	Out of network
Cost share		
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family
Deductible	$400 per member $800 per family	$800 per member $1,600 per family
Coinsurance	10% (where applicable)	20% for most services
Fixed dollar copay	$0 copay for telehealth (Blue Cross online tool) $20 copay for online telehealth visits (Provider's tool)	Note: Fixed dollar copays do not apply out of network. See appropriate section below for out of network coverage.
Emergency Care		
Ambulance – medically necessary ambulance charges	Covered 90% after deductible	
Emergency room	$200 copay for non-Medicare members (waived if admitted to the same hospital)	
Hospital care (Inpatient)		
Hospital care – behavioral health (Requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Hospital care – substance use disorder (Requires authorization)		
Consultations		
Neuropsychological testing		
Psychological testing		
Behavioral health		
Autism spectrum disorders – ABA (Requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Electro-Convulsive Therapy (ECT)		
Intensive Outpatient Program (IOP)		
Neuropsychological testing – outpatient	Covered 90% after deductible	
Outpatient behavioral health	Covered 90% after deductible	Covered 80% after deductible
Partial Hospitalization Program (PHP) (Requires authorization)		
Psychological testing – outpatient	Covered 90% after deductible	

	In network	Out of network
Residential Mental Health treatment (Requires authorization)	Covered 90% after deductible	Not covered
Telehealth (Online visits) – Blue Cross Online Tool	$0 copay	
Telehealth (Online visits) – Provider's Tool	$20 copay	Covered 80% after deductible
Substance use disorder		
Intensive Outpatient Program (IOP)	Covered 90% after deductible	Covered 80% after deductible
Outpatient care – substance use disorder (Includes office based opioid treatment and methadone maintenance)		
Partial Hospitalization Program (PHP) (Requires authorization)		
Residential Substance Use Disorder treatment (Requires authorization)		

What is not covered

The following behavioral health services aren't covered under the State Health Plan:

- Art therapy
- Biofeedback
- Claims deem fraudulent which, through the exercise of due diligence by contractor could have been prevented
- Completion on any insurance form
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance use disorder
- Hypnotherapy
- Marital counseling
- Medical services or drugs not administered for BH/SU treatment
- Music therapy
- Phone consultations or therapeutic phone questions
- Psychodrama
- Recreation therapy
- Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide
- Services received at private residences (except for autism spectrum disorder to treat ABA)
- Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member
- Services provided while the member is not covered for this benefit
- Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days.

The facility is not primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance use disorder treatment

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Ambulatory Detoxification is non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of the client’s needs and motivation toward continuing participation in the treatment process.

Ambulatory surgery facility is a separate outpatient facility that is not part of a hospital, where surgery is performed, and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Appeal is a complaint made if a member disagrees with a decision to deny a request for health care services or payment for services already received, or to stop services that are being received.

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved amount is the Blue Cross maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved Autism Evaluation Center (AAEC) is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

Approved facility is a hospital that provides medical and other services, such as skilled nursing care or physical therapy, and has been approved as a provider by Blue Cross. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by either the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a facility that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by Blue Cross or an affiliate of Blue Cross.

Autism Spectrum Disorders (ASD) are disorders that are defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the Blue Cross allowed amount is $70, the provider may bill you for the remaining $30. A Blue Cross PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan (Blue Cross) is a nonprofit, independent company. Blue Cross is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Clinical trial is a study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- Phase I – A study conducted on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition.
- Phase II – A study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III – A study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Coinsurance is a member's out-of-pocket percentage of the Blue Cross allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

Confinement is a medically necessary inpatient stay that is due to injury or illness.

Coordination of benefits is a program that coordinates your health benefits when you have coverage under more than one group health plan.

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

Covered services are services, treatments or supplies identified as payable under the SHP PPO. Covered services must be medically necessary to be payable, unless otherwise specified.

Crisis Stabilization Bed (CARES Unit) is an inpatient crisis intervention service that provides intensive short-term rapid assessment, stabilization, and disposition management for children under the age of 18 experiencing an acute behavioral health crisis who can be stabilized or discharged within 72 hours. The CARES Unit is designed to provide diversion from inpatient care for those children/adolescents who are in psychiatric crisis and who can be rapidly stabilized. Referrals will come primarily from local Emergency Mobile Psychiatric Services (EMPS) and affiliated Hospital Emergency Departments.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

Deductible is the specified amount you pay each calendar year for services before your plan begins to pay.

Designated cancer center is a site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility is a facility that Blue Cross determines to be qualified to perform a specific organ and bone marrow transplant.

Detoxification is an immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs.

Diabetes - Self management See the document entitled, 'State Health Plan PPO - Preventive services for active employees' located at **bcbsm.com/som** for benefit details.

Durable medical equipment (DME) is equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Electro Convulsive Therapy (ECT) is brain stimulation techniques such as electroconvulsive therapy (ECT) can be used to treat major depression that hasn't responded to standard treatments.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions
- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied
- Application of butterfly suture
- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

End Stage Renal Disease is permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Excluded services are health care services for which your health plan does not pay or cover.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Blue Cross makes this determination based on a review of established criteria, such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross and Blue Shield Association or other local or national bodies

Extended Day Treatment (EDT) is a community-based program for children and their families that offers a structured, intensive, therapeutic milieu with group, family and individual therapy services. Services are typically after school for several days per week and the program can last up to six months. EDT provides a broad range of treatment services and psycho-social interventions.

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

Grievance is a complaint that does not involve coverage or payment disputes. For example, a complaint regarding one of our network providers or a complaint concerning the quality of care is considered a grievance. This type of complaint does not involve a request for an initial determination or an appeal.

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

Hospital is a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Independent physical therapist is a licensed physical therapist that is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office separate from a hospital or freestanding outpatient physical therapy facility with the equipment necessary to provide adequately physician-prescribed physical therapy.

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

Intensive Outpatient Services (IOP) is an integrated program of outpatient psychiatric services that are designed for more intensive treatment than routine outpatient psychiatric services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance use disorder, or an outpatient psychiatric clinic for children.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person expects that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity for payment of hospital services requires that all of the following conditions are met:

- The covered service is for the treatment, diagnosis of the symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
  - *Appropriate* means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for services even when they are medically necessary. These limited situations are:

- When you do not inform the hospital that you are a Blue Cross member at the time of admission or within 30 days after you have been discharged
- When you fail to provide the hospital with information that identifies your coverage

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that the covered service is:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medication Assisted Treatment (MAT) is an approach to treating both opioid and alcohol substance use disorders. The FDA has approved several different medications to treat Opioid Use and Alcohol Use Disorders. These medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused substance. Research has shown that when provided at the proper dose, MAT medications used have no negative effects on a person's intelligence, mental capability, physical functioning, or employability.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in Blue Cross membership records.

Methadone Maintenance is treatment where the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder.

Network is a group of doctors, hospitals, DME and other health care providers contracted with Blue Cross to provide services to members. Members typically pay less for using a network provider.

Nonparticipating providers are providers that have not signed participation agreements with Blue Cross agreeing to accept the Blue Cross payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross-approved amount as payment in full on a per claim basis.

Observation consists of services up to 48 hours at a hospital to assess whether further inpatient services or community-based services might be needed; usually following a visit to the Emergency Room.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Out-of-network refers to services not rendered by a Blue Cross PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the Blue Cross PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved Blue Cross amount.

Outpatient Services (for behavioral health and substance use disorder) includes behavioral health evaluation and treatment services such as individual, group, family therapy, medication management, Autism Spectrum Disorder services, psychological and developmental testing, consultation, and case management that are provided to people who have a primary behavioral health diagnosis. Services may be provided in a freestanding clinic, hospital outpatient clinic, or by a group practice or solo practitioner who is a licensed behavioral health professional.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

Partial Hospitalization Program (PHP) is a program used to treat mental health and/or substance use disorders. In partial hospitalization, the member continues to live at home, but commutes to a hospital-based or clinic-based program several days per week.

Participating providers are providers who have signed agreements with Blue Cross to accept the Blue Cross-approved amount for covered services as payment in full.

Patient is the subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per claim is a provider's acceptance of the Blue Cross-approved amount as payment in full for a specific claim or procedure.

Physical therapy is treatment intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Physician or professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD), or a fully licensed psychologist.

Provider is a person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychiatric Hospitalization consists of services where a member stays overnight at a hospital (inpatient) either at a general hospital, psychiatric hospital, or freestanding detox service in the case of a substance use disorder.

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-Blue Cross PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Residential Mental Health Treatment Program is a specialized form of inpatient care in a participating psychiatric residential treatment facility (PRTF) that typically includes 24-hour supervision and monitoring within a non-hospital setting, often aimed at providing an intensive therapeutic environment and treatment for members with mental health issues.

Residential Substance Use Disorder Treatment Program is a community based (non-hospital) facility that provides medical and other services specifically for substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in this type of a program is sometimes called intermediate care and may include subacute detoxification early in the treatment course.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

Skilled nursing facility is a facility that provides short or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty hospital is a hospital, such as a children's hospital or a chronic disease hospital that provides care for a specific disease or population.

Speech therapy is active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem cells are primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the SHP PPO.

State Health Plan PPO Medicare Supplemental Retiree Plan Design

Your behavioral health/Substance use disorder benefits, A–Z

When you or your covered dependents become eligible for Medicare, your health insurance continues through your Medicare Supplemental benefits with the State Health Plan PPO if you opted out of Medicare Advantage and provided proof to ORS of other primary coverage. These benefits work hand-in-hand with Original Medicare so that you enjoy the same covered services as non-Medicare members.

Although you have PPO benefits through the State Health Plan PPO, Medicare (your primary insurance) requires that you obtain care from Medicare-affiliated providers.

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions.

Ambulance	**Covered – 90% after deductible**

You are covered for ambulance services to transport you to the nearest medical facility capable of treating your condition for behavioral health or substance use disorders. To be covered, the services must be medically necessary.

Autism spectrum disorders Applied Behavioral Analysis (ABA)	**Covered – 90% after deductible**

You are covered for ABA services administered by a licensed clinician, such as a board-certified behavior analyst, working in association with a paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician. Your benefit covers autism spectrum disorders to treat ABA.

Consultations – hospital (inpatient)	**Covered – 90% after deductible**

Medical consultations are payable when a physician requires assistance in diagnosing or treating a condition relating to behavioral health or substance use disorder.

Electroconvulsive Therapy (ECT)	**Covered – 90% after deductible**

You are covered for medically necessary ECT treatment including anesthesia services for this benefit. Anesthesia services for ECT are covered at 90% after deductible.

Emergency care	**Covered – Up to $50 copay for emergency room (waived if admitted to the same hospital)**

Your benefit plan covers emergency care for behavioral health and substance use disorder diagnoses. Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

Halfway house	**Covered – 90% after deductible**

Halfway houses provide substance-free residences for those in recovery from alcohol and substance use. Prior authorization is required.

Hospital care – inpatient behavioral health	**Covered – 90% after deductible**

You are covered for behavioral health care services that require a hospital stay. Your benefit allows for unlimited days.

Hospital care – inpatient substance use disorder	**Covered – 90% after deductible**

You are covered for inpatient substance use disorder services as well as sub-acute detoxification services.

Intensive Outpatient Program (IOP) – behavioral health	**Covered – 90% after deductible**

You are covered for IOP mental health services provided on an outpatient basis. These services involve frequent visits (usually 3 to 5 days per week) and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Intensive Outpatient Program (IOP) – substance use disorder	**Covered – 90% after deductible**

You are covered for IOP substance use disorder services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Neuropsychological testing – inpatient	**Covered – 90% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Neuropsychological testing – outpatient or office	**Covered – 90% after deductible**

Your benefit covers medically necessary neuropsychological testing for behavioral health diagnoses.

Office visits and office consultations	**Covered – Up to $20 copay**

Your benefit covers office visits and office consultations when rendered in an office setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – behavioral health	**Covered – 90% after deductible**

You are covered for individual, conjoint, family or group psychotherapy and crisis intervention services. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – substance use disorder	**Covered – 90% after deductible**

Services include office based opioid treatment and methadone maintenance. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Partial Hospitalization Program (PHP) – behavioral health	**Covered – 90% after deductible**

PHP is a comprehensive care given for a minimum of 6 hours per day, 5 days a week. Treatment may include counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. PHP services are often provided in lieu of inpatient behavioral health for non-acute conditions. Two PHP days equal one inpatient day.

Partial Hospitalization Program (PHP) – substance use disorder	**Covered – 90% after deductible**

Program offered at least five hours of therapy a day, up to seven days a week. Two PHP days equal one inpatient day.

Physical, occupational, and speech therapy	**Covered – 90% after deductible**

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for behavioral health and substance use disorder treatment.

Psychological testing – inpatient	**Covered – 90% after deductible**

Your benefit covers medically necessary psychological testing from behavioral health providers.

Psychological testing – outpatient or office	**Covered – 90% after deductible**

Your benefit covers medically necessary psychological testing from behavioral health providers.

Residential Mental Health treatment	**Covered – 90% after deductible**

A specialized form of inpatient care. It includes supervision and monitoring within a non-hospital setting.

Residential Substance Use Disorder treatment	**Covered – 90% after deductible**

Acute care services provided in a structured full day setting when patient is ambulatory and does not require medical hospitalization. Residential services may include 24-hour supervision, counseling, detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan.

Rural health clinic	**Covered – Up to $20 copay**

Your benefit covers visits rendered at a rural health clinic relating to behavioral health. Services rendered at a rural health clinic relating to a medical are covered under the State's medical plan.

Telehealth - Blue Cross online tool (online visits)	**Covered – $0 copay**

You have access to online health care powered by Virtual Care, available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	**Covered – Up to $20 copay**

You have access to online health care using your provider's online tool.

Transcranial magnetic stimulation (TMS)	**Covered – 90% after deductible**

TMS is a treatment technique that uses a magnetic field to influence brain activity. It can treat depression, obsessive-compulsive disorder and other brain-related conditions. A prior authorization is required for in-network, out-of-network and non-participating providers.

Benefit summary

	In network
Cost share	
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family
Deductible	$400 per member $800 per family
Coinsurance	10% (where applicable)
Copays	Up to $20 copay for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation $0 copay for telehealth (Blue Cross online tool)
Emergency Care	
Ambulance – medically necessary ambulance charges	Covered 90% after deductible
Emergency room	Up to $50 copay
Hospital care (Inpatient)	
Hospital care – behavioral health	Covered 90% after deductible
Hospital care – substance use disorder	
Consultations	
Neuropsychological testing	
Psychological testing	
Behavioral health	
Autism spectrum disorders – ABA	Covered 90% after deductible
Electro-Convulsive Therapy (ECT)	
Intensive Outpatient Program (IOP)	
Neuropsychological testing – outpatient	
Outpatient behavioral health	
Partial Hospitalization Program (PHP)	
Psychological testing – outpatient	
Residential Mental Health treatment	
Substance use disorder	
Intensive Outpatient Program (IOP)	Covered 90% after deductible
Outpatient care – substance use disorder (Includes office based opioid treatment and methadone maintenance)	
Partial Hospitalization Program (PHP)	
Residential Substance Use Disorder treatment	

What is not covered

The following behavioral health services aren't covered under the State Health Plan:

- Art therapy
- Biofeedback
- Claims deem fraudulent which, through the exercise of due diligence by contractor could have been prevented
- Completion on any insurance form
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance use disorder
- Hypnotherapy
- Marital counseling
- Medical services or drugs not administered for BH/SU treatment
- Music therapy
- Phone consultations or therapeutic phone questions
- Psychodrama
- Recreation therapy
- Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide
- Services received at private residences (except for autism spectrum disorder to treat ABA)
- Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member
- Services provided while the member is not covered for this benefit
- Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days.

The facility is not primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance use disorder treatment

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Ambulatory Detoxification is non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of the client’s needs and motivation toward continuing participation in the treatment process.

Ambulatory surgery facility is a separate outpatient facility that is not part of a hospital, where surgery is performed, and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Appeal is a complaint made if a member disagrees with a decision to deny a request for health care services or payment for services already received, or to stop services that are being received.

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved amount is the Blue Cross maximum payment level or the provider’s billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved Autism Evaluation Center (AAEC) is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

Approved facility is a hospital that provides medical and other services, such as skilled nursing care or physical therapy, and has been approved as a provider by Blue Cross. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by either the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a facility that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by Blue Cross or an affiliate of Blue Cross.

Autism Spectrum Disorders (ASD) are disorders that are defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the Blue Cross allowed amount is $70, the provider may bill you for the remaining $30. A Blue Cross PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan (Blue Cross) is a nonprofit, independent company. Blue Cross is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Clinical trial is a study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- Phase I – A study conducted on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition
- Phase II – A study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment
- Phase III – A study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Coinsurance is a member's out-of-pocket percentage of the Blue Cross allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

Confinement is a medically necessary inpatient stay that is due to injury or illness.

Coordination of benefits is a program that coordinates your health benefits when you have coverage under more than one group health plan.

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

Covered services are services, treatments or supplies identified as payable under the SHP PPO. Covered services must be medically necessary to be payable, unless otherwise specified.

Crisis Stabilization Bed (CARES Unit) is an inpatient crisis intervention service that provides intensive short-term rapid assessment, stabilization, and disposition management for children under the age of 18 experiencing an acute behavioral health crisis who can be stabilized or discharged within 72 hours. The CARES Unit is designed to provide diversion from inpatient care for those children/adolescents who are in psychiatric crisis and who can be rapidly stabilized. Referrals will come primarily from local Emergency Mobile Psychiatric Services (EMPS) and affiliated Hospital Emergency Departments.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

Deductible is the specified amount you pay each calendar year for services before your plan begins to pay.

Designated cancer center is a site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility is a facility that Blue Cross determines to be qualified to perform a specific organ and bone marrow transplant.

Detoxification is an immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs.

Diabetes - Self management See the document entitled, 'State Health Plan PPO - Preventive services for active employees' located at **bcbsm.com/som** for benefit details.

Durable medical equipment (DME) is equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Electro Convulsive Therapy (ECT) is brain stimulation techniques such as electroconvulsive therapy (ECT) can be used to treat major depression that hasn't responded to standard treatments.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions
- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied
- Application of butterfly suture
- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

End Stage Renal Disease is permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Excluded services are health care services for which your health plan does not pay or cover.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Blue Cross makes this determination based on a review of established criteria, such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross and Blue Shield Association or other local or national bodies

Extended Day Treatment (EDT) is a community-based program for children and their families that offers a structured, intensive, therapeutic milieu with group, family and individual therapy services. Services are typically after school for several days per week and the program can last up to six months. EDT provides a broad range of treatment services and psycho-social interventions.

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

Grievance is a complaint that does not involve coverage or payment disputes. For example, a complaint regarding one of our network providers or a complaint concerning the quality of care is considered a grievance. This type of complaint does not involve a request for an initial determination or an appeal.

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

Hospital is a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Independent physical therapist is a licensed physical therapist that is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office separate from a hospital or freestanding outpatient physical therapy facility with the equipment necessary to provide adequately physician-prescribed physical therapy.

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

Intensive Outpatient Services (IOP) is an integrated program of outpatient psychiatric services that are designed for more intensive treatment than routine outpatient psychiatric services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance use disorder, or an outpatient psychiatric clinic for children.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person expects that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity for payment of hospital services requires that all of the following conditions are met:

- The covered service is for the treatment, diagnosis of the symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
  - — *Appropriate* means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for services even when they are medically necessary. These limited situations are:

- When you do not inform the hospital that you are a Blue Cross member at the time of admission or within 30 days after you have been discharged.
- When you fail to provide the hospital with information that identifies your coverage.

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that the covered service is:

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medication Assisted Treatment (MAT) is an approach to treating both opioid and alcohol substance use disorders. The FDA has approved several different medications to treat Opioid Use and Alcohol Use Disorders. These medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused substance. Research has shown that when provided at the proper dose, MAT medications used have no negative effects on a person's intelligence, mental capability, physical functioning, or employability.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in Blue Cross membership records.

Methadone Maintenance is treatment where the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder.

Network is a group of doctors, hospitals, DME and other health care providers contracted with Blue Cross to provide services to members. Members typically pay less for using a network provider.

Nonparticipating providers are providers that have not signed participation agreements with Blue Cross agreeing to accept the Blue Cross payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross-approved amount as payment in full on a per claim basis.

Observation consists of services up to 48 hours at a hospital to assess whether further inpatient services or community-based services might be needed; usually following a visit to the Emergency Room.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Out-of-network refers to services not rendered by a Blue Cross PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the Blue Cross PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved Blue Cross amount.

Outpatient Services (for behavioral health and substance use disorder) includes behavioral health evaluation and treatment services such as individual, group, family therapy, medication management, Autism Spectrum Disorder services, psychological and developmental testing, consultation, and case management that are provided to people who have a primary behavioral health diagnosis. Services may be provided in a freestanding clinic, hospital outpatient clinic, or by a group practice or solo practitioner who is a licensed behavioral health professional.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

Partial Hospitalization Program (PHP) is a program used to treat mental health and/or substance use disorders. In partial hospitalization, the member continues to live at home, but commutes to a hospital-based or clinic-based program several days per week.

Participating providers are providers who have signed agreements with Blue Cross to accept the Blue Cross-approved amount for covered services as payment in full.

Patient is the subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per claim is a provider's acceptance of the Blue Cross-approved amount as payment in full for a specific claim or procedure.

Physical therapy is treatment intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Physician or professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD), or a fully licensed psychologist.

Provider is a person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychiatric Hospitalization consists of services where a member stays overnight at a hospital (inpatient) either at a general hospital, psychiatric hospital, or freestanding detox service in the case of a substance use disorder.

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-Blue Cross PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Residential Mental Health Treatment Program is a specialized form of inpatient care in a participating psychiatric residential treatment facility (PRTF) that typically includes 24-hour supervision and monitoring within a non-hospital setting, often aimed at providing an intensive therapeutic environment and treatment for members with mental health issues.

Residential Substance Use Disorder Treatment Program is a community based (non-hospital) facility that provides medical and other services specifically for substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in this type of a program is sometimes called intermediate care and may include subacute detoxification early in the treatment course.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

Skilled nursing facility is a facility that provides short or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty hospital is a hospital, such as a children's hospital or a chronic disease hospital that provides care for a specific disease or population.

Speech therapy is active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem cells are primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the SHP PPO.

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **3**

to

Contract Number **190000000755**

CONTRACTOR	
	BLUE CROSS BLUE SHIELD OF MICHIGAN
	600 E Lafayette 517 J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024315

STATE			
	Program Manager	Bethany Beauchine	MCSC
		800-505-5011	
		beauchineb@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

BEHAVORIAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS (BH/SUD) FOR STATE HEALTH PLAN PPO

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
July 25, 2019	December 31, 2022	5 - 1 Year	December 31, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

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

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$90,000,000.00	$35,000,000.00	$125,000,000.00

DESCRIPTION

Effective January 31, 2024, this Contract is increased by $35,000,000.00 for Pass-though Claims utilization and Administration Costs.

All other terms, conditions, specifications, and pricing remain the same. Per contractor and agency agreement, DTMB Central Procurement Services approval, and State Administrative Board approval on January 30, 2024.

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **2**

to

Contract Number **190000000755**

CONTRACTOR	
	BLUE CROSS BLUE SHIELD OF MICHIGAN
	600 E Lafayette 517 J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024315

STATE			
	Program Manager	Bethany Beauchine	MCSC
		800-505-5011	
		beauchineb@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

Behavioral Health and Substance Use Disorder Benefits (BH/SUD) for the State Health Plan PPO

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
July 25, 2019	December 31, 2022	5 - 1 Year	December 31, 2024

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

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

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$90,000,000.00	$0.00	$90,000,000.00

DESCRIPTION

Effective January 1, 2024, Schedule A, Section 3.6 Disclosure of Subcontractors is updated and replaced with the language below, which removes New Directions Behavioral Health LLC, American Well, and myStrength, and adds Optum Health, OptumInsight, and Teladoc Health, Inc.
All other terms, conditions, specifications and pricing remain the same. Per Contractor and Agency agreement, and DTMB Central Procurement approval.

3.6 Disclosure of Subcontractors

If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

1. The legal business name; address; telephone number.
2. A description of subcontractor's organization and the services it will provide.
3. Information concerning subcontractor's ability to provide the Contract Activities.
4. The relationship of the subcontractor to the Contractor.
5. Whether the Contractor has a previous working experience with the subcontractor.
6. If yes, provide the details of that previous relationship.
7. A complete description of the Contract Activities that will be performed or provided bythe subcontractor.

Subcontractor Table	
Legal business name and full address.	**Optum Health** 11000 Optum Circle Eden Prairie, MN 55344
Phone number.	888-445-8745
Description of the Contract Activities that will be performed or provided by the subcontractor.	Launching 01/01/2024, the Blue Cross Behavioral Health solution, powered by Optum Health, will offer behavioral health care management, utilization management and solutions focused on integrating behavioral and physical health care, offers 24/7 phone support for mental health and substance use disorders, expansion of specialty programs, additional digital health and wellbeing resources, including a digital navigation tool, to help ensure members are matched with resources and providers based on their needs.
Legal business name and full address.	**OptumInsight** 11000 Optum Circle Eden Prairie, MN 55344
Phone number.	952-833-7100
Description of the Contract Activities that will be performed or provided by the subcontractor.	Help clinicians make the most informed and clinically advanced patient care decisions, more quickly and easily. Apply edits to claims to enforce correct coding. Primary Editing: Optum's Claims Editing System ensures adherence to clinical guidelines, for professional, durable medical equipment, and facility claims. Emergency Department Claim Analyzer: EDC Analyzer reviews submitted outpatient facility emergency department claims to evaluate whether the E/M code entered on such claims is supported by the associated claim detail in order to recommend an appropriate facility emergency department CPT Visit Level. Hospital Credit Balance: Optum will detect, identify and resolve credit balances due from overpayments within in state hospital accounting systems. The intent is to increase accuracy and automation to supplement any resubmissions currently done by hospitals. Hospitals provide BCBSM access to their

	revenue cycle systems. Every finding is acknowledged and approved by the hospital prior to any recovery. Dedicated expert's reviews hospital's financials and revenue cycle systems to expedite and maximize recoveries.
Legal business name and full address.	**Teladoc Health, Inc** 2 Manhattanville Road Purchase, NY 10577
Phone number.	800-835-2362
Description of the Contract Activities that will be performed or provided by the subcontractor.	A network of providers who will provide general medical and behavioral health virtual visits.
Legal business name and full address.	**Accumulation Technologies, LLC d/b/a AccumTech** 17199 N Laurel Park Dr Suite 110 Livonia, MI 48152
Phone number.	734-237-5100
Description of the Contract Activities that will be performed or provided by the subcontractor.	AccumTech will perform data integration on behalf of BCBSM with any third parties requiring cost share integration or accumulator services.

STATE OF MICHIGAN
CENTRAL PROCUREMENT SERVICES
Department of Technology, Management, and Budget
320 S. WALNUT ST., LANSING, MICHIGAN 48933
P.O. BOX 30026 LANSING, MICHIGAN 48909

CONTRACT CHANGE NOTICE

Change Notice Number **1**

to

Contract Number **190000000755**

CONTRACTOR	
	BLUE CROSS BLUE SHIELD OF MICHIGAN
	600 E Lafayette 517 J
	Detroit, MI 48226
	Arva Overton
	313-448-5912
	aoverton@bcbsm.com
	CV0024315

STATE			
	Program Manager	Bethany Beauchine	MCSC
		800-505-5011	
		beauchineb@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY

Behavioral Health and Substance Use Disorder Benefits (BH/SUD) for the State Health Plan PPO

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	INITIAL AVAILABLE OPTIONS	EXPIRATION DATE BEFORE
July 25, 2019	December 31, 2022	5 - 1 Year	December 31, 2022

PAYMENT TERMS	DELIVERY TIMEFRAME
NET 45	N/A

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

MINIMUM DELIVERY REQUIREMENTS

N/A

DESCRIPTION OF CHANGE NOTICE

OPTION	LENGTH OF OPTION	EXTENSION	LENGTH OF EXTENSION	REVISED EXP. DATE
☒	2 - One Year	☐		December 31, 2024

CURRENT VALUE	VALUE OF CHANGE NOTICE	ESTIMATED AGGREGATE CONTRACT VALUE
$90,000,000.00	$0.00	$90,000,000.00

DESCRIPTION

Effective January 1, 2023, the State is exercising 2 option years. The revised Contract expiration date is December 31, 2024. In addition, the updates in Change Notice 1, Attachment 1 are incorporated.

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

Change Notice 1, Attachment 1
Contract No. 190000000755

1.) **Contract Cover Page and Schedule A Title** is updated from Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO to Behavioral Health and Substance Use Disorder Benefits (BH/SUD) for the State Health Plan PPO.

2.) Effective 1/1/2020, this contract no longer covers BH/SUD benefits for retirees enrolled in the State Health Plan Medicare Advantage PPO.

3.) **Schedule A, Section 4.3.D Reporting** is updated and replaced with the language below which adjusts language to monthly, quarterly, and annual reports and adjusts report due date timing:

D. The Contractor must provide their standard report package in addition to the required reports below. See **Schedule H Sample Claims Report and Invoice Format**. Failure to adhere to the timeframes indicated will result in penalties.

Monthly Schedule **Contractor must provide complete monthly reports on the 15th of the second subsequent month, (e.g., October reporting is due December 15th).**		
Quarterly and Annual Schedule		
Quarter designation	**Date Range (inclusive)**	**Report Due Date**
First Quarter (Q1)	January 1 - March 31	May 15
Second Quarter (Q2)	April 1-June 30	August 15
Third Quarter (Q3)	July 1 – September 30	November 15
Fourth Quarter (Q4) (includes annual CY reporting)	October 1 – December 31	March 15 next calendar year
Fiscal Year (FY) Financial Reporting		
Projected claims trend factors for two upcoming FYs		August 31
Estimate of IBNR claims & total claims billed/paid (split by actives & retirees)		October 20

1) Monthly reports. These reports must be split between Actives, COBRA and Retirees:
   a. Monthly Dashboard
      1. A brief summary of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months, including fraud detection and remedy (i.e. Executive Summary).
      2. Claims reporting, showing number of claims paid in the month, total number of subscribers who obtained services, and the total plan paid and member paid dollars, and split by In-network and Out of Network.
      3. Number of subscribers and dependents covered. This enrollment count is provided by the State of Michigan's Financial Services department due to Contractor system limitations.
   b. Claims Lag report, separated by Actives, COBRA participants, and Retirees (broken out by retirement system, SERS, SPRS, JRS & MRS), updated monthly for year-to-date claims.

c. Service Availability report. The Service Availability Report must include all systems/solutions utilized to service this Contract. See Schedule M, Service Availability Report for the required Service Availability Report format.

2) Quarterly reports.

a. Quarterly and YTD summaries of Claims Reporting to include:

1. Claim volume
   - Claims cost per contract
   - Number of members utilizing services
2. Financial reporting of Plan Sponsor and member cost share
   - By provider level
   - By Current Procedural Terminology (CPT) code
3. Performance Standard Guarantee Report detailing the Service Level Agreements with supporting documentation provided upon request of Plan Sponsor.
4. Utilization review and case management summaries, which provide the following items:
   - Response time in days to practitioner's request for authorization of admission and continued care.
   - Time in days from the day of admission or referral to the day reviewed.
   - Admits per thousand and Average Length of Stay (ALOS) for adults and adolescents for claims under case management.
   - Number of reconsideration claims submitted and length of time in days to make reconsideration.
   - Reversal rate for medical necessity decisions for internal reconsideration and external appeals.
   - Case management information, including the number and cost of case management activities, referencing the type of provider utilized, and focus of task.
   - Number and percent of total cases in case management that resulted in alternative treatments.
   - Percentage of members terminating treatment prior to completion of treatment plan.
5. Network and Utilization Management report, including the following items:
   - Number of providers identified as requiring further investigation.
   - Number of providers for which more details were requested and are currently pending, with number concluded with no adverse recommendations.
   - Percent of providers reviewed in monitoring patterns of abuse.
   - Average time from identification of the problem to conclusion of the investigation.
   - Number of complaints made and the number unresolved.
   - Summary of all reconsiderations and appeals.
   - Number of providers and ratio of providers to claims.
6. Professional reviews and/or audits conducted during the period.
7. Grievance and Appeal reporting that details the count, issue, date received and responded to, and outcome.

3) Annual Reports**.**

a. Annual attestation for HIPAA privacy and security compliance. (See also Section 1.C.3).
b. Management summary: Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis.
c. Claims coordinated, split by claims coordinated with the State-sponsored health plans, and by spouse's employer-sponsored medical or MHSA plans.
d. Results of member satisfaction surveys
e. Annual SSAE SOC 1 and SOC 2 Type II with applicable bridge report
   i. Contractor must supply Plan sponsor with an annual copy of the results of this audit. If the report is qualified, a memo will be issued providing further information around the qualification including remediation efforts to be undertaken to address the risks (if applicable).
   ii. Subject to BCBSM's corporate policies and procedures, Contractor will provide to Plan Sponsor additional information pertaining to internal controls upon request.

iii. Contractor must provide Plan Sponsor with a memo that provides further information on the remediation efforts to be undertaken to address the risks viewed as significant by the auditor and provide regular updates on those items until they are resolved.
iv. If Contractor's current SOC report has qualifications which are viewed as significant by the auditor, the Contractor must provide the Plan Sponsor with the corrective action plan and provide regular updates until issues have been corrected. If the SOC reporting does not cover through September 30 of the current fiscal year, a bridge/gap letter to cover the full fiscal year must accompany it.
v. Contractor will obtain and review SOC 1 Type 2 and/or SOC 2 Type 2 or equivalent reports from subcontractors who are deemed by the contractor to have financially significant impact to the contractor. The determination of financial significance is made by the contractor and may change each year. For subcontractors deemed to be financially significant by the contractor that provide a service significant to the State, the contractor will review and monitor compliance with a corrective action plan for any qualified reports and for any exceptions noted for control activity applicable to operations applicable to Plan Sponsor. Contractor will also perform a vendor security assessment and/or request a valid HITRUST certification for subcontractors that will have access to confidential data and/or data systems. Contractor will provide annual attestation of completion of Subcontractor security review.
vi. If the audit report does not cover through September 30th of the current year, the Contractor must provide a bride/gap letter to cover the full fiscal year for the Plan Sponsor. The audit report must be submitted within 15 days of availability.

The Contractor will provide access to standard reporting through Whyzen Analytics. Over 100 standard reports will be available in the tool. These reports will include all types of services, such as inpatient, outpatient, professional, and pharmacy claims, and also sorted by product categories such as PPO, HMO, etc. Included in these reports will be standard reports, such as use, cost, trends, and episodes of care.

Reports will be updated monthly on the most recent rolling 39 months. Standard reports will have a 1 month run-out for incurred claims, however run-out periods can be adjusted between 0 and 3 months. Users can also create their own standard reports and schedule them to update on a routine basis.

All reporting can be obtained through the Contractor or via self-service. Standard reporting will be available monthly, quarterly, and annually (calendar and rolling). Reports can be scheduled to be run automatically with each update or can be run manually anytime.
The Contractor will work with the Plan Sponsor’s technical team to provide Cobra reporting by October 1, 2019. The Plan Sponsor will provide the proper COBRA indicators to the Contractor. In addition, the Contractor will partner with the Plan Sponsor to develop any new standard reporting as needed for monthly, quarterly, or annual reporting

f. Pursuant to the Consolidated Appropriations Act (CAA) of 2021, group health plans and health insurance issuers must submit an annual report to the federal government with information about prescription drugs and health care spending. BCBSM agrees to support the State’s compliance with the spending and utilization reporting requirements under Section 29 USC 1185N by generating and submitting D1 and D2 reports and providing associated narrative responses on behalf of the State containing medical and behavioral health data for the 2020 and 2021 reference years. Contractor’s support for the 2022 reference year and thereafter will be discussed and agreed upon with the State.

4.) **Schedule A., Section 1.E.7 Utilization Management (UM) and Quality Assurance** is updated and replaced with the language below which incorporates timing clarifications:

7) The Contractor must regularly conduct satisfaction surveys of their Network Providers.

The Contractor will conduct a provider satisfaction survey on an annual basis upon the Plan Sponsor's request beginning the earlier of the next July 1st or next January 1st. There will be no provider satisfaction survey conducted in calendar year 2022. The primary focus of the survey will be utilization management services. Behavioral health providers will be included and the outcomes will be reviewed to identify areas of improvement. The Contractor's Sample Provider Survey is attached as Schedule N, Sample Provider Survey and changes may be made by mutual agreement between Contractor and Plan Sponsor.

5.) **Schedule A, Section 1.F.2 Member Support** is updated and replaced with the language below which revises clinician responsibilities in 2.b.7:

2) The Customer Service call center must, at a minimum include:
   a. A single front-end toll-free dedicated telephone number with touch-tone routing (if necessary) for Customer Service staff to respond to Member requests for participating Provider locations, for questions on Claims and Access, and complaints about Providers and Services.
   b. The toll-free line must be available 24/7 and 365 days a year. This line must be staffed at a level guaranteeing the following:
      1. Incorporation of a State of Michigan specific script to guide a member to other resources available through State of Michigan.
      2. Warm transfer to other SHP PPO carrier case management staff (medical or prescription)
      3. No busy signals
      4. Call pick-up by the third ring or under 30 seconds
      5. Call abandonment less than 2%
      6. There are specific procedures to handle emergency calls during and after hours and specific procedures to handle threats of violence.
      7. Clinicians and non-clinicians can make referrals, basing their decision on the caller's identified needs and a brief assessment. Triage clinicians will be completely trained on State of Michigan's medical benefits and other related programs, including Plan Sponsor's Employee Services Program.

         Clinicians will handle referrals relating to a) urgent/emergent needs b) callers extremely agitated and/or who have escalating behavior on the phone (e.g., crying, yelling, etc.) c) callers interested in case management or who have an assigned case manager and d) callers seeking substance use disorder information/treatment or inquiring about a higher level of care.

         Non-clinicians may handle referrals relating to a) non-urgent/emergent need for services b) routine referral requests for lower levels of care providers/services and c) inquiry on behalf of a family member or friend.

The Contractor will utilize the Genesys omnichannel communications system, and is able to see, in real-time, metrics posted on screens throughout the call center (e.g., average speed to answer, abandonment rate, availability, utilization, and occupancy). Throughout each day the workforce manager will provide reports to the managers showing average speed to answer, abandonment rates, calls forecasted, and other relevant metrics for each staff member compiled to that point in the day. Summary reports will also be supplied to managers daily for the previous day's metrics.
The behavioral health services team will assist members with:

- Finding and making an appointment with a behavioral health provider to meet their specific needs
- Locating community resources and support (e.g., food pantries, transportation, financial assistance)
- Warm transfers to Blue Cross Blue Shield of Michigan case management staff to assist with facilitating an integrated care experience for members with comorbid medical and behavioral health conditions
- Warm transfers to any other health and wellness vendors the State of Michigan utilizes
- Access to self-management resources and tools

Members calling the toll-free number can “press 1 if this is an emergency” to immediately speak to a behavioral health clinician. The behavioral health clinician will conduct a focused screening with the member using a structured interview to determine the level of urgency (emergent, urgent or routine) and the level of care necessary to address the member’s clinical needs safely and effectively. All emergent and urgent referrals will be followed up on by the Contractor to assure that the participant presented for evaluation. If the member did not present, the clinician will attempt to contact the member to ensure their safety and assist them in obtaining appropriate care. In cases where the member is in imminent danger, the clinician will contact law enforcement to intervene and will stay on the phone with the member until help arrives.

For routine calls when a member is seeking services, a Contractor behavioral health clinician will conduct a clinical assessment for mental health and substance abuse conditions, urgency (e.g., emergent, urgent or routine), and the level of care necessary to address the members immediate clinical needs safely and effectively. The clinician will conduct a structured interview with the member and utilize screening tools such as PHQ-9, GAD-7, and/or CAGE to complete the comprehensive assessment. The clinician will then assist the member with a referral to a behavioral health provider who can best meet their clinical needs.

6.) **Schedule A, Section 1.G** is updated and replaced which revises language in Section 1.a.4 and Section 3:

A. Member Communications Materials and Meetings

1) Member Communication Materials

a. All communication materials must be provided in a web-ready format and reviewed and approved by Plan Sponsor in advance of distribution. All communication materials presented to Plan Sponsor for approval must allow for 10 business days for review and editing. 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 including, but not limited to the following:

1. The Contractor must create both a brief Guide to Accessing Care and a detailed Plan Booklet for members which accurately aligns with Plan Sponsor’s Plan Design.

2. The Contractor must provide reimbursement and claim forms which have been reviewed and approved by Plan Sponsor.

3. The Contractor must prepare and distribute, at its own cost, all communication materials, including but not limited to announcements, letters, notices, brochures, forms, postage, and other supplies and Services for distribution to Members.

4. Customized Member communications must be provided, by the Contractor to Members, at no additional charge and are subject to the Plan Sponsor’s approval. This also includes co-branding materials with the name of Contractor and Plan Sponsor, where desired by Plan Sponsor. Materials must be customized and Plan Sponsor approved. Open enrollment materials must be available by July 25th of each year.

5. The Contractor must provide Explanation of Benefits (EOB) that details charges, copays, outstanding benefit limits, and contact information for following up with questions or Appeal in easy-to-read language. Any denial of claims must have a detailed, understandable explanation of reason for denial.

2) Meetings:

a. The Contractor must provide speakers at meetings designated by Plan Sponsor at no additional charge to the Plan Sponsor. Meeting requests may vary from year-to-year.

b. In addition to Plan Sponsor designated meetings, the Contractor may receive requests for speakers from Member support organizations (i.e.: State Employees Retiree Association or state employee unions). All requests for meetings must be channeled through the Plan Sponsor and accommodated upon request. If the Contractor is unable to accommodate a meeting request, the Contractor must seek and obtain Plan Sponsor approval for excusal.

c. The Contractor must agree to participate in health fairs for State of Michigan members in a frequency mutually agreed to by the Contractor and Plan Sponsor.

3) Member Satisfaction: The Contractor must send a Plan specific member satisfaction survey, that is mutually agreed upon between the Plan Sponsor and Contractor on an annual basis. The Contractor must report results of the survey to the Plan Sponsor in conjunction with annual reporting requirements. All areas where Member satisfaction levels are low must be remedied by the Contractor within a timeframe acceptable to the Plan Sponsor. Sample sizes of responses must be sufficient to produce statistically valid results.

The Contractor will survey a population of members whom have had at least one behavioral health unit in the prior 12 months. A service unit is defined as a member who has an authorized visit with a provider and/or contact with the Contractor. The survey will be fielded in the fall of each year, via postal mail, using a two-wave approach. In the event there is no reply to the first mailing, a second survey will be mailed.

Objectives for the member satisfaction study include:

- Measurement of the member experience with the Contractor, including overall satisfaction
- Measurement of the member's health status and perceived improvement in their health, as compared to the previous twelve months
- Measurement of the members' experience with his/her behavioral health provider, access and overall rating of behavioral health care treatment
- Assessment of the members' perception of medical/behavioral integration around their plan of care (e.g., communication between behavioral health and primary care providers)
- Insight into the members' experience with the Contractor and the services received, such as customer service or case management
- Member perceptions as to how their ability to function in daily life has changed within the last twelve months
- Determination as to how well members' cultural and linguistic needs and preferences were accommodated

Member survey data will be reviewed by the Contractor Quality Management Committee. Year- over-year data and key driver analyses will be compared to identify areas where the Contractor has improved and areas where there are opportunities to improve upon. Action plans are then developed to improve member satisfaction with our services.

In addition to the annual member satisfaction surveys and after-call surveys, program surveys will also be conducted to measure member satisfaction and gather feedback on specific programs and services. Members in our case management program will be offered a survey of their experience with case management upon completion of the case management program. Results will be compiled and reviewed on a monthly basis.

4) The Contractor must supply a hyperlink to an electronic Provider directory to the Plan Sponsor for placement on the Plan Sponsor's website.

7.) **Schedule A, Section 3.4.A Key Personnel** is updated and replaced with the language below which adjusts the key personnel positions from 5 to 4 and updates names of assigned individuals:

A. The Contractor must appoint 4 dedicated key personnel positions to work with Plan Sponsor benefits and employee assistance program (ESP) staff, and 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 1 business day.

Contractor may identify personnel and positions in addition to the list of the required Key Personnel positions below which includes:

Key Personnel	Minimum Experience Recommended
Senior Account Manager (SAM)	-Five (5) years of Account Management with accounts of similar size and scope to Plan Sponsor's.
Back-Up to the SAM	- Five years of Account Management.
Data/Eligibility Specialist	At least three years of eligibility file upload and integration experience.
Clinical Expert	No minimum experience recommended

The Contractor must identify all Key Personnel who will be assigned to this contract including the following for each individual:

a. Name of staff designated.
b. Years of experience and title, in their current classification.
c. Which of the 5 required key personnel positions they are fulfilling.
d. Key Personnel's roles and responsibilities for this Contractor
e. Identify if Key Personnel is a direct, subcontract, or contract employee.
f. Identify if Key Personnel is employed full-time, part-time or temporarily.
g. Length of employment or affiliation with the Contractor's organization.
h. Identify Key Personnel's percentage of work time devoted to this Contract versus Key Personnel's staff member's total overall workload.
i. Identify where Key Personnel staff member will be physically located (city and state) during the Contract performance.

1. Name	*3. Position*	4. Role(s) / Responsibilities	5. Direct/ Subcontract / Contract	6. FT/ PT/T	8. % of Work Time	9. Physical Location
Arva Overton	SAM	Responsible for overseeing all aspects of the Plan Sponsor's contract; functioning as the single point of accountability to ensure the group's servicing expectations are met.	Direct	FT	100%	Detroit, MI
Sydney Lipsey	Back-Up SAM	Back up SAM in servicing Plan Sponsor when needed	Direct	FT	25 – 50% - allocated accordingly	Detroit, MI
Holly Blundo	Data/Eligibility Specialist	Process member eligibility updates from the weekly 834-member eligibility files along with completing enrollment updates	Direct	FT	75%	Detroit, MI

Veena Luthra, MD	Clinical Expert	Peer reviews, case rounds, interface with BCBSM Medical Director	Subcontractor	FT	20%	Plymouth, MI

8.) **Schedule C Plan Design and Claim Payment Rules** is updated and replaced with the attached Schedule C Plan Design and Claim Payment Rules, with updates as described in the following table:

Benefit Description	**Updated Detail**
Year	Plan year for enrollment and benefit changes begins January 1st. The 4th quarter carryover provision is retained for the active population but eliminated for retiree members.
Autism Spectrum Disorders (Including ABA)	Pre-certification (authorization) required Annual Maximums are removed for each age group.
Bridge Appointments	Certification is not required. Please see Outpatient BH.
Inpatient Behavioral Health	Pre-certification (authorization) required
Inpatient Substance Use Disorder	Pre-certification (authorization) required
Laboratory Expense	Not applicable. All laboratory expenses will be paid through the health benefit.
Neuropsychological Testing – outpatient or office	Covered 90% of allowed amount and no certification (authorization) required for In-Network or Out-of-Network services
Psychological Testing – outpatient or office	Covered 90% of allowed amount and no certification (authorization) required for In-Network or Out-of-Network services
Outpatient SA	No certification (authorization) required for In-Network or Out-of-Network services. $3,500 calendar year maximum benefit for services for chemical dependency removed.
Tele-behavioral health	Effective 1/1/2023 Copay is eliminated for use of carrier's online telehealth tool. Copay remains the lesser of $20 or 10% for online visits using the provider's telehealth tool.

9.) **Standard Contract Terms Section 2 Notices** and **Section 3 Contract Administrator** is updated and replaced with the language below which updates the Contractor assigned representative to Gary Gavin:

> **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:
Mary Ostrowski 525 W Allegan St., 1st Flr NE Lansing MI 48909 ostrowskim@michigan.gov 517-249-0438	Gary Gavin 600 E. Lafayette Blvd – Mail Code 516F Detroit, MI 48226-2998 ggavin@bcbsm.com 313-448-5683

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:
Mary Ostrowski 525 W Allegan St., 1st Flr NE Lansing MI 48909 ostrowskim@michigan.gov 517-249-0438	Gary Gavin 600 E. Lafayette Blvd – Mail Code 516F Detroit, MI 48226-2998 ggavin@bcbsm.com 313-448-5683

10.) **Schedule K, HIPAA Business Associate Agreement** is updated and replaced with the attached Schedule K, which updates the Business Associate Representative to Gary Gavin:

Gary Gavin VP – Autos & Natl & Key Accounts
600 E. Lafayette Blvd – Mail Code 516F
Detroit, MI 48226-2998
(313) 448-5683
ggavin@bcbsm.com

11.) **Schedule A, Section J Performance Guarantees /Service Level Agreements (SLAs)** is updated and replaced with Section J below.

J. Performance Guarantees / Service Level Agreements (SLAs)

1) The Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. 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 under Standard Contract Terms.

2) Within the time specified after the end of each reporting period, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA and provide payment for any applicable credits to the Plan Sponsor annually via invoice credit. The SLAs relate to on-going Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised).

3) SLA Reports: Any metric that is reported must be accompanied by supporting documentation upon request of the Plan Sponsor and retained by Contractor for a mutually agreed-upon timeframe. SLAs without a corresponding report will be deemed unmet and subject to the credits. SLA Reporting Format must be mutually agreed-upon by the Plan Sponsor and Contractor.

4) Service Level Agreement Settlements:

a. Quarterly. In conjunction with the payment development for the next Quarterly Payment Period, BCBSM will, approximately sixty (60) days after the close of each Quarterly Payment Period,

provide a detailed settlement showing Amounts Billed to and owed by the State during the prior available Quarter including any surplus or deficit amounts. Credits for missed SLA(s) will be against the administrative fees billed by the Contractor and will be reflected on an invoice as soon as administratively feasible but no later than the end of the next quarterly reporting period. By mutual agreement the credit may be made annually before the end of the first quarter of the next year.

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

5) SLAs are for all Services provided under this Contract for the Plan Sponsor as detailed in the Table below.

SLA #1A & 1B: Eligibility Files
Guarantee
A.) The Contractor must upload and accurately process eligibility files (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) within one business day of receiving them from the State. B.) Discrepancies must be reported in the Contractor's standard report format within two business days after the eligibility files have been uploaded. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet the requirement for the Eligibility Upload SLA (#1A) is 2% of the monthly administrative fees for each month missed. The credit for failure to meet the requirement for the Discrepancy Reporting SLA (#1B) is 2% of the monthly administrative fees for each month missed.
SLA #2A & 2B: Identification (ID) Cards
Guarantee
A.) 100% of ID cards must be created and distributed through the U.S. Mail within 10 business days of receipt of the Plan Sponsor's eligibility file. Performance must be substantiated by documentation providing proof of receipt date and mailing date. B.) ID Cards must have an accuracy rate of 99% or higher. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet the requirement for the Identification Card Timeliness SLA (#2A) is 1.0% of the monthly administrative fees for each month missed. The credit for failure to meet the requirement for the Identification Card Accuracy SLA (#2B) is 1.0% of the monthly administrative fees for each month missed.
SLA #3A – #3B: Average Claims Turnaround

Guarantee
A.) 94% of all claims must be processed within 14 calendar days; assumes that the claims are filed completely and with valid information. B.) 99% of all claims must be processed within 30 calendar days; assumes that the claims are filed completely and with valid information. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet the requirement for SLA #3A is 1.0% of the monthly administrative fees for each month missed. The credit for failure to meet the requirement for SLA #3B is 1.0% of the monthly administrative fees for each month missed.
SLA #4: Claims Processing Accuracy (Non-financial Error Rate)
Guarantee
The non-financial error rate (as defined as the number of claims with a non-financial error divided by the total number of claims) must not exceed 2.0%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #4) is 1% of the monthly administrative fees for each month missed.
SLA #5: Payment Incident Accuracy
Guarantee
The financial error (as defined as the number of claims containing a financial error divided by the total number of claims) must not exceed 3%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #6) is 1% of the monthly administrative fees for each month missed.
SLA #6: Financial Payment Accuracy
Guarantee

Financial Accuracy measures the percentage of benefit dollars paid correctly. The financial accuracy rate calculation is the total dollars paid in the sample, less the absolute value of overpayments and underpayments, divided by the total dollars paid in the sample. The acceptable error rate for each year of the Contract will be 0.7%.

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

Credit

The credit for failure to meet this requirement (SLA #6) is 1% of the monthly administrative fees for each month missed.

SLA #7A – 7B: Customer Service Response Time to Written Inquiries

Guarantee

A.) Contractor must resolve 90% of all Written Inquiries within 14 calendar days of receipt. Written inquiries mean any inquiry other than telephonic. They include mail, email, fax, or web portal inquiries and include those submitted to the Contractor by the Plan Sponsor. The receipt date will be considered the date the Written Inquiry is received by the Contractor.

B.) 100% of all Written Inquiries must be resolved within 30 calendar days.

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

Credit

The credit for failure to meet the requirement for SLA #7A is 1.0% of the monthly administrative fees for each month missed.

The credit for failure to meet the requirement for SLA #7B is an additional 1.0% of the monthly administrative fees for each month missed.

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SLA #8: Customer Service Call – Average Speed of Answer

Guarantee

On a monthly basis, calls must be answered within an average of 30 seconds. The average speed of answer is the average length of time a caller waits in queue prior to the call being answered by a customer service representative.

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

Credit

The credit for failure to meet this requirement (SLA #8) is 1.0% of the monthly administrative fees for each month missed.

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SLA #9: Customer Service Response Time - Percent of Calls Abandoned
Guarantee
The monthly call abandonment rate must not exceed 2.0% (determined by the number of calls abandoned divided by the total number of calls). A call will be considered abandoned if the Member hangs up at any time after initiating a transfer out of the Interactive Voice Response (IVR) system. The Contractor must measure monthly and report their performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #9) is 1% of the monthly administrative fees for each month missed.
SLA #10: Participating Provider List Audit
Guarantee
Contractor must perform a random audit of 3% of the Michigan based In-Network participating provider list to assure accuracy of identified providers accepting new patients and guaranteeing appointment availability. The Contractor must measure monthly and report their performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #10) is 1% of the monthly administrative fees for each month missed.
SLA #11: Network Accessibility
Guarantee
97% of provider appointments must be offered within the following timeframes: • Immediate for Emergency (Life-threatening) • 6 hours for Emergency (Non-Life-threatening) • 48 hours for urgent • 10 calendar days for routine The Contractor must measure monthly and report their performance on this SLA on an annual basis.
Credit
The credit for failure to meet this requirement (SLA #11) is 4% of the annual administrative fees.
SLA #12: Network Access Standards
Guarantee

Network Access is at least 95% of the standards outlined in Section 1.D.2; calculation of access will exclude any providers operating with income dependent access restriction (e.g., community mental health facilities/providers) or those not accepting new patients.

The following is not subject to this SLA: Network Access in rural areas where there is a shortage of MD/DO specializing in child/adolescent psychiatry and where there is a shortage of ABA board certified providers.

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

Credit

The credit for failure to meet this requirement (SLA #12) is 4% of the monthly administrative fees for each month missed.

SLA #13A – 13C: Timely Production of Complete Management Reports

Guarantee

A.) Contractor must provide complete monthly reports on the 15th of the second subsequent month (e.g., October reporting is due December 15th).

B.) Contractor must provide complete quarterly reports on the following dates:
Q1: 05/15 of the current calendar year
Q2: 08/15 of the current calendar year
Q3: 11/15 of the current calendar year
Q4: 03/15 of the next calendar year.

C.) Contractor must provide complete annual reports on 03/15 of the next calendar year.

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

Credit

The credit for failure to meet the monthly reporting requirement (SLA #13A) is 2% of the monthly administrative fees for each month missed.

The credit for failure to meet the quarterly reporting requirement (SLA #13B) is 2% of the combined monthly administrative fee for the months in that quarter.

The credit for failure to meet the annual reporting requirement (SLA #13C) is 2% of the full annual administrative fee.

Description	Detail
Reimbursement and Allowed Amount – Out of Network	Usual & Customary Rate based on FairHealth or Medicare rates or billed charges, or In Network allowed amount; (whichever is less).
Claims Filing Limitation	12 months from date of service for all providers
Pre-existing conditions	No pre-existing condition clause applies.
Certification	Preauthorization of services where required for full provider reimbursement at network rates.
Coordination of benefits	• Birthday Rule • Lesser of A. balance of the service, or B. amount that would have been paid if SHP PPO was primary • Medicare coordination is in accordance with Medicare primacy rules
Lifetime Maximum	None
Year	Plan Year for enrollment and benefit changes begins January 1st. Deductibles and Maximums reset with the Calendar Year. This provision for 4th quarter carryover is retained for the active population but eliminated for retiree members: Plan includes 4th quarter carryover: Any amount accumulated toward in-network deductible for dates of service from October 1-December 31 will carry over and be applied toward the in-network deductible the following year. Calculations made by Health Plan Accumulator Contractor.
Plan Deductible	In Network $400 Individual/$800 Family. Out-of-Network $800 Individual/$1,600 Family. Shared with other carriers to track Out of Pocket Maximum (OOPM) Calculations made by Health Plan Accumulator Contractor.
Out of Pocket Maximum (OOPM)	In Network $2000 individual/$4000 Family. Out-of-Network $3000 individual/$6000 Family Shared with other carriers to track Out of Pocket Maximum (OOPM) Calculations made by Health Plan Accumulator Contractor.
Autism Spectrum Disorders Including Applied Behavioral Analysis (ABA)	Covered 90% of allowed amount In Network after deductible Covered 80% of allowed amount Out of Network after deductible Pre-certification (authorization) required. Annual Maximum does not apply.
Tele-behavioral health – Carrier's online tool	Covered In-Network only For the carrier's online telehealth tool covered in-network only. effective 1/1/2023 Copay is eliminated for use of carrier's online telehealth tool.
	Medicare Enrolled individuals not eligible.

Tele-behavioral health – Provider's online tool	In-Network	Covered the lesser of $20 copay or 10%
	Out-of-network	Covered 50% of allowed amount or billed charges (whichever is less)
Outpatient BH	In-Network	Covered 90% of allowed amount
	Out of Network	Covered 50% of allowed amount or billed charges (whichever is less)
Outpatient SA Includes Office Based Opioid Treatment & Methadone Maintenance	In-Network	Covered 90% of allowed amount No certification (authorization) required
	Out of Network	Covered 50% of allowed amount No certification (authorization) required or billed charges (whichever is less)
Detox	• Substance abuse/Sub-acute detox is covered and is included in the normal annual limits. • All detox services are covered under Inpatient benefits, including ambulatory and outpatient detox and paid at 100%. • Acute detox is covered under the medical benefits.	
Inpatient BH – 365 days/year	• 365 days per calendar year for both INN and OON	
	In-Network	• Covered 100% of allowed amount Pre-certification (authorization) required
	Out of Network	• Covered 50% (allowed amount or billed charges; whichever is less) • Pre-certification (authorization) required
Inpatient SA	• Up to 28 days per treatment period; maximum of two periods per calendar year • SA treatment periods must be separated by at least 60 days (either in or out of network). If a member relapses soon after discharge a second inpatient may be included as the same treatment period but combined cannot exceed the 28 day total. Second SA treatment period is renewable after 60 days from the date of discharge. • Prior Plan Sponsor approval required to waive 60-day separation.	
	In-Network	• Covered 100% of allowed amount • Pre-certification (authorization) required
	Out of Network	• Covered 50% (allowed amount or billed charges; whichever is less) • Pre-certification (authorization) required
Bridge Appointments	In-Network	• Covered 100% of allowed amount Certification is not required. Please see Outpatient BH
	Out of Network	• Not covered
Alternative Levels of Care	• Residential – 1:1 to inpatient (Substance Abuse Only) • Halfway House– 2:1 to inpatient (only if clinical services are provided) • Partial Hospital – 2:1 to inpatient • IOP –2:1 to inpatient	
Psychological Testing – outpatient or office	• Covered 90% of allowed amount and no certification (authorization) required for In-Network or Out-of-Network services	
Neuropsychological Testing – outpatient or office	• Covered 90% of allowed amount and no certification (authorization) required for In-Network or Out-of-Network services	

Electro-Convulsive Therapy (ECT)	In-Network	• Outpatient (OP) ECT will pay as one partial hospital day at 100% of the allowed rate. • Anesthesiology – covered at 100% of allowed amount. • Hospital, psychiatrist and other associated costs covered 100% of allowed amount.
	Out of Network	• Outpatient (OP) ECT will pay as one partial hospital day at 50% (allowed amount or billed charges; whichever is less). • Anesthesiology – covered at 100% of allowed amount. • Hospital, psychiatrist and other associated costs covered 50% (allowed amount or billed charges; whichever is less).
Emergency Room	• $200 Copay (waived if admitted to same facility with a BH or SA diagnosis) • All others are processed by medical carrier.	
Laboratory Expense:	• Not applicable. All laboratory expenses will be paid through the health benefit.	
Ambulance	Medically necessary ambulance charges, covered 90% after deductible.	
Excluded Services	• Residential Mental Health • rTMS • Biofeedback • Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide. • Hypnotherapy • Marital counseling • Psychodrama • Art therapy • Recreation therapy • Counseling for vocational, academic, or education purposes • Court-ordered psychotherapy, including substance abuse • Services received at private residences • Phone consultations or therapeutic phone questions • Music therapy • Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member. • Serviced provided while the member is not covered for this benefit. • Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice. • Claims deemed fraudulent which, through the exercise of due diligence by contractor could have been prevented • Completion of any insurance form • Medical services or drugs not administered for BH/SA treatment.	
Diagnosis Codes:	Mixed Service Protocol with ICD-10 codes for included and excluded services will be discussed by Plan Sponsor and Contractor, and any questions resolved prior to implementation.	

SCHEDULE K

HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the State of Michigan State Health Plan PPO ("Covered Entity") and Blue Cross Blue Shield of Michigan ("Business Associate").

RECITALS

A. Under this Agreement, Business Associate will collect or receive certain information on the Covered Entity's behalf, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, Business Associate agreesto protect the privacy and security of the information as set forth in this Agreement.

B. Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI collected or received by Business Associate under the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HIPAA Rules, as amended.

C. The HIPAA Rules require the Covered Entity to enter into an agreement containing specific requirements with Business Associate before Business Associate's receipt of PHI.

AGREEMENT

1. Definitions.

   a. The following terms used in this Agreement have the same meaning as those terms in the HIPAA Rules: Breach; Data Aggregation; Designated Record Set; Disclosure; Health Care Obligations; Individual; Minimum Necessary; Notice of Privacy Practices; Protected Health Information; Required by Law; Secretary; Security Incident; Security Measures, Subcontractor; Unsecured Protected Health Information, and Use.

   b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103, and as used in this agreement refers to Blue Cross Blue Shield of Michigan.

   c. "Covered Entity" has the same meaning as the term "covered entity" at45 CFR 160.103 and regarding this Agreement means the State of Michigan State HealthPlan PPO.

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

2. Obligations of Business Associate. Business Associate agrees to:

   a. use and disclose PHI only as permitted or required by this Agreement or as required by law.

   b. implement and use appropriate safeguards, and comply with Subpart C of 45 CFR164 regarding electronic protected health information, to prevent use or disclosureof PHI other than as provided in this Agreement. Business Associate must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relativeto the size and complexity of Business Associate's operations and the nature andthe scope of its activities.

   c. report to the Covered Entity within five calendar days of any use or disclosure ofPHI

not provided for by the Agreement of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If BusinessAssociate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and Business Associate will cooperate in investigating whether abreach has occurred, to decide how to provide breach notifications to individuals,the federal Health and Human Services' Office for Civil Rights, and potentially themedia.

d. ensure, according to 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, thatany subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate regarding such information. Each subcontractor must sign an agreement with Business Associate containing substantially the same provisions as this Agreement. Business Associate must implement and maintain sanctions against subcontractors that violate such restrictions and conditions and must mitigate the effects of any such violation.

e. make available PHI in a Designated Record Set to the Covered Entity within tendays of a request from the Covered Entity to satisfy the Covered Entity's obligations under 45 CFR 164.524.

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under, 45 CFR § 164.526. If any individual requests an amendment ofPHI directly from Business Associate or its agents or subcontractors, Business Associate must notify the Covered Entity in writing within five days of the requestand amend the information within ten days of the request. Any denial of amendment of PHI maintained by Business Associate or its agents or subcontractors is the responsibility of Business Associate.

g. maintain, and within ten days of a request from the Covered Entity makeavailable, the information required to provide an accounting of disclosures to enable the Covered Entity to fulfill its obligations under 45 CFR §164.528. Business Associate is not required to provide an accounting to the Covered Entityof disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes asset forth in 45 CFR § 164.512(k)(2); (vi) to correctional institutions or lawenforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by BusinessAssociate and its agents or subcontractors for at least six years before the request,but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) abrief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure ora copy of the written request for disclosure. If the request for an accounting is delivered directly to Business Associate or its agents or subcontractors, BusinessAssociate must, within ten days of the receipt of the request, forward it to the Covered Entity in

writing.

h. to the extent Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity when performing those obligations.

i. make its internal practices, books, and records relating to Business Associate's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate must concurrently provideto the Covered Entity a copy of any PHI that Business Associate provides to the Secretary.

j. retain all PHI throughout the term of the Agreement and for a period of six yearsfrom the date of creation or the date when it last was in effect, whichever islater, or as required by law. This obligation survives the termination of the Agreement.

k. implement policies and procedures for the final disposition of PHI and thehardware and equipment on which it is stored, including but not limited to, removal of PHI before re-use.

l. within ten days of a written request by the Covered Entity, Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Agreement. Business Associate and the Covered Entity will mutually agree in advance upon the scope, timing and location of such an inspection. Covered Entityand Business Associate will execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement. Covered Entity's (i) failure to detector (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rightsunder this Agreement.

3. Permitted Uses and Disclosures by Business Associate.

a. Business Associate may use or disclose PHI:

(1) for the proper management and administration of Business Associate or to carry out its legal responsibilities; provided, however, either (A) the disclosures are required by law, or (B) Business Associate obtains reasonableassurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(2) as required by law;

(3) for Data Aggregation services relating to the health care operations of the Covered Entity;

(4) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If Business Associates de-identifies the PHI it receives from the Covered Entity, Business Associate may use the de-identified informationfor any purpose not prohibited by the HIPAA Rules; and

(5) In conformance with the provisions and requirements set forth in HIPAA, Business Associate may use PHI to create De-Identified Health Information and Limited Data Sets containing the minimum necessary amount of PHI reasonably needed for Research, Public Health or Health Care Operations activities; and

(6) may use and disclose a Limited Data Set for Research, Public Health or Health Care Operations purposes. Business Associate may make such use anddisclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of the underlying agreement between BusinessAssociate and Covered Entity.

b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specificuses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations Covered Entity agrees to:

a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to Business Associate under this Agreement until the PHI is received by Business Associate.

b. provide Business Associate with a copy of its Notice of Privacy Practices and must notify Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation mayaffect Business Associate's use or disclosure of PHI.

c. notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changesmay affect Business Associate's use or disclosure of PHI.

d. notify Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Term. This Agreement continues in effect until terminated or is replaced with a new agreement between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Agreement regarding breach, a breach by Business Associate of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreementand provides grounds for Covered Entity to terminate this Agreement for cause. Termination for cause is subject to 6.b.:

(1) Default. If Business Associate refuses or fails to timely perform any of the provisions of this Agreement, the Covered Entity may notify Business Associate in writing of the non-performance, and if not corrected within 30 days, Covered Entity may immediately terminate the Agreement. Business Associate must continue performance of the Agreement to the extent it is notterminated.

(2) Business Associate's Duties. Notwithstanding termination of the Agreement,and subject to any directions from the Covered Entity, Business Associate must protect and preserve property in the possession of Business Associate inwhich the

Covered Entity has an interest.

(3) Erroneous Termination for Default. If Covered Entity terminates this Agreement under Section 6(a) and after such termination it is determined, forany reason, that Business Associate was not in default, then such terminationwill be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Agreement had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement underSection 6(a), then Covered Entity must notify Business Associate of the pattern of activity or practice. Business Associate must then take reasonable steps to curesuch breach or end such violation, as applicable. If the Business Associate's effortsto cure such breach or end such violation are unsuccessful, Covered Entity may either (i) terminate this Agreement, if feasible or (ii) report Business Associate's breach or violation to the Secretary.

c. Effect of Termination. After termination of this Agreement for any reason, Business Associate, with respect to PHI it received from the Covered Entity, or PHI created, maintained, or received by Business Associate on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(2) return to Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that Business Associate still maintains in any form;

(3) continue to use appropriate safeguards and comply with Subpart C of 45 CFRPart 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for aslong as Business Associate retains the PHI;

(4) not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditionsset out at Section 3(a)(1) which applied before termination; and

(5) return to Covered Entity (or, if agreed to by Covered Entity in writing, destroy) the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

7. No Waiver of Immunity. The parties do not intend to waive any of the immunities, rights, benefits, protection, or other provisions of the Michigan Governmental Immunity Act, MCL 691.1401, *et seq*., the Federal Tort Claims Act, 28 U.S.C. 2671 *etseq.*, or the common law.

8. Data Ownership. Business Associate has no ownership rights in the PHI. CoveredEntity retains all ownership rights of the PHI.

9. Disclaimer. Covered Entity does not warrant or represent that compliance by Business Associate with this Agreement, HIPAA, or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

10. Certification. If Covered Entity determines an examination is necessary to complywith

Covered Entity's legal obligations under HIPAA relating to certification of itssecurity practices, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, proceduresand records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this Agreement.

11. Amendment. Upon the compliance date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of electronic PHI, or other aspects of HIPAA applicable to this Agreement or to the ASC, this Agreement will automatically amend such that the obligations imposed on Covered Entity and Business Associate remain in compliance with such regulations.
12. Assistance in Litigation or Administrative Proceedings. Business Associate must make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against Covered Entity, itsdirectors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules or other laws relating to Business Associate's or its subcontractors' use or disclosure of PHI under this Agreement, except where Business Associate or its subcontractor, employee or agent is a namedadverse party.
13. No Third-Party Beneficiaries. Nothing express or implied in this Agreement isintended to confer upon any person other than the Covered Entity, Business Associate, and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
14. Interpretation and Order of Precedence. Any ambiguity in this Agreement must be interpreted to permit compliance with the HIPAA Rules. In the event of any conflict between the mandatory provisions of the HIPAA Regulations and the HITECH Act and the provisions of this Agreement, the HIPAA Regulations and the HITECH Act shall control. Where the provisions of this Agreement differ from those mandated bythe HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement control.
15. Effective Date. This Agreement is effective upon receipt of the last approval necessary and the affixing of the last signature required.
16. Survival of Certain Agreement Terms. Notwithstanding any contrary provision in this Agreement, Business Associate's obligations under Section 6(c) and record retention laws ("Effect of Termination") and Section 13 ("No Third Party Beneficiaries") survive termination of this Agreement and are enforceable by CoveredEntity.
17. Representatives and Notice.
    a. Representatives. The individuals listed below are designated as the parties' respective representatives for purposes of this Agreement. Either party may fromtime to time designate in writing new or substitute representatives.
    b. Notices. All required notices must be in writing and must be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

Bethany C. Beauchine
Director, Bureau of Benefits Administration
Michigan Civil Service Commission
P.O. Box 30002
Lansing, MI 48909
(517) 284-0086
beauchineb@michigan.gov

with copy to:

Mary Ostrowski
Category Specialist
DTMB, Central Procurement
320 S. Walnut St.
Lansing, MI 48933
(517) 249-0438
ostrowskim@michigan.gov

Business Associate Representative:

Gary Gavin
Vice President, Autos & Natl & Key Accounts
600 E. Lafayette Blvd – Mail Code 516F
Detroit, MI 48226-2998
(313) 448-5683
ggavin@bcbsm.com

Any notice given to a party under this Agreement shall be deemed effective, if addressedto such party, upon: (i) delivery, if hand delivered; or (ii) the third Business Day after beingsent by certified or registered mail.

Covered Entity **State Health Plan PPO**	**Business Associate** **Blue Cross Blue Shield of Michigan**
By:_____	By:_____
Date: _____	Date: _____
Print Name: Bethany C. Beauchine	Print Name: Gary Gavin
Title: Director, Bureau of Benefits Administration, Michigan Civil Service Commission	Title: Vice President, Autos & Natl & Key Accounts

STATE OF MICHIGAN PROCUREMENT

Department of Technology, Management, and Budget
525 W. Allegan St. Lansing, MI 48933
P.O. Box 30026, Lansing, MI 48909

NOTICE OF CONTRACT

NOTICE OF CONTRACT NO. **190000000755**
between
THE STATE OF MICHIGAN
and

CONTRACTOR	
	Blue Cross Blue Shield of Michigan
	600 E Lafayette 517 J
	Detroit, MI 48226
	Arva Overton
	(313) 448-5912
	aoverton@bcbsm.com
	CV0024315

STATE			
	Program Manager	Bethany Beauchine	CSC, EBD
		(800) 505-5011	
		beauchineb@michigan.gov	
	Contract Administrator	Mary Ostrowski	DTMB
		(517) 249-0438	
		ostrowskim@michigan.gov	

CONTRACT SUMMARY			
DESCRIPTION:			
INITIAL EFFECTIVE DATE	**INITIAL EXPIRATION DATE**	**INITIAL AVAILABLE OPTIONS**	**EXPIRATION DATE BEFORE CHANGE(S) NOTED BELOW**
July 25, 2019	December 31, 2022	5 – One Year	December 31, 2022
PAYMENT TERMS		**DELIVERY TIMEFRAME**	
Net 45		N/A	
ALTERNATE PAYMENT OPTIONS			**EXTENDED PURCHASING**
☐ P-card ☐ Payment Request (PRC) ☐ Other			☐ Yes ☒ No
MINIMUM DELIVERY REQUIREMENTS			
N/A			
MISCELLANEOUS INFORMATION			
N/A			
ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION			**$90,000,000.00**

Standard Contract Terms

This STANDARD CONTRACT ("**Contract**") is agreed to between the State of Michigan (the "**State**") and Blue Cross Blue Shield of Michigan ("**Contractor**"), a Michigan corporation. This Contract is effective on July 25, 2019 ("**Effective Date**"), and unless terminated, expires on December 31, 2022. July 25, 2019 through September 30, 2019 is the implementation period, and services are to begin without interruption on October 1, 2019. No payment will be made to the Contractor during the implementation period. The implementation period begins with Contract award date through the Plan Effective Date.

This Contract may be renewed for up to five additional one-year period(s). Renewal is at the sole discretion of the State and will automatically extend the Term of this Contract. The State will document its exercise of renewal options via Contract Change Notice.

1. Definitions. For the purposes of this Contract, the following terms have the following meanings:

"**Acceptance**" has the meaning set forth in **Section 21**.

"**Affiliate**" of a Person means any other Person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, such Person. For purposes of this definition, the term "control" (including the terms "controlled by" and "under common control with") means the direct or indirect ownership of more than fifty percent (50%) of the voting securities of a Person.

"**Allegedly Infringing Materials**" has the meaning set forth in **Section 32**.

"**Authorized Users**" means all Persons authorized by the State to access and use the Software under this Contract, subject to the maximum number of users specified in the applicable Statement of Work.

"**Business Day**" means a day other than a Saturday, Sunday or other day on which the State is authorized or required by Law to be closed for business.

"Change" has the meaning set forth in **Section 7.**

"Change Notice" has the meaning set forth in **Section 7.**

"Change Proposal" has the meaning set forth in **Section 7.**

"Change Request" has the meaning set forth in **Section 7.**

"Confidential Information" has the meaning set forth in **Section 38.**

"**Contract**" has the meaning set forth in the preamble.

"**Contract Administrator**" is the individual appointed by each party to (a) administer the terms of this Contract, and (b) approve any Change Notices under this Contract. Each party's Contract Administrator will be identified in the Statement of Work.

"**Contractor**" has the meaning set forth in the preamble.

"**Contractor's Bid Response**" means the Contractor's proposal submitted in response to the RFP

"**Contractor Personnel**" means all employees of Contractor or any Permitted Subcontractors involved in the performance of Services hereunder.

"**Deliverables**" means the services, Software, and all other documents and other materials that Contractor is required to or otherwise does provide to the State under this Contract and otherwise in connection with any Services, including all items specifically identified as Deliverables in the Statement of Work.

"**Dispute Resolution Procedure**" has the meaning set forth in **Section 59**.

"**Documentation**" means all user manuals, operating manuals, technical manuals and any other instructions, specifications, documents or materials, in any form or media, that describe the functionality, installation, testing, operation, use, maintenance, support, technical or other components, features or requirements of the Software.

"**DTMB**" means the Michigan Department of Technology, Management and Budget.

"**Effective Date**" has the meaning set forth in the preamble.

"**Financial Audit Period**" has the meaning set forth in **Section 44**.

"**Force Majeure**" has the meaning set forth in **Section 58.**

"**Implementation Plan**" means the schedule included in the Statement of Work setting forth the sequence of events for the performance of Services under the Statement of Work, including the Milestones and Milestone Dates.

“**Intellectual Property Rights**” means all or any of the following: (a) patents, patent disclosures, and inventions (whether patentable or not); (b) trademarks, service marks, trade dress, trade names, logos, corporate names, and domain names, together with all of the associated goodwill; (c) copyrights and copyrightable works (including computer programs), mask works and rights in data and databases; (d) trade secrets, know-how and other confidential information; and (e) all other intellectual property rights, in each case whether registered or unregistered and including all applications for, and renewals or extensions of, such rights, and all similar or equivalent rights or forms of protection provided by applicable Law in any jurisdiction throughout the world.
“**Key Personnel**” means any Contractor Personnel identified as key personnel in the Statement of Work.
“**Law**” means any statute, law, ordinance, regulation, rule, code, order, constitution, treaty, common law, judgment, decree or other requirement or rule of any federal, state, local or foreign government or political subdivision thereof, or any arbitrator, court or tribunal of competent jurisdiction.
“**License Agreement**” has the meaning set forth in **Section 8.**
“**Loss or Losses**” means all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs or expenses of whatever kind, including reasonable attorneys' fees and the costs of enforcing any right to indemnification hereunder and the cost of pursuing any insurance providers.
“**Maintenance Release**” means any update, upgrade, release or other adaptation or modification of the Software, including any updated Documentation, that Contractor may generally provide to its licensees from time to time during the Term, which may contain, among other things, error corrections, enhancements, improvements or other changes to the user interface, functionality, compatibility, capabilities, performance, efficiency or quality of the Software.
“**Milestone**” means an event or task described in the Implementation Plan under the Statement of Work that must be completed by the corresponding Milestone Date.
“**Milestone Date**” means the date by which a particular Milestone must be completed as set forth in the Implementation Plan under the Statement of Work.
“**New Version**” means any new version of the Software that the Contractor may from time to time introduce and market generally as a distinct licensed product, as may be indicated by Contractor's designation of a new version number.
“**Open-Source Components**” means any software component that is subject to any open-source copyright license agreement, including any GNU General Public License or GNU Library or Lesser Public License, or other obligation, restriction or license agreement that substantially conforms to the Open Source Definition as prescribed by the Open Source Initiative or otherwise may require disclosure or licensing to any third party of any source code with which such software component is used or compiled.
“**Operating Environment**” means, collectively, the platform, environment and conditions on, in or under which the Software is intended to be installed and operate, as set forth in the Statement of Work, including such structural, functional and other features, conditions and components as hardware, operating software and system architecture and configuration.
“**Permitted Subcontractor**” has the meaning set forth in **Section 13**.
“**Person**” means an individual, corporation, partnership, joint venture, limited liability company, governmental authority, unincorporated organization, trust, association or other entity.
“**Pricing**” means any and all fees, rates and prices payable under this Contract, including pursuant to any Schedule or Exhibit hereto.
“**Pricing Schedule**” means the schedule attached as **Schedule B, Pricing which sets for the all pricing payable under the Contract.**, setting forth the License Fees, Implementation Fees, Support Services Fees, and any other fees, rates and prices payable under this Contract.
“**Program Manager**” means the State Representative specifically assigned to this Contract and responsible for the day to day Contract Activities. See also Section 4.

"**Representatives**" means a party's employees, officers, directors, partners, shareholders, agents, attorneys, successors and permitted assigns.
"**RFP**" means the State's request for proposal designed to solicit responses for Services under this Contract.
"**Senior Account Manager**" (SAM) means the Contractor Representative specifically assigned to State of Michigan accounts and responsible for the day to day Contract Activities. See also Section 4.
"**Services**" means any of the services Contractor is required to or otherwise does provide under this Contract, the Statement of Work, the Maintenance and Support Schedule (if applicable), or the Service Level Agreement (if applicable).
"**Service Level Agreement**" means, if applicable, the service level agreement referenced in the Statement of Work.
"**Site**" means the physical location designated by the State in, or in accordance with, this Contract or the Statement of Work for delivery and installation of the Software.
"**Software**" means Contractor's software set forth in the Statement of Work, and any Maintenance Releases or New Versions provided to the State and any Configurations made by or for the State pursuant to this Contract, and all copies of the foregoing permitted under this Contract and the License Agreement.
"**State**" means the State of Michigan.
"**State Data**" has the meaning set forth in **Section 37**.
"**State Materials**" means all materials and information, including documents, data, know-how, ideas, methodologies, specifications, software, content and technology, in any form or media, directly or indirectly provided or made available to Contractor by or on behalf of the State in connection with this Contract.
"**State Resources**" has the meaning set forth in **Section 67**.
"**Statement of Work**" means any statement of work entered into by the parties and attached as a schedule to this Contract. The initial Statement of Work is attached as **Schedule A**, and subsequent Statements of Work.
"**Stop Work Order**" has the meaning set forth in **Section 28**.
"**Support Services**" means the software maintenance and support services Contractor is required to or otherwise does provide to the State under the Maintenance and Support Schedule (if applicable) or the Service Level Agreement (if applicable).
"**Term**" has the meaning set forth in the preamble.
"**Third Party**" means any Person other than the State or Contractor.
"**Transition Period**" has the meaning set forth in **Section 31**.
"**Transition Responsibilities**" has the meaning set forth in **Section 31**.
"**User Data**" means all data, information and other content of any type and in any format, medium or form, whether audio, visual, digital, screen, GUI or other, that is input, uploaded to, placed into or collected, stored, processed, generated or output by any device, system or network by or on behalf of the State, including any and all works, inventions, data, analyses and other information and materials resulting from any use of the Software by or on behalf of the State under this Contract, except that User Data does not include the Software or data, information or content, including any GUI, audio, visual or digital or other display or output, that is generated automatically upon executing the Software without additional user input.
"**Warranty Period**" means the ninety (90) calendar-day period commencing on the date of the State's Acceptance of the Software.
"**Work Product**" means all State-specific deliverables that Contractor is required to, or otherwise does, provide to the State under this Contract including but not limited to computer scripts, macros, user interfaces, reports, project management documents, forms, templates, and other State-specific documents and related materials together with all ideas, concepts, processes, and methodologies developed in connection with this Contract whether or not embodied in this Contract.

The parties agree as follows:

1. **Duties of Contractor.** Contractor must perform the services and provide the deliverables described in **Schedule 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 Schedule 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:
Mary Ostrowski 525 W Allegan St., 1st Flr NE Lansing MI 48909 ostrowskim@michigan.gov 517-249-0438	Lori Shannon 600 E. Lafayette Blvd – Mail Code 517A Detroit, MI 48226-2998 lshannon2@bcbsm.com 313-448-8270

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:
Mary Ostrowski 525 W Allegan St., 1st Flr NE Lansing MI 48909 ostrowskim@michigan.gov 517-249-0438	Lori Shannon 600 E. Lafayette Blvd – Mail Code 517A Detroit, MI 48226-2998 lshannon2@bcbsm.com 313-448-8270

4. **Program Manager and Senior Account Manager (SAM).** The Program Manager is the account representative for the State and the SAM is the account representative for the Contractor. This role for each party will monitor and coordinate the day-to-day activities of the Contract:

State: (Program Manager)	Contractor: (SAM)
Bethany Beauchine 400 South Pine St. 3rd floor Lansing, MI 48913 beauchineb@michigan.gov 800-505-5011	Arva Overton 600 E. Lafayette Blvd – Mail Code 517J Detroit, MI 48226-2998 aoverton@bcbsm.com 313-448-5912

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 Schedule A) if, in the opinion of the State, it will ensure performance of the Contract.

6. **Insurance Requirements.** Contractor must either self-insure or 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.

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 using endorsement CG 20 10 11 85, or both CG 2010 07 04 and CG 2037 07 04.
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: $500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease.	
Privacy and Security Liability (Cyber Liability) Insurance	
Minimal Limits: $10,000,000 Each Occurrence $10,000,000 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
Professional Liability (Errors and Omissions) Insurance	
Minimal Limits: $5,000,000 Each Occurrence $5,000,000 Annual Aggregate	

If Contractor's policy contains limits higher than the minimum limits, the State is entitled to coverage to the extent of the higher limits. The minimum limits are not intended, and may not be construed to limit any liability or indemnity of Contractor to any indemnified party or other persons.

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 (3) 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 (3) 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 5 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. **Change Control Process.** The State may at any time request in writing (each, a "Change Request") changes to the Statement of Work, including changes to the Services and Implementation Plan (each, a "Change"). Upon the State's submission of a Change Request, the parties will evaluate and implement all agreed upon Changes in accordance with this Section 2.2.

   As soon as reasonably practicable, and in any case within thirty (30) Business Days (or as otherwise agree to by the parties) following receipt of a Change Request, Contractor will provide the State with a written proposal for implementing the requested Change ("Change Proposal"), setting forth:

   a written description of the proposed Changes to any Services or Deliverables;
   an amended Implementation Plan reflecting: (A) the schedule for commencing and completing any additional or modified Services or Deliverables; and (B) the effect of such Changes, if any, on completing any other Services under the Statement of Work;
   any additional State Resources Contractor deems necessary to carry out such Changes; and
   any increase or decrease in Fees resulting from the proposed Changes, which increase or decrease will reflect only the increase or decrease in time and expenses Contractor requires to carry out the Change.

   Within thirty (30) Business Days (or as otherwise agreed to by the parties) following the State's receipt of a Change Proposal, the State will by written notice to Contractor, approve, reject, or propose modifications to such Change Proposal. If the State proposes modifications, Contractor must modify and re-deliver the Change Proposal reflecting such modifications, or notify the State of any disagreement, in which event the parties will negotiate in good faith to resolve their disagreement. Upon the State's approval of the Change Proposal or the parties' agreement on all proposed modifications, as the case may be, the parties will execute a written agreement to the Change Proposal ("Change Notice"), which Change Notice will be signed by the State's Contract Administrator and will constitute an amendment to the Statement of Work to which it relates; and

   If the parties fail to enter into a Change Notice within fifteen (15) Business Days following the State's response to a Change Proposal, the State may, in its discretion:

   require Contractor to perform the Services under the Statement of Work without the Change;
   require Contractor to continue to negotiate a Change Notice;
   initiate a Dispute Resolution Procedure; or
   notwithstanding any provision to the contrary in the Statement of Work, terminate this Contract under Section 29.

   No Change will be effective until the parties have executed a Change Notice. Except as the State may request in its Change Request or otherwise in writing, Contractor must continue to perform its obligations in accordance with the Statement of Work pending negotiation and execution of a Change Notice. Contractor will use its best efforts to limit any delays or Fee increases from any Change to those necessary to perform the Change in accordance with the applicable Change Notice. Each party is responsible for its own costs and expenses of preparing, evaluating, negotiating, and otherwise processing any Change Request, Change Proposal, and Change Notice.

   The performance of any functions, activities, tasks, obligations, roles and responsibilities comprising the Services as described in this Contract are considered part of the Services and, thus, will not be considered a Change. This includes the delivery of all Deliverables in accordance with their respective Specifications, and the diagnosis and correction of Non-Conformities discovered in Deliverables prior to their Acceptance by the State or, subsequent to their Acceptance by the State, as necessary for Contractor to fulfill its associated warranty requirements and its Support Services under this Contract.

   Contractor may, on its own initiative and at its own expense, prepare and submit its own Change Request to the State. However, the State will be under no obligation to approve or otherwise respond to a Change Request initiated by Contractor.

8. **Software License**. Contractor hereby grants to the State and its Authorized Users the right and license to use the Software and Documentation in accordance with the terms and conditions of this Contract.

9. **Hosting.** If the Operating Environment for the Software is externally hosted by Contractor or a subcontractor, Contractor will maintain the Availability Requirement.

10. **Service Availability**

10.1 Availability Requirement. Contractor will make the Hosted Services Available, as provided in the Statement of Work.

11. Reserved.

12. 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.

13. Subcontracting. Contractor may not delegate any of its obligations under the Contract without the prior notice to the State. Contractor must notify the State at least 90 calendar days before the proposed delegation, unless already provided to the State during the RFP process, and provide the State any information the State may reasonably request. The State reserves the right to object to a subcontractor and request Contractor to engage an alternative subcontractor. If Contractor is unable to engage an alternative subcontractor the State in its sole discretion may terminate this Contract in whole or in part. 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 the 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, including but not limited to any security requirements as well as obtain any reports or other security information required to be provided to the State by Contractor.

A. Contractor's notification to the State of subcontractor usage does not relieve Contractor of its representations, warranties or obligations under this Contract. Without limiting the foregoing, Contractor will:
   (1) be responsible and liable for the acts and omissions of each such Subcontractor (including such Subcontractor's employees who, to the extent providing Services or Deliverables, shall be deemed Contractor Personnel) to the same extent as if such acts or omissions were by Contractor or its employees;
   (2) be responsible for all fees and expenses payable to, by or on behalf of each Subcontractor in connection with this Contract, including, if applicable, withholding of income taxes, and the payment and withholding of social security and other payroll taxes, unemployment insurance, workers' compensation insurance payments and disability benefits; and
   (3) notify the State of the location of the Subcontractor and indicate if it is located within the continental United States.

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

15. 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.

16. Assignment. Contractor may not assign or otherwise transfer any of its rights, or delegate or otherwise transfer any of its obligations or performance, under this Contract, in each case whether voluntarily, involuntarily, by operation of law or otherwise, without the State's prior written consent. The State has the right to terminate this Contract in its entirety or any Services or Statements of Work hereunder, pursuant to Section 29, if Contractor delegates or otherwise transfers any of its obligations or performance hereunder, whether voluntarily, involuntarily, by operation of law or otherwise, and no such delegation or other transfer will relieve Contractor of any of such obligations or performance. For purposes of the preceding sentence, and without limiting its generality, any merger, consolidation or reorganization involving Contractor (regardless of whether Contractor is a surviving or disappearing entity) will be deemed to be a transfer of rights, obligations, or performance under this Contract for which the State's prior written consent is required. Any purported assignment, delegation, or transfer in violation of this Section is void.

17. No Third-party Beneficiaries. This Contract is for the sole benefit of the parties and their respective successors and permitted assigns. Nothing herein, express or implied, is intended to or will confer on any other person or entity any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Contract.

18. 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 the confidentiality terms of any transaction. 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.

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

20. **Reserved**

21. **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 Schedule 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 29, Termination for Cause.
Within 15 business days (unless otherwise agreed upon by the parties) 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 Program Manager and Contractor's SAM 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.

22. **Reserved.**

23. **Reserved.**

24. **Reserved.**

25. **Reserved.**

26. **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 Schedule 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, 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. Contractor shall not withhold any Services or fail to perform any obligation hereunder by reason of the State's good faith withholding of any payment or amount in accordance with this Section 27 or any dispute arising therefrom.

    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/SIGMAVSS 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.

27. **Reserved.**

28. **Stop Work Order.** The State may, at any time, order the Services of Contractor fully or partially stopped for its own convenience for up to ninety (90) calendar days at no additional cost to the State. The State will provide Contractor a written notice detailing such suspension (a "**Stop Work Order**"). 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.

29. **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 30, 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.

30. **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 31, 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.

31. **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 365 calendar days; the "**Transition Period**"), 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**") and which shall include all standard quarterly and year end reporting. This Contract will automatically be extended through the end of the transition period.

32. **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.

    1) **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, to the full extent contemplated by this Contract; or if this option is not reasonably available to Contractor, (b) modify or replace the materials that infringe or are alleged to infringe ("**Allegedly Infringing Materials**") to make the equipment, software, commodity, or service and all of its components non-infringing while providing fully equivalent features and functionality.; 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.

2) If Contractor directs the State to cease using any the equipment, software, commodity, or service under **subsection 1)**, the State may terminate this Contract for cause under **Section 29 (Termination for Cause)**.

3) Contractor will have no liability for any claim of infringement arising solely from:

(i) Contractor's compliance with any designs, specifications, or instructions of the State; or

(ii) modification of the equipment, software, commodity, or service by the State without the prior knowledge and approval of Contractor;

unless the claim arose against the equipment, software, commodity, or service independently of any of the above specified actions.

33. Damages Disclaimers and Limitations.

A. The State's Disclaimer of Damages. THE STATE WILL NOT BE LIABLE, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS CONTRACT FOR CONSEQUENTIAL, INCIDENTAL, INDIRECT, OR SPECIAL DAMAGES, INCLUDING WITHOUT LIMITATION LOST PROFITS AND LOST BUSINESS OPPORTUNITIES.

B. State's Limitation of Liability. IN NO EVENT WILL THE STATE'S AGGREGATE LIABILITY TO CONTRACTOR UNDER THIS CONTRACT, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY OR BY STATUTE OR OTHERWISE, FOR ANY CLAIM RELATED TO OR ARISING UNDER THIS CONTRACT, EXCEED THE MAXIMUM AMOUNT OF ADMINISTRATIVE FEES PAYABLE UNDER THIS CONTRACT.

34. 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, unless disclosure is prohibited by such Proceeding, 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.

35. Reserved.

36. State Data.

A. Ownership. The State's data ("**State Data**"), which will be treated by Contractor as Confidential Information, includes: (a) User Data; and (b) any other data collected, used, processed, stored, or generated by the State in connection with the Services, including but not limited to (i) personally identifiable information ("**PII**") collected, used, processed, stored, or generated as the result of the Services, 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 (ii) personal health information ("**PHI**") collected, used, processed, stored, or generated as the result of the Services, 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 termination or expiration 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 Services, including a license to collect, process, store, generate, and display State Data only to the extent necessary in the provision of the Services. 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 Services, 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 termination or expiration of this Contract.

C. Extraction of State Data. Contractor must, within five (5) 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 Schedule 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 Schedule A, Contractor must maintain a contemporaneous backup of State Data that can be recovered within two (2) hours at any point in time.

E. Loss or Compromise of Data. In the event of any act, error or omission, negligence, misconduct, or breach on the part of Contractor 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 twenty-four (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) with approval and assistance from the State, 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 (5) 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 twenty-four (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) pay for any costs associated with the occurrence, including but not limited to any costs incurred by the State in investigating and resolving the occurrence, including reasonable attorney's fees associated with such investigation and resolution; (g) 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 incidental expenses, which may be suffered by, accrued against, charged to, or recoverable from the State in connection with the occurrence; (h) be responsible for recreating lost State Data in the manner and on the schedule set by the State without charge to the State; and (i) provide to the State a detailed plan within ten (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, not be tangentially used for any solicitation purposes, 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. The State will have the option to review and approve any notification sent to affected individuals prior to its delivery. Notification to any other party, including but not limited to public media outlets, must be reviewed and approved by the State in writing prior to its dissemination. This section survives termination or expiration of this Contract.

37. Confidential Information. Each party acknowledges that it may be exposed to or acquire communication or data of the other party that is confidential in nature and is not intended to be disclosed to third parties. This section survives termination or expiration of this Contract.

A. Meaning of Confidential Information. 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 or is: (a) in the possession of the State and 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). Notwithstanding the above, 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 HIPAA for health plan administration purposes under the Business Associate Agreement. The parties agree to advise and require their respective employees, agents, and subcontractors of their obligations to keep all Confidential Information confidential. Disclosure to the Contractor's subcontractor is permissible where: (a) the subcontractor is a Permitted Subcontractor; (b) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Permitted Subcontractor's responsibilities; and (c) Contractor obligates the Permitted Subcontractor in a written contract to maintain the State's Confidential Information in confidence. At the State's request, any of the Contractor's Representatives 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. 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 5 Business 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. If 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 5 Business days from the date of termination to the other party. However, the State's legal ability to destroy Contractor data may be restricted by its retention and disposal schedule, in which case Contractor's Confidential Information will be destroyed after the retention period expires

38. 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 Contractor Representatives 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 at http://www.michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html.

B. To the extent that Contractor has access to the State's computer system, Contractor must comply with the State's Acceptable Use Policy, see http://michigan.gov/cybersecurity/0,1607,7-217-34395_34476---,00.html. All Contractor Personnel will be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State's system. The State reserves the right to terminate Contractor's access to the State's system if a violation occurs.

C. 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.

D. 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.

E. 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.

F. 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.

G. Security Requirements for Externally Hosted Software. If the Operating Environment for the Software is externally hosted by Contractor or a subcontractor, Contractor shall comply with the security requirements set forth in **Schedule J** to this Contract.

39. Reserved.

40. Reserved.

41. Reserved.

42. Reserved.

43. 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 seven 7 years after the latter of termination, expiration, or final payment under this Contract or any extension **("Financial 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 30 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.

44. 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;(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; and that (i) Contractor is neither currently engaged in nor will engage in the boycott of a person based in or doing business with a strategic partner as described in 22 USC 8601 to 8606. A breach of this Section is considered a material breach of this Contract, which entitles the State to terminate this Contract under Section 29, Termination for Cause.

45. Intellectual Property Rights

A. Ownership Rights in Software

1. Subject to the rights and licenses granted by Contractor in this Contract and the License Agreement, and the provisions of **Section 2**:
   a. Contractor reserves and retains its entire right, title and interest in and to all Intellectual Property Rights arising out of or relating to the Software; and
   b. none of the State or Authorized Users acquire any ownership of Intellectual Property Rights in or to the Software or Documentation as a result of this Contract.
2. As between the State, on the one hand, and Contractor, on the other hand, the State has, reserves and retains, sole and exclusive ownership of all right, title and interest in and to User Data, including all Intellectual Property Rights arising therefrom or relating thereto.

B. Rights in Open-Source Components. Ownership of all Intellectual Property Rights in Open-Source Components shall remain with the respective owners thereof, subject to the State's rights under the applicable Open-Source Licenses.

46. 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.

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

48. **Reserved.**

49. **Reserved.**

50. **Reserved.**

51. **Reserved.**

52. **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.

53. **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.

54. **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.

55. **Effect of Contractor Bankruptcy.** All rights and licenses granted by Contractor under this Contract are and will be deemed to be rights and licenses to "intellectual property," and all Software and Deliverables are and will be deemed to be "embodiments" of "intellectual property," for purposes of, and as such terms are used in and interpreted under, Section 365(n) of the United States Bankruptcy Code (the "Code"). If Contractor or its estate becomes subject to any bankruptcy or similar proceeding, the State retains and has the right to fully exercise all rights, licenses, elections, and protections under this Contract, the Code and all other applicable bankruptcy, insolvency, and similar Laws with respect to all Software and other Deliverables. Without limiting the generality of the foregoing, Contractor acknowledges and agrees that, if Contractor or its estate shall become subject to any bankruptcy or similar proceeding:

    a. all rights and licenses granted to the State under this Contract will continue subject to the terms and conditions of this Contract, and will not be affected, even by Contractor's rejection of this Contract; and

    b. the State will be entitled to a complete duplicate of (or complete access to, as appropriate) all such intellectual property and embodiments of intellectual property comprising or relating to any Software or other Deliverables, and the same, if not already in the State's possession, will be promptly delivered to the State, unless Contractor elects to and does in fact continue to perform all of its obligations under this Contract.

56. **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.

57. **Force Majeure.**
    A. Force Majeure Events: Subject to Subsection (b) below, neither party will be liable or responsible to the other party, or be deemed to have defaulted under or breached this Contract, for any failure or delay in fulfilling or performing any term hereof, when and to the extent such failure or delay is caused by: acts of God, flood, fire or explosion, war, terrorism, invasion, riot or other civil unrest, embargoes or blockades in effect on or after the date of this Contract, national or regional emergency, or any passage of law or governmental order, rule, regulation or direction, or any action taken by a governmental or public authority, including imposing an embargo, export or import restriction, quota or other restriction or prohibition (each of the foregoing, a "**Force Majeure**"), in each case provided that: (a) such event is outside the reasonable control of the affected party; (b) the affected party gives prompt written notice to the other party, stating the period of time the occurrence is expected to continue; (c) the affected party uses diligent efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

    B. State Performance; Termination. In the event of a Force Majeure Event affecting Contractor's performance under this Contract, the State may suspend its performance hereunder until such time as Contractor resumes performance. The State may terminate this Contract by written notice to Contractor if a Force Majeure Event affecting Contractor's performance hereunder continues substantially uninterrupted for a period of five (5)

Business Days or more. Unless the State terminates this Contract pursuant to the preceding sentence, any date specifically designated for Contractor's performance under this Contract will automatically be extended for a period up to the duration of the Force Majeure Event.

58. **Dispute Resolution.** The parties will endeavor to resolve any Contract dispute in accordance with this provision (the **"Dispute Resolution Procedure"**). The initiating party will reduce its description of the dispute to writing (including all supporting documentation) and deliver it to the Program Manager and the SAM. The responding party's Program Manager and SAM must respond in writing within five (5) Business Days. The initiating party has five (5) Business Days to review the response. If after such review resolution cannot be reached, both parties will have an additional five (5) Business Days to negotiate in good faith to resolve the dispute. If the dispute cannot be resolved within a total of fifteen (15) Business Days, the parties must submit the dispute to the parties' Contract Administrators. 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.

59. **Relationship of the Parties**. The relationship between the parties is that of independent contractors. Nothing contained in this Contract is to be construed as creating any agency, partnership, joint venture or other form of joint enterprise, employment or fiduciary relationship between the parties, and neither party has authority to contract for or bind the other party in any manner whatsoever.

60. **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.

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

62. **Entire Agreement and Order of Precedence.** This Contract, which includes Schedule A – Statement of Work, and expressly incorporated schedules and exhibits, is the entire agreement of the parties related to the Contract Activities. This Contract supersedes and replaces all previous understandings and agreements between the parties for the Contract Activities. If there is a conflict between documents, the order of precedence is: (a) first, this Contract, excluding its schedules, exhibits, and Schedule A – Statement of Work; (b) second, Schedule A – Statement of Work as of the Effective Date; and (c) third, schedules expressly incorporated into this Contract as of the Effective Date. NO TERMS ON CONTRACTOR'S INVOICES, ORDERING DOCUMENTS, WEBSITE, BROWSE-WRAP, SHRINK-WRAP, CLICK-WRAP, CLICK-THROUGH OR OTHER NON-NEGOTIATED TERMS AND CONDITIONS PROVIDED WITH ANY OF THE CONTRACT ACTIVITIES WILL CONSTITUTE A PART OR AMENDMENT OF THIS CONTRACT OR IS BINDING ON THE STATE FOR ANY PURPOSE. ALL SUCH OTHER TERMS AND CONDITIONS HAVE NO FORCE AND EFFECT AND ARE DEEMED REJECTED BY THE STATE, EVEN IF ACCESS TO OR USE OF THE CONTRACT ACTIVITIES REQUIRES AFFIRMATIVE ACCEPTANCE OF SUCH TERMS AND CONDITIONS.

63. **Severability.** If any term or provision of this Contract is invalid, illegal or unenforceable in any jurisdiction, such invalidity, illegality or unenforceability will not affect any other term or provision of this Contract or invalidate or render unenforceable such term or provision in any other jurisdiction. Upon such determination that any term or other provision is invalid, illegal or unenforceable, the parties hereto will negotiate in good faith to modify this Contract so as to effect the original intent of the parties as closely as possible in a mutually acceptable manner in order that the transactions contemplated hereby be consummated as originally contemplated to the greatest extent possible.

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

65. **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.

66. **State Obligations**: State Resources and Access. The State is responsible for:
    providing the State Materials and such other resources as may be specified in the Statement of Work (collectively, "**State Resources**"); and State Program Manager. Throughout the Term of this Contract, the State will maintain a State employee to serve as the State's Program Manager under this Contract.

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE A
STATEMENT OF WORK
CONTRACT ACTIVITIES

BACKGROUND
The Michigan Civil Service Commission (MCSC), Employee Benefits Division (EBD), administers benefits for eligible State employees, retirees, dependents and COBRA participants. EBD serves as the Plan Sponsor for this Contract. In addition to offering several Health Maintenance Organizations, the State offers coverage to eligible employees in the State Health Plan Preferred Provider Organization (SHP PPO). This Contract is for the administration of Behavioral Health and Substance Abuse (BH/SA) benefits to enrollees in the SHP PPO. Medical benefits provided to enrollees through the SHP PPO, and prescription drug benefits are administered under a separate contract. Member out-of-pocket expenses are transmitted to and from the medical contractor's third party administrator (TPA), currently AccumTech, to accurately track deductibles and out-of-pocket maximum accumulation. Plan Sponsor has an internal employee assistance program that provides assessment and referral services and Traumatic or Critical Incident services for state employees and eligible dependents.

SHP PPO Population as of October 2018:

	Contract Holder	Dependents	Total
Active Population	18,955	28,074	47,029
Retiree Population	54,120	27,835	81,955
COBRA Participants	205	175	380
Total	73,280	56,084	129,364

A majority of the member population resides in Michigan with a portion residing in other states across the nation. The current plan is an Administrative Services Only (ASO) plan.

SCOPE
This Contract is for administration of the BH/SA benefit for the SHP PPO for eligible State employees, retirees, dependents, and COBRA participants, on an Administrative Services Only (ASO) basis.

The Contractor must provide all staffing, systems, and procedures required to perform the services described herein. **Provision of Employee Assistance Program services is out-of-scope for this contract.**

The Contract is effective July 25, 2019 through December 31, 2022. July 25, 2019 through September 30, 2019 is the implementation period, and services are to begin without interruption on October 1, 2019. No payment will be made to the Contractor during the implementation period. The implementation period begins with Contract award date through the Plan Effective Date.

REQUIREMENTS

1.Contractor Requirements

A. General.

1) The Contractor must provide a fully functional BH/SA plan as defined by the Plan Sponsor, for members which includes active State employees, retirees, dependents and COBRA participants.

2) The Contractor must be a licensed Third-Party Administrator (TPA) in the State of Michigan or insurance company licensed to do business in Michigan or must qualify in any other capacity as an entity that is properly licensed by statute to provide administrative services only and cost-plus arrangements, or to act as a TPA.

3) The Contractor must partner with the Plan Sponsor to manage the BH/SA plan effectively and collaborate with the Plan Sponsor to ensure the future success and ability of the Plan to continue to offer competitive BH/SA coverage.

4) The Contractor must provide financial management, reporting, and analytical support as required by this contract and which meets or exceeds current industry standards.

5) The Contractor must ensure transparency for all services provided on behalf of the Plan Sponsor.

6) The Contractor must comply with the State of Michigan's Public Act 454 of 2004 (Social Security Number Privacy Act).

7) The Contractor must provide exceptional customer service for both State of Michigan benefits personnel and members.

8) The Contractor must provide services that meet or exceed current industry standards in the administration of Eligibility, Claims Processing, Member Servicing, and the review and administration of Grievances and Appeals.

   Contractor's plan for measuring, tracking, and reporting on account service performance:
   For member servicing, the Contractor will utilize CISCO technology which offers tracking and reporting capabilities. Call metrics, speech analytics, and reports will be used to improve member experience. Speech analytics technology will identify and report issues impacting members. This information will allow the Contractor to strategize on member servicing solutions. For claims processing, the Contractor will review a valid sample of claims to ensure they are adhering to the State's Plan Design and medical policy guidelines. If errors are discovered because of the claims review, the necessary steps will be taken to correct the problem. Reports will be generated on a monthly, quarterly and annual basis. For eligibility, an Access database will track the electronic eligibility files received from the Plan Sponsor. The database will track the file from the receipt date until the file is processed. Reports will be generated from the database identifying the total turnaround time for uploading the Plan Sponsor's membership files. Any issues with uploading the membership files will be immediately shared with the Plan Sponsor along with an interim solution. For grievances and appeals, the Contractor will use a database to track adherence to timeliness standards of 72-hours (urgent), 30-days (pre-service), and 60-days (post service). The Contractor will also track the type of appeal and whether the appeal was overturned or upheld. In addition, the Contractor will adhere to the National Committee Quality Assurance (NCQA) standards. The reporting will aid the Contractor in identifying patterns and determining how to improve the member and provider experience.

9) The Contractor must provide support of strategic planning efforts and identifying areas of improvement upon request including, but not limited to, comparative analysis of Plan Sponsor's membership to other like plan sponsors across Contractor's book of business.

10) The Contractor must provide all necessary administrative functions. This must include, but is not limited to:
    a. Producing and distributing Plan Sponsor-approved BH/SA plan member communications at no additional cost to Plan Sponsor.
    b. Processing claims in accordance with State of Michigan plan design.
    c. Accepting and transmitting data to and from third party member payment accumulator if applicable.
    d. Providing monthly, quarterly, year-end, reporting as defined herein and ad-hoc reporting, upon Plan Sponsor's request. See Section 4.3 Reporting.

11) The Contractor must provide independent ratings of financial strength to the Plan Sponsor such as an A.M. Best Financial Strength Rating.

12) The Contractor must demonstrate the total value in administrative fees and claims cost of the Contractor's program. The Contractor must provide Pass-Through Pricing to Plan Sponsor. The 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. All pricing must exclude commissions.

13) There must be no fee to Plan Sponsor for Contract Implementation. The Contractor must smoothly transition administration of the BH/SA plan from the current administrator, if not the incumbent. See also Section 4.1 Project Plan.

B. Plan Design

1) The Contractor must administer the BH/SA plan in accordance with the Plan Design outlined in **Schedule C Plan Design and Claims Payment Rules**. Covered services and exclusions from covered services are described in the Plan Designs in **Schedule C**.

2) The Contractor must duplicate the current Plan Design.

3) This Plan is a bargained benefit and is subject to change throughout the duration of this Contract, depending upon the results of future collective bargaining agreements and/or decision of the Civil Service Commission. Historically, non-bargaining unit employees have received the same benefits as bargaining unit employees, but this is not guaranteed. Retiree benefits are also subject to change.

   a. The Contractor must be able to administer multiple plan designs.

   b. The Contractor must implement BH/SA plan changes as requested by the Plan Sponsor or as required to comply with changes in law or regulation in a mutually agreed time frame, at no additional fee to the Plan Sponsor.

C. Claims Processing

1) The Contractor must only pay claims for eligible participants.

2) The Contractor must only charge against the Plan Sponsor's account claim payments authorized under the Plan Sponsor's Plan Design. If it is determined that claims have been improperly paid due to Contractor system rules or programming error(s), the Plan Sponsor will be reimbursed for the cost of improper payment and the member will not be billed. System rules or programming errors that result in improper payment of claims or payment of claims to ineligible participants will be considered financial errors.

3) The Contractor must maintain confidentiality of all data collected by the Contractor, according to all applicable laws, rules and regulations. All data identifying specific enrollees or their dependents is to be treated and secured according to HIPAA privacy and security regulations. The Contractor's system must comply with HIPAA. The Contractor must provide Plan Sponsor with an annual attestation that it meets this requirement. See **Schedule K, HIPAA Business Associate Agreement (BAA)**.

4) The Contractor must capture and store all Claim data elements involved in the processing or payment of Claims. The Contractor's Claims system must be available 99% of the time and have service availability performance of 100%.

5) The Contractor must capture additional Claim data elements, if requested by the Plan Sponsor.

6) The Contractor must have processes in place to detect fraud and abuse. Detected fraud or abuse must be reported to the Plan Sponsor immediately and remedied in conjunction with the monthly reporting schedule in Section 4.3 Reporting.

   Contractor's protocols to detect fraud, waste and abuse and process for notification to the Plan Sponsor for any situations of fraud, waste or abuse: The Contractor has multiple triggers in their claims processing and payment systems to flag aberrant claims. Unusual or excessive claims activity will be escalated to Contractor's Corporate Financial Investigations (CFI) department for review. CFI will be responsible for investigating allegations of fraud, waste and abuse (FWA) and for initiating loss prevention and cost containment strategies to address and minimize FWA across the enterprise. CFI will use both proactive and reactive approaches to detect fraud, abuse and overutilization of services. The Contractor's CFI staffs a hotline for employees, members and providers to report concerns regarding fraud, waste and abuse. The hotline number, as well as an online email submission form will be communicated through internal training and the hotline number will appear on ID cards, explanation of benefit forms, and Contractor newsletters. In addition, the Contractor's CFI will use data mining tools to include the SAS Fraud Framework for

Healthcare predictive analytics software to proactively identify potential fraud, waste and abuse. The SAS tool will review all paid claim data and will identify outliers and aberrant claim activity utilizing 261 provider scenarios, 168 pharmacy scenarios and 53-member scenarios. All Contractor employees will receive annual training related to identifying and reporting potential fraud, waste and abuse. The Contractor's CFI personnel will conduct additional training with specific business areas and in the community regarding identification and reporting of FWA. The Contractor's CFI will maintain policies and procedures for notifying the Plan Sponsor of fraud and abuse in accordance with Contract requirements.

7) The Contractor must have procedures for handling overpayments and recoveries in place. Any procedures impacting members must be mutually agreed upon.

   Contractor's Procedures for handling overpayment and recoveries:
   If the Plan Sponsor overpays on their invoice, a credit balance will flow to the next invoice generated in the system and appear as a balance forward credit balance. If a recovery is processed on the invoice, it will show as a credit and be included in their total balance due.

8) The Contractor must perform Coordination of Benefits (COB) for claims administration when a member is covered by more than one BH/SA plan. See **Schedule C Plan Design and Claims Payment Rules**.

   Contractor Plan:
   The Contractor will perform COB processing, maintenance, and outreach and will utilize a method called Passive Pursue and Pay COB. This method will function as indicated below:
   - Primary Claim submission from a spouse or dependent on contract will trigger Letter of Inquiry (LOI) process.
   - Claim will be paid during 45-day LOI process (not suspended). State of Michigan members will be eligible to potentially receive two COB letters during the LOI process.
   - If no response is received after 45 days, the members' COB record will be updated to assume no other coverage and claims continue to pay as Contractor/ SOM primary.
   - Standard time frame for State of Michigan LOI process is 12 months (365 days) after the contracts last COB update. If other coverage is already on file, no further LOI's will be triggered until that other insurance is cancelled.

9) The Contractor must deliver real time files daily to the Plan Sponsor's medical carrier (unless Contractor is also the medical carrier) for integration of out-of-pocket accumulators in an agreed upon format. The Contractor must receive or access accumulator data for use in calculating member charges.

10) The Contractor is responsible for all expenses, including the cost of any subcontractors, related to producing the data and providing it to the medical contractor. This includes any costs associated with resubmissions and processing costs incurred by the medical contractor due to the transmittal of incomplete, inaccurate, or unreadable data files belonging to the Plan Sponsor.

11) The Contractor is responsible to work with the medical contractor, including developing any process improvement procedures needed to correct all issues that impede or prevent accurate data for out-of-pocket accumulators.

12) Mixed Services Protocols:

    a. The Contractor must ensure that financial responsibility is clearly articulated and that responsible parties are in agreement.

    b. The Contactor must practice effective and efficient payment administration for mixed services protocols.

13) Data collected on behalf of the State is not to be distributed to any party without the written consent of the State and is not to be used by the Contractor for any purposes without expressed, written approval by the State.

D. Network Adequacy, Access and Management

1) The Contractor must provide effective plan management for BH/SA services by maintaining a broad national network of participating preferred community BH/SA Providers where members reside. The network must offer convenient access to employees, retirees, dependents, and COBRA participants who reside throughout the country.

2) Geographically adequate: Network providers/facilities must be available within the distances below:

	Providers	Facilities
Urban	5 miles	10 miles
Suburban	10 miles	25 miles
Rural	20 miles	50 miles

3) Availability of network benefits: Network benefits must be available in all 50 states and the District of Columbia, even if single case agreements must be negotiated with out-of-network (OON) providers where network providers are either not available within the access standards listed above or lack the qualifications needed.

   In addition, the Plan Sponsor may nominate physicians and other providers for inclusion in the network; however, the provider must complete a participation application as part of the credentialing process. The provider will only be approved if all required credentialing criteria are met. The Contractor is willing to recruit additional providers if network access is determined to be not acceptable; however, these providers must comply with the Contractor's credentialing process.

4) The Contractor's network requirements must include, but not be limited to, the following:

   a. All levels of care: Contracted network providers include office visit, inpatient, residential treatment centers, partial hospitalization programs and intensive outpatient programs. The Contractor must agree to a 95% match of employees/retirees within the designated geographic standards provided in this Contract.

      Contractor's plan to commit to improving the issue of certain provider types in rural areas not being available:
      The Contractor will ensure that its TRUST network is sufficient in numbers and types of practitioners/providers to meet the needs of its members. The Contractor establishes standards for network adequacy for the number and geographic distribution of practitioners and providers based on requirements of governing bodies and customer expectations. Routine network adequacy analyses will be performed throughout the year to evaluate compliance with the Contractor's geographic standards.

      Counties requiring recruitment will be identified and a variety of methods will be employed to supplement recruitment:
      - Review participation in the various networks to identify potential providers to contract with in the networks that have gaps
      - Perform internet searches
      - Check the Medicare.gov database
      - Check adjacent counties to determine if providers are available in close proximity to fill gaps
      - Involve Provider Outreach as needed
      - Out-of-network referrals and access waivers will be available in low access areas based on contracted member's benefits.

   b. All network clinicians must be credentialed (i.e., Master's degree minimum, state license to practice independently and malpractice insurance ($1M/$3M for prescribers; $1M/$1M for non-prescribers), with licensure and malpractice insurance verified at the primary source. NCQA standards must be followed in initial credentialing of network providers and in monitoring compliance with credentialing requirements. Comparable standards may be used if authorized by Plan Sponsor.

c. The Contractor must ensure that all providers agree to the following appointment access times:
   1. Life-threatening emergency - immediately
   2. Non-Life-threatening emergency - within 6 hours
   3. Urgent care - within 48 hours
   4. Initial visit for routine care - within 10 business days

   The Contractor will conduct an accessibility analysis for access to behavioral health care annually in accordance with the NCQA standard timeframes indicates above.

   Using motivational interviewing techniques, the Contractor's clinicians will conduct a thorough intake and assessment with each member, exploring the domains of physical health, behavioral health, social determinants and access to and experience with the health system. They will also explore any barriers to care, such as language, culture, cognitive impairment, denial of illness, transportation, and health literacy. This intake and assessment process will identify the most appropriate provider and resources to direct the member to. The Contractor will follow-up with each member to ensure that the provider and resources the Contractor directed them to, are meeting their needs and preferences and the treatment setting is appropriate, eliminating any barriers in receiving care (e.g., travel distance, transportation issues, office hours, accessibility, etc.). A link to the Contractor's provider directory will be embedded in the clinical platform, allowing the clinicians to refer members to high quality providers that best meet their needs. The Contractor will solicit feedback from the member in regard to their experience with the provider and will share that information with the Contractor's provider relations team for follow-up when appropriate.

d. The Contractor must add Providers to the Provider Network to meet network access requirements. All network gaps will be filled by 60 days after the effective date.

   Contractor's plan to commit to improving provider access in any areas where standard access is not met:
   The Contractor will establish standards for network adequacy for the number and geographic distribution of practitioners and providers based on requirements of governing bodies and Plan Sponsor expectations. Routine network adequacy analyses will be performed throughout the year to evaluate compliance with the geographic standards for the State's PPO plan. Counties requiring recruitment will be identified and a variety of methods will be employed to supplement recruitment:
   - Review participation in the various networks to identify potential providers to contract with in the networks that have gaps
   - Perform internet searches
   - Check the Medicare.gov database
   - Check adjacent counties to determine if providers are available in close proximity to fill gaps
   - Involve Provider Consulting Services as needed
   - Out-of-network referrals and access waivers will be available in low access areas based on contracted member's benefits.

   Online office visits will be provided to members via Contractor's subcontractor, American Well. American Well will manage the Online Care Group which will have providers available for behavioral health therapy, and psychiatry services. Providers will be added to their network to assure adequate access.

e. The Contractor must ensure that the In-Network provider list applicable for this Contract accurately identifies providers accepting new patients and guarantees appointment availability. See Section J Performance Guarantees / Service Level Agreements (SLAs) for related SLAs.

   Contractor's plan to ensure that the In-Network provider list applicable to Plan Sponsor accurately identifies providers accepting new patients and guarantees appointment availability:
   The Contractor will perform a random audit of 3% of the Michigan based In-Network participating provider list to assure accuracy of identified providers accepting new patients and guaranteeing appointment availability.

f. Average Turnover:

Contractor's average 1-year and 3-year turnover of the credentialed professionals/facilities:

	Professionals Response	Facilities Response
1-Year (%)	4.56%	0%
3-Year (%)	4.95%	0%

g. The Contractor must have a plan and process for recruiting new professionals.

The Contractor will utilize the process identified under Section 1.D.4.d.

h. Evolving to Heightened Needs:

Contractor's Plan:
The Contractor will support patients recovering from opioid addiction through a variety of outreach and other interventional strategies including:

- Access to Medication-Assisted Treatment (MAT)
- Care transitions to assist members in accessing the right care after inpatient or residential treatment, including MAT
- Coordination of care with other providers with member's permission;
- Education and support for family members
- Case management as appropriate (e.g., as a result of readmissions, comorbid medical issues, high emergency department utilization)
- Integration with medical case management when member has a comorbid medical condition (e.g., for chronic pain)
- Outreach to patients identified as having had an ER visit for an opioid overdose

The Contractor has developed a comprehensive strategy focusing on prevention, treatment and partnership. The Contractor is committed to utilizing their resources, programs and expertise and have created an enterprise-wide task force to ensure that all programs are coordinated. The Contractor will utilize all the levers they have to impact the crisis. The task force will include robust pharmacy management programs, engagement with providers, clinical care programs, strong communication efforts to build awareness, funding for and partnership with community coalitions, public policy advocacy, and programs to actively detect and investigate potential issues of fraud, waste and abuse.

Clinic programs and initiatives will be in place to address opioid misuse and overprescribing. Members receiving opioids from multiple providers and pharmacies will be identified through a *Doctor Shopper* program, and those receiving dangerous drug combinations with opioids will be flagged through the *Triple Threat* initiative.

The Contractor will utilize formulary management efforts to help ensure appropriate dosing. These efforts will include prior authorization on highly abused opioids and quality limits, including day supply restrictions for first fills.

The Contractor will do significant work with partners to improve community health and strengthen the safety net and providing funding to community coalitions through the "*Taking Action on Opioid and Prescription Drug Abuse in Michigan*" grants. The Contractor will form a unique partnership with Michigan's top provider organizations to educate patients and providers, and partner with pharmacies to expand drug take back locations.

The Contractor's Online Visits will be managed to ensure that they are maintaining an adequate provider network so that our members are able to get access to qualified therapists and psychiatrists quickly even though these services are not intended to treat substance use disorder as a primary diagnosis.

The Contractor will use their clinical practice guideline on adult substance use disorders and also a set of Guiding Principles in the Treatment of Substance Use Disorders that are based

on nationally recognized sources such as the Substance Abuse and Mental Health Services Administration, the American Society of Addiction Medicine, and the National Institute for Drug Abuse. This document will be utilized to foster dialogue with providers and facilities about:

- Adopting evidence-based substance use disorders treatment practices.
- Addressing unmet needs of persons with substance use disorders through innovation.
- Collaborating to improve systems of care for members with substance use disorders.
- Refer members with opioid use disorders to medication-assisted treatment (MAT) which is evidence-based, and can be conducted on an outpatient basis.

Members with opioid use disorder that have comorbid opioid use disorder and a medical condition will be served in the Contractor's integrated case management program.

The Contractor supports that members in need of substance abuse treatment will be better served getting treatment close to home where their support system lives and where their post discharge services are available. Management of members in out-of-network/out-of-state substance abuse treatment facilities will start before the member is admitted. The Member Substance Use Disorder Clinical Response Unit will help the clinical staff educate members about the potential cost implications and quality of care considerations of using out-of-network, out-of-area providers. The Unit will educate members about their condition and treatment options and guiding them to local, in-network residential treatment facilities and lower levels of care, including Medication-Assisted Treatment, when clinically appropriate. Staffed by mental health clinicians who are trained in addiction services and member outreach, this program will use early engagement and member education to influence members' decisions and encourages decisions that result in optimal treatment. When a member calls requesting information about their benefits for out-of-area, out-of-network treatment, the call will be transferred to a clinician who provides this education. In addition, if a physician/provider reaches out to the Contractor on behalf of their patient, the clinician will outreach to the member to provide information on the benefits of in-network, local treatment.

The Contractor will follow additional protocols for out-of-network facilities. Every admission to an out-of-network inpatient hospital, residential facility, partial hospitalization program or intensive outpatient program will have an intensity of service review for the hours of service, specific types of program services, and appropriate personnel. The Contractor requires that the facility fax a copy of their licensure to provide the level of care requested prior to authorization.

The Contractor will provide computerized cognitive behavior therapy, to complement and enhance traditional care while helping to address issues of cost, lack of access and stigma. Computerized cognitive behavior therapy modules to address depression, anxiety, stress, substance use disorders, chronic pain/opioid management and insomnia will be offered.

i. Evolving Data Analytics:

Contractor's Plan:
Contractor's clinical staff will have a link to a listing of Contractor's behavioral health/substance abuse providers, with specific sub-specialties, that will be embedded within the clinical platform, enabling clinical staff to refer acute members to the most appropriate provider to meet their specific clinical needs and ensure that members with the greatest clinical complexities are matched with the highest performing provider.

The Member Substance Use Disorder Clinical Response Unit will help the clinical staff educate members about the potential cost implications and quality of care considerations of using out-of-network, out-of-area providers as indicated in Section 1.D.4.h above.

j. Service Delivery Models:

The Contractor will provide a downloadable application for members, BCBSM Online Visits, or services can be obtained at Contractor's website: BCBSMOnlineVisits.com.
Both platforms will give members the capability to have a video face-to-face visit with a provider. As a back-up to experiencing any technical difficulties, members can call the Online Visits support line and have a telephonic visit.

The Contractor will offer digital interactive experiences through their subcontractor, myStrength, Inc., and their site mystrength.com. These experiences include interactive exercises, self-care modules and daily wellness inspiration personalized to each member. This will assist members in building resiliency, managing stress, improving mood, sleeping better, finding daily inspiration, empowering users with individualized pathways and incorporating multiple programs to help manage and overcome co-occurring challenges. The platform will include clinically-reviewed wellness resources for diabetes, smoking cessation, nutrition, depression, pregnancy and postpartum mental health, anxiety, stress, substance use (including opioid management and addiction recovery), chronic pain, insomnia, and LGBTQ+ resources.

k. Mobile Capabilities:

Members will be able to use their Apple or Android-compatible smartphone or tablet to access information and services. Highlights include:

- Log in with Touch ID® for iPhone users, or fingerprint for Android users whose plans support it
- View, share or order an ID card
- See and search for services covered by their plan
- View and search deductibles and other plan balances
- Find doctors and hospitals in their plan
- View or update their primary care physician
- Check claims and explanation of benefits statements
- Estimate cost and quality for medical procedures and drugs
- Compare procedure costs
- Visit the Health & Wellness site to take a health assessment and use tools like the Personal Health Record, Digital Health Assistant programs and Health Trackers
- View and dial a 24-hour nurse line for expert medical advice
- View and dial customer support to get help with their plan
- Get Blue365® member discounts
- Update their account profile, preferences, and permissions

The Contractor will add new functionality regularly.

The Contractor's member portal and mobile app displays will be customized for each member. Once an employee's access is authenticated, members will be able to find a doctor, view their benefits, claim detail, and explanation of benefits statements; and update their account. They'll also find transparency and wellness tools through the secure member portal to help them make informed decisions about their health care.

See Section 1.D.4.j for Contractor's offering of mystrength.com which is mobile accessible. The Contractor's clinical team will be available through the 24/7 contact center to assist members with any features, benefits and questions in regard to the myStrength platform. There will also be Contact Center support staff available to warm transfer members to myStrength for additional technical support when needed.

5) Tele-behavioral Health

a. The Contractor must offer tele-behavioral health.

The Contractor provides tele-behavioral health through their Blue Cross Online Visits solution. This includes the BCBSM Online Visits app and the BCBSMOnlineVisits.com website. The online behavioral health services include psychiatry and therapy visits which are pre-scheduled and generally available with extended hours.

When applicable, based upon the member's benefit plan, the Contractors customer contact center clinical team will guide and assist members in accessing care through this tele-behavioral health solution.

b. Credentialing Requirements:

All providers in the Online Care Group are credentialed, have an average of 10-15 years in a brick-and-mortar practice, and many are licensed in multiple states. Online Care Group's internal credentialing process meets all standards as dictated by NCQA and is certified by NCQA in credentialing and recredentialing. Online Care Group has an internal credentialing team responsible for performing quality oversight and primary source verifications in accordance with NCQA and Utilization Review Accreditation Corporation (URAC) standards. The Online Care Group also has a robust credentialing infrastructure including detailed policies and procedures, as well as a staff physician-led credentialing committee (comprised of a chief medical officer, staff physician, and director of behavioral health) that will review and approve all practitioners before they are permitted to practice on the Contractor's system.

c. Operation:

In the Blue Cross Online Visits solution, the Contractor utilizes the Online Care Group of providers to have video consultations with members. These video visits will be pre-scheduled and can be for therapy or psychiatry services.

Therapists such as psychologists, licensed clinical social workers, marriage and family therapists and professional counselors will conduct therapy video visits with members. Therapy will be available to adults and children age 10 and older by appointment and visits typically last 45 minutes.

Psychiatry will be available to adults age 18 and over and visits will be by appointment only. Extended hours during evenings and on weekends may be available. The initial visit will usually last 45 minutes with 15-minute follow-up visits.

d. Locations:

Blue Cross Online Visits medical, therapy, and psychiatry services are available in all 50 states. See also Section 1.D.3.

e. Free Test Call:

The Contractor will arrange for a coupon code to be provided to the Plan Sponsor for a free test call with a behavioral health provider to evaluate the service. The Contractor will keep a video available that walks through the process of setting up an account and conducting a visit using the Contractor's telemedicine solution which may be a helpful resource to those who have not yet signed up for the Blue Cross Online Visits solution. That video can be found here: https://wwwl.youtube.com/watch?v=TvjLqli4Ivc

6) Applied Behavior Analysis (ABA)

a. The Contractor must offer ABA.

The Contractor will provide an Autism Resource Program specializing in the treatment of autism spectrum disorder (ASD) that provides utilization management and case management for members receiving Applied Behavior Analysis (ABA) services. The program is comprehensive in its approach and includes care coordination and family education; network access and support; provider and community outreach and a full array of metrics and reporting to track progress and utilization. The Contractor will adhere to an ASD Medical Policy that incorporates treatment guidelines grounded in clinical research. The Policy sets forth the requirements for service that are considered to be medically necessary.

The Contractor's Autism Resource Program will serve all members who initiate contact with the Contractor and express an interest in enrolling in the program. Upon enrollment, a Care Manager will be assigned to assist the member with referrals to medical and behavioral health specialists who can contribute to a comprehensive diagnostic evaluation for the member. This diagnostic evaluation process can often take some time and the Care Manager will support and guide the member throughout that entire process. The Care Manager will also refer the member to other community and professional resources, as determined through the care management process.

The Contractor's pre-certification process for ABA will generally be initiated by the provider after the initial assessment of the member. At the initial assessment, target symptoms will be identified and a treatment plan will be developed that identifies the core deficits and challenging behaviors, and will include designated interventions intended to address these deficits and behaviors and achieve individualized goals. Treatment plans will be reviewed for medical necessity at least twice annually to allow re-assessment and to document treatment progress. A Functional Behavioral Assessment (FBA) may also be a part of any assessment. An FBA consists of:

1) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity)
2) History of the problematic behavior (long-term and recent)
3) Antecedent analysis (setting, people, time of day, events)
4) Consequence analysis
5) Impression and analysis of the function of the problematic behavior

The Contractor's ABA program data collection system will track member progress over the course of treatment. Data points will include tracking standardized adaptive functioning scores, treatment plan goal progress, and industry standard assessment scores. This collage of data will allow the Contractor to accurately measure clinically significant progress. Aggregate member treatment intensity data by age band by geographical area will provide the Contractor with provider outlier utilization behavior.

b. ASD Diagnosis:

The Contractor requires that an ASD diagnosis be made by a qualified provider. In Michigan, the member must have a diagnosis of ASD and a recommendation for ABA treatment made as a result of an evaluation at a Michigan Approved Autism Evaluation Center (AAEC). If the member is located out of the State of Michigan, the diagnosis will require all evaluation components listed in the Contractor's Michigan Blue out-of-state Multidisciplinary Evaluation Checklist (MEC).

A qualified health care professional is defined as a health care professional who is an autism specialist with appropriate state licensure, experience and training to conduct a comprehensive diagnostic evaluation of ASD. Such specialists will be typically one of the following clinical specialties: pediatric neurologist, developmental pediatrician, board-certified pediatrician, board-certified child psychiatrist, fully licensed child psychologist, or a medical doctor experienced in the diagnosis of ASD.

c. Other Diagnosis:

The ABA benefit will only be payable with the diagnosis of an Autism Spectrum Disorder.

d. Criteria for Children:

Once a member has received a diagnosis of Autism Spectrum Disorder by a qualified provider, the member will have access to their ABA benefits and can begin working with a Board-Certified Behavior Analysts to receive ABA treatment.

e. Utilization and Case Management Processes:

The Contractor's Autism Resource Program will utilize a holistic approach that integrates the efforts of families, providers, community resources and New Directions in the treatment of autism spectrum disorder to ensures that each member receives the right level of high-quality care while delivering unsurpassed efficiency, lower costs and positive member outcomes. This program will provide state-of-the art services to members and health plans and will include the following:

- The program will be led by licensed and experienced clinicians, including psychiatrists, licensed clinical social workers and certified case managers
- All utilization and case management services will be provided by experienced board-certified behavior analysts

- The program will be administered by a centralized unit using a well-defined, evidence-based autism spectrum disorder medical policy that incorporates treatment guidelines grounded in clinical research
- An Autism Provider Advisory Committee will meet a minimum of four times per year with program leadership to provide feedback on issues such as access, clinical outcomes, and barriers to treatment. On an annual basis, they will provide input on Contractor's medical policy and clinical practice guideline.

This program is comprehensive in its approach and includes the following services to support individuals and families:

- Support and Guidance through Evaluation and Diagnosis as referenced in Section 1.D.6.a.

- Care Coordination
  After diagnosis of autism spectrum disorder is confirmed, care managers will support the member by coordinating referrals, as needed, to medical and behavioral health providers, community support resources, and providing educational information. Care managers will also provide support to the member to help foster and facilitate communication among various behavioral health and medical providers, care facilities, and care resources. This case management program is accredited by the NCQA and URAC.

  In addition, care managers will educate members about the treatment and utilization review process. For members who are not benefitting from applied behavior analysis treatment or have made maximum gains from treatment, care managers will collaborate with the family and applied behavior analysis provider to assist in transitioning the member to other community-based help and professional health care.

- Utilization Management (UM)
  The ABA for the Treatment of Autism Spectrum Disorder Medical Policy sets forth the requirements for an applied behavior analysis service request to be considered "medically necessary" and thus, a covered service.

  The Contractor will conduct utilization review on all ABA service requests. For a member who has not previously been authorized by the Contractor for ABA services, a Contractor care manager will review the submitted documentation to validate that the member meets diagnostic criteria for an autism spectrum diagnosis from a licensed qualified health care provider. The Contractor will also review other data sources, including but not limited to the member's developmental and medical history, behavioral and cognitive evaluations, information pertaining to medical comorbidity and neurological evaluations. If the Contractor determines that the member has an active benefit and confirmed diagnosis, an authorization for an assessment to develop the ABA treatment plan will be issued to the ABA provider.

  The initial assessment will include a Board-Certified Behavior Analyst provider meeting face to face with the member and his or her family for an in-depth evaluation. Based upon the needs and deficits in function identified in the initial assessment, a proposed treatment plan created by the provider will be submitted for Contractor benefit coverage determination. Upon receipt of the assessment and treatment plan, a Contractor Board Certified Behavior Analyst will review the submission to determine if the request supports medical necessity under Contractor's Autism Spectrum Disorder Medical Policy. If the member is of primary school age or older, the reviewer will also ensure that the treatment plan is not purely academic in nature. The Contractor does not approve for reimbursement ABA services that duplicate or replicate services received in a member's primary educational setting or are within an individualized education plan or individualized service plan. Approvals for service requests will be consistent with the state mandate and/or health plan policy language that apply to the request.

  The total authorized hours of treatment will be determined based upon on the provider's submitted treatment plan and request, the member's age, the severity of his or her core symptoms (including aberrant behaviors), and developmental functioning as indicated by standardized psychological testing. For individuals already receiving ABA therapy, all of

the aforementioned factors will be considered in addition to outcomes measured by goal attainment, demonstrated ability to learn, and other factors outlined in the Autism Spectrum Disorder Medical Policy. The Contractor staff clinician reviewing the service request may collaborate with the ABA provider to seek clarity on the proposed ABA treatment submitted for coverage consideration. If the staff clinician is unable to approve all services requested after a review of the criteria set forth in the Autism Spectrum Disorder Medical Policy, the case will be sent to a licensed psychiatrist who reviews the provider's service request and will make a determination whether the request is eligible for benefit coverage based on medical necessity. The staff clinician will inform the member's guardian and provider of the physician's determination regarding benefit coverage and why the particular service request was not approved.

Concurrent reviews will be conducted every six (6) months. A comprehensive medical record will be submitted by the ABA provider to include:

1. Collected data, including additional non-standardized testing such as Assessment of Basic Language and Learning Skills (ABLLS), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or other developmentally appropriate assessments, celeration charts, graphs, progress notes that link to interventions of specific treatment plan goals/objectives. Only those portions of assessments that address core deficits of autism are reimbursable; this excludes assessments or portions of assessments that cover academic, speech, vocational deficits, etc.
2. Individualized treatment plan with clinically significant and measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD.
3. Goals should be written with measurable criteria such that they can be reasonably achieved within six months.
4. Goals should include documentation of core symptoms of ASD identified on the treatment plan, date of treatment introduction, measured baseline of targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, a specific plan for Generalization of skills, and the number of hours per week estimated to achieve each goal.
5. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated.
6. Documentation of treatment participants, procedures and setting.
7. Appeal rights will always be offered to the provider and family if a determination is made to not certify any or all the services requested. As with any requested service that requires authorization, multiple appeal rights exist for a medical necessity-based denial. State mandates will typically dictate that care treatment plans can be reviewed twice annually. The biannual reviews will help the Contractor monitor ongoing treatment and confirm treatment is improving the member's level of functioning and is consistent with the requirements of applicable state regulations, the member's insurance benefit, and the Autism Spectrum Disorder Medical Policy.

- <u>Standardized Assessment Tools</u>
  Standardized Assessments will include, but not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and will be administered and scored in a uniform way with all patients. (AMA CPT, 2019) The autism specific assessments will assist in the confirmation of diagnosis and in determining the severity and intensity of the baseline core ASD behaviors.

- <u>Autism Specific Standardized Assessments</u>
  - Childhood Autism Rating Scale, second edition. (CARS-2)
  - Childhood Autism Spectrum Test. (CAST)
  - Social Communications Questionnaire (SCQ)
  - Social Responsiveness Scale, second edition. (SRS-2)
  - Autism Behavior Checklist (ABC)
  - Gillian Autism Rating Scale (GARS)
  - Aberrant Behavior Checklist
  - Autism Diagnostic Observation Schedule, second edition. (ADOS-2)
  - Autism Diagnostic Interview, revised (ADI-R)

- Checklist for Autism in Toddlers (CHAT)

- Other Standardized Assessment Instruments
  - Vineland Adaptive behavior Scale (VABS)
  - Adaptive behavior Assessment Scale (ABAS)
  - Behavior Assessment System for Children (BASC)
  - Pervasive Developmental Disorder Behavior Inventory (PDDBI)

- Standardized Cognitive Assessments
  - Leiter International Performance Scale-R
  - Mullen Scales of Early Learning
  - Bayley Scales of Infant Development
  - Kaufmann Assessment Battery for Children, second edition. (K-ABC-II)
  - Wechsler Preschool and Primary Scale of Intelligence, third edition. (WPPSI-III)
  - Wechsler Intelligence Scale for Children, fourth edition. (WISC-IV)
  - Test of Non-Verbal Intelligence, fourth edition (TONI-4)

f. Reserved.

g. Reserved.

h. Standard Exclusions:

The Contractor's Medical Policy on ABA lists services that have insufficient or no evidence to support efficacy and, therefore, do not meet medical necessity. Other exclusions are services that are academic or custodial in nature and should be provided through educational or other systems that are not medical. Services specifically excluded for certification or authorization include:

- Services that are purely academic and duplicate or replicate academic learning in a school setting for a school age member
- Services that are not congruent with the Autism Spectrum Disorder for ABA Medical Necessity Coverage Criteria and/or the Service Intensity Guidelines
- Cognitive Therapy or retraining
- Treatment that is considered to be investigational/experimental, including, but not limited to: Auditory Integration Therapy; Facilitated Communication; Floor Time (DIR, Developmental Individual-difference Relationship-based model); Higashi Schools/Daily Life; Individual Support Program; LEAP; SPELL; Waldon; Hanen; Early Bird; Bright Start; Social Stories; Gentle Teaching; Response Teaching Curriculum and Developmental Intervention Model; Holding therapy; Movement Therapy; Music therapy; Pet Therapy; Psychoanalysis; Son-Rise Program; Scotopic Sensitivity training; Sensory Integration training; Neurotherapy (EEG biofeedback); Gluten-free/Casein-free diets; Mega-vitamin therapy; chelation of heavy metals; Anti-fungal drugs for presumed fungal infection; Secretin administration
- Respite, shadow, para-professional, or companion services in any setting
- Personal training or life coaching
- ABA services in residential facilities to replace or augment the internal behavioral health or ABA program
- Custodial care with focus on activities of daily living - bathing, dressing, eating and maintaining personal hygiene, etc. - that do not require the special attention of trained/professional ABA staff
- Any program or service performed in nonconventional settings (even if the services are performed by a licensed provider), including: spas/resorts; vocational or recreational settings; Outward Bound; and wilderness, camp or ranch programs

7) The Contractor must commit to providing innovative Solutions for Families within Rural Locations:

The Contractor's Online Visits will provide an alternative solution for families in rural locations. Members will be able to talk to a therapist or psychiatrist on the Online Visits app and the BCBSMOnlineVisits.com website.

In addition to tele-behavioral health access to psychiatrists, the Contractor will offer a PCP Helpline that offers PCPs and other medical specialists an easy way to refer their members for behavioral health treatment as well to have discussions with Contractor's staff psychiatrist. The Contractor's digital health offerings through myStrength will offer alternative mobile/web-based methodologies for members to access services and will be particularly valuable for members in rural areas with limited access to behavioral health providers. To address the opioid epidemic, the Contractor will work to increase the number of medication-assisted treatment providers in Michigan.

The Contractor's provided Resource Access Portal (RAP) platform will evaluate member access to community resources (e.g., condition support groups, housing and financial assistance, literacy programs, etc.). The RAP will include a spatial analysis platform to wrap services around members by displaying multiple resources at one time in relation to the member's zip code. The Contractor will analyze member's communities to see which resources/programs can do the most good and provide multiple links between the social services infrastructure and challenges each member faces, such as access to transportation, meal preparation/ delivery, support groups and resources, etc.

8) Reserved.

9) Reserved.

E. Utilization Management (UM) and Quality Assurance

1) Utilization measures for all service methods must be tracked, including but not limited to (1) admit rates, average length of stay, and days or visits/1000, by level of care, (2) readmission rates for higher levels of care, (3) number of visits per episode of care, and (4) interventions by the Plan Sponsor. Separate calculations must be provided for in-network and out-of-network utilization.

   The Contractor will track these measures and provide comprehensive reporting on a monthly, quarterly and annual basis as required in Section 4.3 Reporting.

   The Contractor will measure the success of its overall management of behavioral health services and the success of individual clinical programs. The Contractor's financial and advanced analytics teams will work with Contractor's clinical program owners to design a measurement methodology that is suited to the program and that is scientifically and statistically sound. The Contractor will continually monitor, adjust, and evolve its programs and services to ensure the value we bring to the State meets or exceeds their expectations.

   a. Periodic on-site audits of participating providers must be conducted according to applicable credentialing standards.

      The Contractor's Quality Management Coordinators (QMC) will conduct a facility site visit and a medical record review for all network practitioners for any of the following reasons:

      - Member complaints about physical accessibility, appearance and adequacy of waiting and exam room space (three complaints per calendar year is the threshold unless the severity of the issue requires action prior to reaching the threshold).
      - Identified deficiencies when a site visit is being conducted for other reasons (for example, HEDIS® reviews, Quality Management (QM) studies/audits, disease-specific medical record reviews, medical record review audit, etc.).
      - Member surveys
      - Reports from provider affairs
      - Executive inquiries
      - Suspicion of fraud, waste and or abuse
      - Nonaccredited organizational provider facilities will be reviewed prior to initial credentialing, and every three years, and must meet and maintain acceptable standards of safe and sanitary conditions. The only exception is any facility under current Centers for Medicare & Medicaid Services (CMS) survey unless the CMS survey is not completed within the three-year timeframe, at which time, the health plan will conduct a site visit. Medical record review will not be required
      - Random reviews to monitor compliance with established standards for adequacy of medical record keeping.

- If the provider doesn't meet the expected standards for the site visit, the QMC will schedule a follow up visit within 30 calendar days to reassess if the provider has taken the necessary actions to meet the expected standards.
- If during the follow up visit, the provider doesn't meet the expected standard (90 percent or greater score) and/or the office meets the complaint threshold for a different standard, the plan medical director will be consulted for recommendations. The QMC will schedule another follow up visit within 30 days to reassess provider office for compliance and share findings with provider and plan medical director. Contractor will provide the practitioner with a written summary of both facility and medical record review findings, signed by the appropriate plan medical director. The summary will include detailed documentation of criteria that didn't meet Contractor standards for facility or medical record review.
- Subsequent monitoring will occur at least every six months for all providers until compliance is achieved.

b. Precertification:

For precertification/prior authorization for all levels of care, the facility or provider provides clinical information regarding the request for treatment to the Contractor prior to the member being admitted/starting services. The request can be made by phone or through the Contractor's web-based, provider self-service WebPass system. The utilization manager will then apply the Medical Necessity Criteria (MNC) for the requested level of care to the clinical information provided and a determination is made. If the clinical information provided supports the requested level of care, the utilization manager will authorize the care. If the clinical information does not support the requested level of care, the case will be sent to a licensed psychiatrist for a peer review. For levels of care requiring precertification, payment will be dependent on having an authorization entered into the clinical information system.

The Contractor's Provider portal (WebPass) must be available 99.5% of the time with service availability performance of 99.5%. Status will be captured in the Contractor's Service availability report. See also Schedule A Section 4.3 and **Schedule M.**

c. Ratio of Clinical Utilization and Care Managers:

For outpatient visits, excluding higher levels of care such as partial hospitalization or IOP, the Contractor's ratio of clinical utilization managers to covered members is 1:180,000. The Contractor does not have separate case managers for outpatient visits. The Contractor's case managers will work with all members who meet criteria for case management, as many members utilize multiple levels of care over time. The Contractor's overall ratio of case managers to covered members is 1:150,000.

The Contractor will proactively monitor staffing ratios based on current and projected membership and customer contracts to ensure all performance standards are met or exceeded. The Contractor will have utilization and care managers located in Michigan, with additional behavioral health clinical support operations based in Kansas City, Missouri. The additional operations provides 24/7/365 service support to ensure there are no disruptions in best-in-class service to the Plan Sponsor's members as a result of an adverse situation (e.g., higher than expected call volume, severe weather, power/telecommunications outages, etc.).

d. Triggers for utilization management reviews:

The Contractor will formulate an outpatient utilization review program based upon claims analysis and risk modeling to determine normative utilization patterns for diagnostic conditions and conduct provider review based on individual member outlier utilization as well as provider practice pattern utilization. These triggers may include:

- Diagnosis of a serious mental illness with no psychiatric evaluation after six (6) sessions.
- Weekly therapy claims for more than 365 days.
- Multiple outpatient therapy claims per week for more than six (6) months.
- Outpatient therapy sessions with a primary diagnosis of substance use but no history of other treatment.
- Diagnosis of a depressive disorder with no psychiatric evaluation after eight (8) sessions.

- Member seeing more than two providers at the same time.
- Member has sequential treatment with three or more providers in a rolling 12-month period.
- Member has more than three assessments in a rolling 12-month period without engaging in subsequent treatment.
- Member is prescribed psychotropic medications from more than one physician.

The Contractor typically will not conduct precertification or concurrent reviews for routine outpatient treatment due to mental health parity legislation. The only outpatient service the Contractor will typically manage is electroconvulsive therapy (ECT). The Contractor may also manage requests for psychological and neuropsychological testing above the number of hours allowed by the Plan Sponsor. The Contractor has MNC for outpatient treatment and will align services and operations with the Plan Sponsors plan design as described in **Schedule C, Plan Design and Claims Payment Rules**.

2) Additional Contractor information for UM and Quality Assurance:
   a. Care Management: Licensed clinicians conduct all medical necessity reviews.
   b. Access to psychiatrists for consultation: Care management clinicians have ready access to psychiatrists for consultation.
   c. Medical necessity denials of BH/SA treatment rendered by psychiatrists: Psychiatrists review and approve all medical necessity denials involving treatment by psychiatrists.
   d. Care management triggers for selected outpatient BH/SA treatment: Outpatient BH/SA visit claims and/or treatment plans are screened for characteristics triggering a care management intervention (e.g., an eating disorder diagnosis).
   e. Medical Director for BH/SA treatment: Board-certified in psychiatry, licensed, experienced in both psychiatric and addictive disorders.

3) The Contractor must have established MNC protocols in place for inpatient, day treatment, partial hospitalization, intensive outpatient, outpatient levels of care in place, that include clinical criteria or guidelines for admission, discharge, and step-down.

   Contractor will utilize their internal MNC that defines each level of care and encompasses explicit clinical review criteria and application approaches for recognized settings of behavioral health treatment. The criteria for each level of care includes intensity of service criteria, admission criteria, continued stay criteria and benefit denial criteria. The criteria will be used to determine the medical necessity and clinical appropriateness of requested services. The MNC accounts for the differential needs between children/adolescents and adults. The following levels of care are included in the criteria:
   - Psychiatric acute inpatient, residential, partial hospitalization, intensive outpatient, and outpatient
   - Substance use disorder inpatient detoxification, residential/subacute detoxification, ambulatory detoxification, inpatient rehabilitation, residential/subacute rehabilitation, partial day rehabilitation, intensive outpatient rehabilitation, and outpatient rehabilitation
   - Eating disorder acute inpatient, residential, partial hospitalization, intensive outpatient, and outpatient
   - Psychological and neuropsychological testing
   - Electroconvulsive therapy (ECT) - inpatient and outpatient
   - 23-hour observation
   - Crisis intervention
   - Community case management

   Copies of the Contractor's MNC and medical policies will be available to all providers via the Contractor's subcontractor website: www.ndbh.com. MNC will be reviewed and approved by Contractor Quality Management Committee and chief medical officer on an annual basis.

4) The Contractor must have established concurrent and retrospective review procedures in place, including staff qualifications to conduct the review, information required to complete the review, decision timeliness requirements, documentation requirements, and how staff are trained and monitored to insure appropriate application of clinical criteria within acceptable levels of inter-rater reliability.

These Contractor procedures are documented in the Contractor's Care Management Program Description as well as in more detailed clinical policies and procedures documents.

Contractor Staff Qualifications:
The Contractor's UM team will handle authorizations and denials for all levels of care requiring authorization. The UM team will be comprised of the Medical Director, Clinical Director, Manager of Utilization Management, Utilization Managers (who are licensed behavioral health clinicians), and Clinical Support Coordinators (CSCs) who are non-clinicians. UM is one arm of the Contractor's Clinical Services Department. The clinicians and CSCs on the UM team will report to the Manager of UM, who reports to the Clinical Director. The Medical Director will report to the Chief Medical Officer.

The Contractor's clinical team supporting the Plan Sponsors members will include individuals with extensive education and experience in their particular discipline. The Contractor's Medical Director is a Michigan-licensed, Board-certified psychiatrist. The clinical team is composed of licensed behavioral health clinicians who represent different disciplines (e.g., nurses, social workers, licensed counselors) and have different clinical experience (e.g., mental health, substance abuse, ABA). Contractor staff must have other qualities such as passion for their job, compassion for others, curiosity about people and their life situations, ability to be a team player, leadership, a strong work ethic, ability to solve problems and a commitment to excellence. The Contractor's behavioral interviewing techniques will assure that the Contractor evaluates candidates on all of these qualities. Functional teams will work closely together on a daily basis, with a shared vision to ensure best-in-class service and support to participants.

Contractor's Concurrent Review Procedures:
The Contractor will schedule concurrent reviews whenever clinically warranted. Authorizations and subsequent concurrent reviews will be based on the information provided and the clinical judgment of the Contractor reviewer. Concurrent reviews will be conducted telephonically or via the Contractor's WebPass system with facility utilization review staff or the attending physician/provider. WebPass can be used to submit initial/concurrent authorization requests and review the status of authorizations that have been submitted.

Continued stay approvals will be contingent upon the justification presented for a length of stay that differs from the original estimate. The Contractor will review any potential barriers to discharge and how those barriers will be addressed along with documentation concerning the member's response to treatment and medication. Failure to provide the required information during a concurrent review will initially result in an attempt to gather further information telephonically. Whether this attempt is successful or not, the Contractor will render a benefit decision based upon the submitted clinical information received, meeting all regulatory guidelines.

Utilization Managers will collect only the minimum information necessary to make a medical necessity determination and ensure quality of care. All information will be entered into and stored securely within the Contractor's proprietary clinical information system, OPTAMUM. During concurrent reviews, the utilization manager will collect information such as:

- Information not available at the time of initial review, e.g. psychosocial history
- Results of diagnostic testing or labs
- Treatment plans and progress notes
- Response to medication and any medication changes
- Discharge plan
- Expected discharge date.

MNC will be applied to help guide the clinical staff in determining if the level of care continues to be appropriate. UM's may approve requests for authorization but cannot deny requests for services. When UM's believe that the clinical information provided in a review does not meet the Contractor's MNC for the requested level of care, the case will be submitted for clinical Peer Review to the Benefits Determination Unit (BDU). The BDU will assure all information is complete and will schedule a Peer Review. In submitting the request for Peer Review, the UM will clearly state the reason for referral, the reasons MNC does not appear to be met, and the recommended alternative level of care. The Peer Reviewer will attempt to discuss the case in detail with the attending physician/provider to ensure all clinical information is available for consideration in the decision. The available clinical information specific to the case will be

considered against MNC and a decision will be rendered. If the requested level of care does not meet medical necessity, an alternative level of care that is clinically appropriate and available to the member will be offered. The member and provider/facility will be notified verbally and in writing of the outcome as well as of the recommended alternative level of care, if the decision is to deny benefit coverage. The member and provider/facility will also be notified any appeal rights if applicable.

Contractors: Retrospective Review Procedures:
The Contractor will rely on the facility to contact them prior to admitting the member to a facility although there may be circumstances that impact the ability of a facility to do so. The Contractor has procedures on handling requests for authorization after the member has already been admitted to a facility. If a facility contacts the Contractor within three days of the admission, the UM will conduct the review, determine if medical necessity is met, and either authorize or submit the information for peer review. If the facility contacts the Contractor more than three days after admission, the provider will have three options:

- The facility can fax the medical record to the Utilization manager. The Contractor requests that they do so within two hours of making the request. The Utilization Manager will review the medical record and make a medical necessity determination. The one-day timeframe for making a determination will start when the record is received.
- The facility can elect to withdraw the request and submit the medical record for retrospective review after the member is discharged. The Contractor will have 30 days from the receipt of the medical record to complete a retrospective review.

Contractor's Decision and Timeliness Requirements
The Contractor will follow NCQA standards for decision timeliness.

- Inpatient and Residential
  - Initial Review: 1 calendar day for concurrent urgent; 3 calendar days for preservice urgent
  - Concurrent Review: 1 calendar day
- PHP, IOP, Outpatient
  - Initial Review: 1 calendar day for urgent; 3 calendar days for preservice urgent and non-urgent
  - Concurrent Review: 1 calendar day for urgent; 3 calendar days for non-urgent
- First level expedited appeals: 72 hours
- First level standard appeals: 30 calendar days

Contractor's Staff Training and Monitoring to Insure Appropriate Application of Clinical Criteria within Acceptable Levels of Inter-Rater Reliability:
The Contractor's established training program begins at time of hire and continues through the staff member's career with the Contractor. Each staff member working on the Plan Sponsors account will receive extensive training on the specifics of the Plan Sponsor account.

The Contractor's program begins with a five-week schedule of training that includes a mentor/shadow program. This shadowing can be run virtually with phone calls, and screen sharing, enabling trainees to follow and work on cases prior to a go-live date. Mentors assigned to new employees will remain available after the initial training period for up to 90 days to further assist with questions and concerns to help ensure successful knowledge transfer. Managers will proactively monitor progress ongoing, to confirm that staff know how they are performing and provide extra training that might be beneficial. Training modules include, but are not limited to:

- Individual job functions
- Managed care basics
- Medical Necessity Criteria, Clinical Practice Guidelines and Medical Policies
- Conducting initial, concurrent and discharge reviews
- Denials and appeals
- Motivational interviewing, readiness for change, member coaching and empowerment strategies
- Health literacy and cultural diversity

In addition to this training, the Contractor provides clinical staff with:

- Robust, clinically-oriented online training, including diagnosis-specific, condition-specific, and treatment-specific training courses (e.g., for depression, schizophrenia, and anxiety disorders).

- Training and resources on common medical conditions (e.g. diabetes, cardiac disease) that will assist staff who do integrated case management.
- Reimbursement for cost of tuition and time off for outside expert training experiences to maintain their licensure.
- Access to detailed Policies and Desktop Procedures via the New Directions intranet site.

Following initial training, staff will be supervised and monitored on an ongoing basis to assure proper and consistent application of level of care guidelines, including:

- Weekly individual and group supervision.
- Case rounds conducted several times per week with both clinical and medical staff to discuss difficult cases and cases with potential over utilization.
- Monthly documentation audits conducted on a random sample of each clinical staff's cases. Results will be shared with the individual staff members and best-practices or frequently observed opportunities for improvement will be shared with the teams.
- Monthly call audits on a random sample of each clinical staff's recorded calls. Results will be shared with the individual staff members and best practices or frequently observed opportunities for improvement will be shared with the teams. Live call monitoring will be conducted on a monthly basis in order to provide immediate feedback.

For UM team members, including medical and clinical staff, quarterly inter-rater reliability (IRR) studies will be conducted to assess the consistency of the application of MNC across all Contractor clinical staff, medical staff and contracted Independent Review Organization staff. An IRR workgroup, consisting of directors and managers of clinical services, will create the vignettes that are then reviewed and approved by the Chief Medical Officer. The vignettes will represent a sample of all levels of care subject to medical necessity review, admission and continued stay requests, child/adolescent and adult presentations and mental health, substance use and eating disorder types of treatment. Staff will be presented with four clinical vignettes each quarter and asked to apply MNC in light of the capabilities of the local care delivery system. Results will be discussed with the team and cases with low inter-rater reliability will be discussed in depth. Aggregate quarterly and year to date IRR scores will be reported to the Regional Care Management Committees for review and recommendations. Annual IRR results will be reported to the Corporate Quality Management Committee.

Monthly clinical scorecards will track productivity and performance metrics of clinical staff. This information will be available by individual staff member, team, account, and at the company level. The information will be shared with staff individually and by team on a monthly basis.

5) The Contractor must have established protocols in place for physician peer review, including clinical or quality of care indicators for physician review, other than medical necessity.

Contractor's protocols:
When the Utilization Managers believe that the clinical information provided in a review does not meet the MNC for the requested level of care, the case will be submitted for clinical Peer Review to the BDU. This portion of the process is described in detail in Section 1.E.4 under Concurrent Review Procedures. If the denial is appealed, there will be another opportunity for a peer-to-peer discussion with a peer who was not involved in the initial denial decision.

Notification of medical necessity decisions will be communicated verbally to the provider/facility and in writing to the provider/facility and to the participant. The denial letter will contain the following elements:

- A statement that the Contractor is responsible for reviewing requests for behavioral health services for medical necessity.
- A statement that the Contractor has reviewed all information submitted by the physician/provider for the requested level of care and requested dates of service and has found that the request did not meet medical necessity.
- The clinical rationale given by the Contractor's psychiatrist reviewer for the denial and the medical necessity criteria not met for the requested level of care.
- The alternative level of care that Contractor's psychiatrist reviewer believes is medically necessary and available to the member.
- An offer to send the MNC to the provider.

- A statement that the assessment of medical necessity has been made for benefit and coverage purposes only and that it is the responsibility of the provider to use their professional judgment to provide the care believed to be in the best interest of the member.
- Instructions on how to file an appeal of the denial.

Peer-to-peer conversations may also be initiated when treatment is not progressing as expected or when there are quality of care concerns. When a quality of care concern is identified, the utilization/case manager will discuss the case with the Contractor's Medical Director. A peer-to-peer conversation may occur to address the quality of care concern. The Contractor will encourage practitioners to engage in peer-to-peer discussions with the Contractor's medical directors to discuss treatment options and coordination of care. These reviews will offer an opportunity to collaborate with providers and share expertise and perspective that may better shape treatment for a particular member and/or positively impact go-forward practice patterns for the participating physician/provider.

6) The Contractor must have established clinical practice guidelines and methods in place for monitoring compliance with the guidelines in both the provider network and the care management process.

Contractor's compliance monitoring methods and process for remediation:
The Contractor currently has eight clinical practice guidelines:
- Adult Depression
- Attention Deficit Hyperactive Disorder
- Adult Substance Abuse Disorders
- Adult Bipolar Disorder: Acute Episode
- Adult Bipolar Disorder: Maintenance Episode
- Autism Spectrum Disorders
- Eating Disorders
- Schizophrenia

In addition, the Contractor has a medical policy for ABA for the treatment of autism spectrum disorders (ASD).

The Contractor will adopt and disseminates clinical practice guidelines (CPGs) that are relevant to members being provided acute and chronic behavioral healthcare services and are intended to improve quality of care. Evidence-based clinical practice guidelines serve as a framework for assisting a clinician to make medical management decisions to support best practices. Clinical practice guidelines are statements that include recommendations intended to optimize patient care and improve treatment outcomes. They are informed by a systematic review of evidence from multiple sources. These include, but are not limited to medical literature published in peer reviewed journals, pertinent documents from professional associations such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Society for Addiction Medicine; and other relevant sources of information, such as the National Institute of Mental Health, Agency for Healthcare Research and Quality, Substance Abuse and Mental Health Services Administration, and others. In addition, a consensus of expert opinion provided by clinicians practicing in a particular field may also be utilized. The CPG is not meant to serve as a standard of care. They reflect population-based recommendations and are not intended to address individual member variations. The Contractor's CPGs meet NCQA accreditation standards.

A CPG workgroup will update the CPG against clinical evidence at least every two years, or more frequently if national guidelines change within the two-year period for updates based on:
1. National Guidelines, scientific evidence or best practices.
2. In-network provider compliance with the CPGs.
3. Recommendations for modifications of the CPGs.

<u>Monitoring</u>
Providers:
Provider use of CPGs will be monitored during utilization review, care transitions and case management activities. Contractor staff will be encouraged to communicate openly with providers and Contractor management when adherence issues are encountered. Contractor's medical

directors will also use peer-to-peer discussions to encourage psychiatrists to utilize CPGs in their daily work with members.

The Contractor's Corporate Quality Management Committee will select at least three of the Contractor's CPGs for monitoring in-network providers' adherence to CPGs. Using valid methodology, the Contractor will annually measure and analyze adherence against at least two important aspects of each of the selected CPGs.

Performance Improvement interventions related to the provider community have included:
- Inclusion of educational material and copies of CPGs within Provider Newsletters and the New Directions Provider Manual.
- Evaluating appointment accessibility for members with a portion of network providers.
- Publishing CPGs on New Directions website for review and download by providers.
- Collaboration with health plan partners to disseminate information regarding CPGs and behavioral health best practices to the medical provider community.

Care Managers
The Contractor will manage adherence to CPGs in the utilization and case management processes in the following ways:
- Daily rounds with the behavioral health Medical Director will be conducted to review members with complex conditions and members not making progress. During these rounds, the Medical Director will assure that the utilization and case managers are managing the members' care according to the CPGs.
- On a monthly basis, clinical managers will conduct call and documentation audits for each utilization manager and case manager. A sample of the clinician's calls and case records will be reviewed to assure compliance with all processes and protocols. One of the areas reviewed will be compliance with CPGs.

7) The Contractor must regularly conduct satisfaction surveys of their Network Providers.

The Contractor will conduct a provider satisfaction survey on an annual basis. The primary focus of the survey will be utilization management services. Behavioral health providers will be included and the outcomes will be reviewed to identify areas of improvement. The Contractor's Sample Provider Survey is attached as **Schedule N, Sample Provider Survey** and changes may be made by mutual agreement between Contractor and Plan Sponsor**.**

8) The Contractor must have a method for conducting outcome analysis within the confines of confidentiality for inpatient and outpatient care that has been proven to be both valid and reliable.

Contractor's Method:
The Contractor will use a systematic approach to collect and analyze data and compare results to the established goal. There will be different types of analyses done related to inpatient and outpatient care, including:
- HEDIS-based follow-up after hospitalization for mental illness: The Contractor will apply the HEDIS technical specifications to claims data received by the payers and monitors 7 and 30-day FUH rates as a measure of outcomes for inpatient care.
- Readmission Rates Analysis: Readmission rates for acute inpatient care will be measured and monitored regularly against targets.
- Cost Impact Analysis: The Contractor will measure and track behavioral health program impact on an annual basis using 12 months of claims data and applying the Milliman Health Cost Guidelines™ for the commercial products (behavioral health) trend rates. Cost impact is the benefit savings PMPM divided by the contracted PMPM. Benefit PMPM is the behavioral health spend (inpatient and outpatient) divided by average behavioral health membership.

When performance does not meet goals, the Contractor will use the performance improvement program, which is a component of the Quality Management Program. It is a management system that provides a structured, measurable approach to drive change and increase performance levels. When opportunities are found, they will be prioritized for action through the Quality Management Committee or by executive leadership, as applicable.

Subcontractor New Directions will receive a monthly claims-detail feed from the Contractor that will be encrypted through an isolated SFTP and combined with the internal data (e.g.

membership). Outcome reporting will be restricted to summary data with no PHI in order to protect the confidentiality of the members.

9) The Contractor must have criteria for evaluating provider performance, such as waiting times for routine and emergency care appointments, patient load, arrangements for non-emergency or urgent care, complaint rates, patient "switching" rates, utilization metrics, and clinical outcome data.

   The Contractor will commit to performing proactive reviews of waiting times for routine and emergency care appointments. For behavioral health specialists, the Contractor will call the top 20 percent by volume plus a 10 percent sample of other behavioral health providers annually to ensure they meet the required time frames. These are immediate care for emergency care, within 48 hours for urgent care and 10 days for routine care. If providers do not meet Contractor expectations, they will be put the provider on a corrective action plan. The Contractor will work with the provider to help them meet these timeframe and standards.

   The Contractor will randomly call providers to ensure they meet the standards for ER and urgent care. If a provider cannot be reached afterhours, the Contractor will ask for a corrective action plan to ensure they are meeting the standards within the contract. The Contractor will evaluate noncompliance with the contracted standards.

   The Contractor will evaluate complaints from members. If there is a consistent problem with a provider this information will be considered in the re-credentialing of the provider. The Contractor will review every complaint that is received from a member or other sources including our nursing and behavioral health staff. If the problem is serious, the Contractor will disaffiliate the provider. If the problem is less serious, the Contractor will request a corrective action plan and ensure that it is implemented. The Contractor will evaluate prescribing patterns of all of the Contractor's providers, including behavioral health providers, proactively. If Contractor finds that a provider is prescribing too many narcotics, benzodiazepines or other control substances, the Contractor will evaluate the charts of those members receiving the medications. A Contractor specialist will discuss the situation with the provider. If the provider doesn't quickly change their prescribing habits, the Contractor will terminate the provider from the network.

   The Contractor will perform random evaluation of in-patient hospitalization charts to ensure members are receiving appropriate care.

   The Contractor will evaluate:
   - Patient switch rates, the number of members who switch from one therapist to another. The Contractor will discuss any therapist or psychiatrist who has a switch more than two standard deviations from the average.
   - Utilization of Contractor's entire program and individual providers.
   - The number of members who see a behavioral health provider to ensure there is no problems with access.
   - Waiting times for our members.
   - The number of visits per therapist to ensure there isn't underutilization or overutilization.
   - Length of stay, readmission rates, the number of visits per 1000 members.
   - HEDIS results for the providers including follow up after hospitalizations within seven days, follow up after an ADHD diagnosis, and taking antidepressants medications appropriately.

10) The Contractor must have a process in place to audit network providers for compliance with contractual terms and ensure the accurate administration of the BH/SA Plan.

    Contractor's Process:
    The Contractor's network management team will reach out to providers when deficiencies occur to remediate performance. The Contractor will monitor 10 percent of providers annually as part of this Contract to ensure they are complying with the Contract. If the Contractor finds noncompliance, the Contractor will request a corrective action plan to ensure the provider complies with the term of the Contract.

11) The Contractor must provide care management that includes the following services:
    a. Pre-certification of all inpatient and higher level of care for services.
    b. Concurrent review of all inpatient and higher level of care cases.

c. Discharge planning for all 24 hour care, including facilitation of ambulatory follow-up appointments to be held within seven days of discharge.
d. Follow-up on all cases discharged from 24 hour care to improve attendance with post-discharge ambulatory appointments.
e. Individual case management (ICM) with high risk cases to identify and mitigate risks, reduce barriers to care, and to optimize recovery.

12) Transition of Care and Other Implementation Considerations:

a. The Contractor must have a process and plan for transition of care for members seeing OON providers.

The Contractor will not actively recruit OON providers unless a network gap is identified.

To ensure continuity of care for members seeing OON providers, the Contractor will work to ensure a seamless transition of care for the member. The Contractor plans to obtain a list of members with current authorizations from the Plan Sponsor. Utilization managers will work with the member's providers to develop a transition plan that is clinically appropriate.

Contractor's high-level summary of transition process:

- Inpatient Mental Health Care – The previous Contractor will manage the hospital admission for members receiving inpatient level of care prior to October 1, 2019 that have not been discharged.
- Outpatient Mental Health Care – Hospital Based Physician and hospital services for mental health in an outpatient setting which began prior to October 1, 2019, will be paid as in-network for a period not to exceed three months. This timeframe will allow the Contractor to assist members in selecting a network provider.
- Mental Health Care-Office Based – Physician services for mental health rendered by an out of network psychiatrist or fully licensed psychologist in an office setting which began prior to October 1, 2019 will be paid as in-network for a period not to exceed three months. This timeframe will allow the Contractor to assist members in selecting a network provider.

b. The Contractor must have a process and plan for transitioning members in all levels of care.

Contractor Processes:
To avoid any disruption in service and care for the members and providers during the transition of vendors, the Contractor will honor all current authorizations issued during preauthorization and concurrent reviews. The Contractor will request that the previous Contractor manage members in inpatient care at the time of transition until the member is discharged and provide the Contractor with a list of those members, in order to provide assistance with care transitions and discharge planning to provide support as the member returns to their community and receives outpatient care. If the Plan Sponsor prefers that the Contractor manage inpatient cases beginning on the first day of the Contract, the Contractor will request a daily list of members in inpatient care beginning a week prior to the transition date. The Contractor will begin contacting facilities a few days prior to the transition date to determine which members are anticipated to discharge prior to the transition date and which members are likely to remain in inpatient care. For those members who are anticipated to remain in inpatient care, the Contractor will begin the authorization process a few days prior to the transition so that all reviews will not need to occur on day one of the Contract, thus impacting care for members.

For other managed levels of care, the Contractor will request a list of members, with current authorizations, beginning approximately two weeks before the transition. The list will include member and provider information, level of care, and authorization dates. The Contractor will request that the previous Contractor continue to authorize care as clinically appropriate through the last day of their contract to prevent a situation where reviews are due on the first day of operations, which can create disruption for members and providers. This list of members with current authorizations will allow the Contractor to assign utilization managers to each of these cases and be prepared to execute a smooth transition.

For members in case management or service coordination at the end of contract, the Contractor will request a list of members approximately two weeks prior to the transition. The Contractor will recommend coordinating case conferences with the previous Contractor to review active cases to better prepare our case managers/service coordinators to assume case management/service coordination responsibilities without having to have the member start from the beginning.

c. The Contractor must ensure that the State of Michigan members have a positive transition of care.

Contractor's plan to ensure a positive transition of care:
Prior to the implementation date, that the Contractor requests the Plan Sponsor provide a list of members currently in care. The Contractor will reach out to those members and conduct an assessment of their current treatment to determine need. During the assessment, Contractor staff will look for any hint of medical comorbidity, the need for available community resources, and the need for additional behavioral health interventions.

d. Reserved.

F. Member Support

1) The 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 call center must be in the United States of America, but the Plan Sponsor prefers that the call center be located in Michigan. The Plan Sponsor also prefers that one service center for business hours be used for taking calls.

The Contractor's call center is located in Kansas City, Missouri.

2) The Customer Service call center must, at a minimum include:
   a. A single front-end toll-free dedicated telephone number with touch-tone routing (if necessary) for Customer Service staff to respond to Member requests for participating Provider locations, for questions on Claims and Access, and complaints about Providers and Services.
   b. The toll-free line must be available 24/7 and 365 days a year. This line must be staffed at a level guaranteeing the following:
      1. Incorporation of a State of Michigan specific script to guide a member to other resources available through State of Michigan.
      2. Warm transfer to other SHP PPO carrier case management staff (medical or prescription)
      3. No busy signals
      4. Call pick-up by the third ring or under 30 seconds
      5. Call abandonment less than 2%
      6. There are specific procedures to handle emergency calls during and after hours and specific procedures to handle threats of violence.
      7. Only clinicians should make referrals, basing their decision on the caller's identified needs and a brief assessment. Triage clinicians will be completely trained on State of Michigan's medical benefits and other related programs, including Plan Sponsor's Employee Services Program.

The Contractor will utilize the Genesys omnichannel communications system, and is able to see, in real-time, metrics posted on screens throughout the call center (e.g., average speed to answer, abandonment rate, availability, utilization, and occupancy). Throughout each day the workforce manager will provide reports to the managers showing average speed to answer, abandonment rates, calls forecasted, and other relevant metrics for each staff member compiled to that point in the day. Summary reports will also be supplied to managers daily for the previous day's metrics.
The behavioral health services team will assist members with:

- Finding and making an appointment with a behavioral health provider to meet their specific needs
- Locating community resources and support (e.g., food pantries, transportation, financial assistance)
- Navigating the health care system

- Warm transfers to Blue Cross Blue Shield of Michigan case management staff to assist with facilitating an integrated care experience for members with comorbid medical and behavioral health conditions
- Warm transfers to any other health and wellness vendors the State of Michigan utilizes
- Access to self-management resources and tools

Members calling the toll-free number can “press 1 if this is an emergency” to immediately speak to a behavioral health clinician. The behavioral health clinician will conduct a focused screening with the member using a structured interview to determine the level of urgency (emergent, urgent or routine) and the level of care necessary to address the member’s clinical needs safely and effectively. All emergent and urgent referrals will be followed up on by the Contractor to assure that the participant presented for evaluation. If the member did not present, the clinician will attempt to contact the member to ensure their safety and assist them in obtaining appropriate care. In cases where the member is in imminent danger, the clinician will contact law enforcement to intervene and will stay on the phone with the member until help arrives.

For routine calls when a member is seeking services, a Contractor behavioral health clinician will conduct a clinical assessment for mental health and substance abuse conditions, urgency (e.g., emergent, urgent or routine), and the level of care necessary to address the members immediate clinical needs safely and effectively. The clinician will conduct a structured interview with the member and utilize screening tools such as PHQ-9, GAD-7, and/or CAGE to complete the comprehensive assessment. The clinician will then assist the member with a referral to a behavioral health provider who can best meet their clinical needs.

c. A designated clinical team to take State of Michigan calls will include a total of 25 behavioral health clinicians, which will include 14 Utilization Managers and 11 Case Managers. The average case load is approximately 50. The Contractor will not have a designated clinical team that will take State of Michigan calls after hours and on weekends and holidays. The Contractor’s after-hours team, Clinical365, serves all Contractor business. Fifteen clinicians are on the Clinical365 team. The 15 Clinical365 clinicians will only assist with referrals and conduct precertification, they do not have caseloads.

    1. Contractor’s plan for the designated team to integrate with the medical care management team in place, includes data integration, reporting, referrals, and co-management of patients with behavioral and medical care needs.

       The Contractor’s clinical team will work closely with the medical team. Medical case managers will be able to refer members with behavioral health issues to the behavioral health team using WebPass, an online portal. Medical case managers will have limited read-only access to the Contractor’s clinical documentation system, so they can see that a member is accessing behavioral health services.

       The behavioral health and medical teams will meet at least monthly for case conferences to discuss members with comorbid medical and behavioral health conditions. These case conferences will be led by the medical and behavioral health Medical Directors. The Contractor’s integrated case management model is set up so that members with comorbid conditions have one case manager and one care plan that focuses on the members’ total health. A primary case manager will be identified as the single point of contact for the member, based on the member’s most salient need. Other case management team members support the primary case manager with the development and execution of the assessment and case management plan. The model encompasses one comprehensive assessment and case management plan. The primary case manager will coordinate care and communicate with the member; working with all physicians/providers (e.g., medical, behavioral, and community agencies).

d. The Contractor’s customer service system must be scalable to future demand.

   The Contractor’s system can be expanded based on volume or plan changes and will do so as needed, without disruption to the high level of quality and service.

Contractor uses Genesys (genesys.com) which has a PureConnect customer experience solution platform. Genesys' virtual interaction distribution system is used to distribute, track, record, and monitor interactions, fostering true omni-channel member engagement. This system integrates with the Contractor's workforce management solution from Aspect Workforce Management to maximize scalability. The Contractor will utilize Aspect to help accurate forecast, staff, and achieve monthly service delivery performance goals.

e. The Contractor must have an advanced telephone system that provides the Plan Sponsor with management tracking and reporting capabilities, including but not limited to:
    1. Methods for logging calls, recording call data and content. The Plan Sponsor prefers that the recorded call be attached to the customer account.
    2. Methods to report metrics, standards and ad-hoc report generation.
    3. Methods to monitor calls for quality.

    All of the Contractor's calls are recorded, tracked stored using an Interaction ID number that is unique to each call. This Interaction ID will be used to access all portions of the call, including call origination, call recording, and detailed call records. Call recordings can be searched and accessed via workgroup, individual, or telephone number. Standard and ad hoc reports for call monitoring will also be available. The Contractor's call monitoring desktop procedure includes live call monitoring, side-by-side call monitoring and monitoring of recorded calls. The Contractor will monitor a random sample of each staff member's call monthly. The number of calls monitored will be dependent on the staff member's length of service and past audit scores.

f. The Contractor must comply with Plan Sponsor requests to remove specific call center staff where quality improvement measures have been ineffective.

g. The Contractor must have an interactive voice response (IVR) system with a user-friendly menu.

h. The Contractor must clearly communicate all information on how to access Customer Service in all Plan specific documents and Identification Cards.

i. The Contractor must attempt to resolve Member complaints during the initial contact with the Member.

3) The Contractor must provide web-based 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, having the ability to:

a. Provide Members with secure access to information specific to their own Claims and enrollment.

    The Contractor will provide the Plan Sponsor access to a group portal which will allow them secure access to their claims, invoices, and eligibility information. See also Schedule A Section 4.3 and **Schedule M.**

    The Contractor will provide Members access through the bcbsm.com "Member Portal". This portal must be available 99.5% of the time with service availability performance of 100%. Web access includes plan information, wellness and transparency services. Member secure access will include at a minimum the following information:
    - General health plan information
    - Explanation of benefit statements
    - Access to claims history
    - Copays/deductibles and maximums verification
    - Eligibility and benefits
    - Ability to view or update primary physician
    - Option to coordinate benefits
    - Option to order ID card

    In addition, members will be able to access online therapy and psychiatry visits through Contractor's Online Visits solution by logging on to the BCBSM Online Visits app on Apple or Android or by visiting www.BCBSMOnlineVisits.com.

b. List Providers based on proximity to Member's home address or zip code with separate identification of tele-behavioral health providers.

The Contractor will use their Find a Doctor application. This application must be available 99% of the time with service availability performance of 100%. See also Schedule A Section 4.3 and Schedule M.

c. Provide detailed Provider network information accessible to members online.

The Contractor will use their Find a Doctor application which will provide the following at a minimum:

- Provider and facility locator and comparison solution
- Cost data for treatments including episodes
- Member Out of Pocket (MOP) Costs available (upon special request)
- Quality data for treatments
- Hospital / facility comparison solution
- Medication and drug treatment comparison and cost solution
- Pharmacy information including mail order refills, tracking and forms

d. Have network information searchable by specialty.

The Contractor will additionally provide functionality for members to search by provider or facility type, and provider or facility name.

e. Answer Member questions about the Plan (Q&A).

Members registered on the Contractor's member portal will be able to send an email to ask questions regarding the Plan with a and obtain a response from Customer Service within 24 hours.

f. Provide Members access to designated electronic Plan-specific documents on the Contractor's Plan-specific website.

g. Contractor's services and functions available to the Plan Sponsor and Members on the Internet and/or via mobile applications:

- Information about mental illness and addictive disorders: Members will be able to access online health resources including articles and news on mental disorders/mental health (for teens, women or men), causes of mental illness, treatments, a depression risk quiz, clinical trial information, and more on the Health & Wellness site, accessible through bcbsm.com. Members will also be able to access the site for articles, causes, health tips and other resources related to addictive disorders (alcohol abuse, bulimia, etc.).
- Self-assessment or screening tools for depression and alcohol abuse and other common mental health conditions: Members will be able to access a variety of behavioral health resources in the Health & Wellness section of the bcbsm.com site including the "Feel Better" depression-focused digital health assistant program, the "Conquer Stress" digital health assistant program, articles and news on mental disorders/mental health (for teens, women or men), causes of mental illness, treatments, a depression risk quiz, clinical trial information, and more.

  The Contractor's Health & Wellness site, powered by WebMD, will include:
  - URAC-accredited platform
  - NCQA-certified health assessments (e.g., ADHD, Bipolar, Depression, Stress, etc.)
  - Digital health assistant tools (e.g., condition quizzes, videos, slide shows, etc.)
  - Personal health record
  - Social wellness challenges (additional fee)
  - Incentive and activity tracking (additional fee)
  - Gift card fulfillment (additional fee)
  - Messages and reminders about health assessment status and more
  - Access to integrated apps, message boards, trackers, videos, tools and other health information
  - Health and wellness libraries and encyclopedias

- Self-development programs (e.g., anger management): In 2020, members will have access to an online resiliency solution aimed at improving member resiliency and productivity. The platform will offer information on topics including mindfulness and meditation, financial stress, chronic pain, meaning and purpose, and financial well-being and resiliency. Web and mobile behavioral health self-care resources will be provided through mystrength.com. See also Section 1.D.4.j.
- Psychotherapeutic medication information: Members will be able to access the Health & Wellness site via bcbsm.com to access psychotherapy treatment information (including medication) for depression, anxiety, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, pain management, binge eating, bulimia, and more.
- Online CBT programs (e.g., depression): Members will have access to the following Digital Health Assistant programs at a minimum: Eat Better, Lose Weight, Enjoy Exercise, Conquer Stress, Quit Tobacco and Feel Happier. These self-guided tools emulate a coach program and let members set small, achievable, weekly goals. They will be accessible on the Health & Wellness site via bcbsm.com. See also myStrength information in Section 1.D.4.j.

h. Contractor must provide access to the member portal for Plan Sponsor staff, which will include access to a demonstration website (URL and password); include access to the member, provider, and client sections of the site.

4) The Contractor's customer service team must respond to Claims, Inquiries, questions, and problems regarding operations from the Plan Sponsor and/or members.
   a. The Contractor must resolve 90% of all Written Inquiries within 14 calendar days of receipt. Written inquiries mean any inquiry other than telephonic. They include mail, email, fax, or web portal inquiries and include those submitted to the Contractor by the Plan Sponsor. The receipt date will be considered the date the Written Inquiry is received by the Contractor. 100% of all Written Inquires must be resolved within 30 calendar days. See also Section J.3, SLA #7A and #7B.
   b. For appeals of payment or coverage decisions, the Contractor must respond in writing within 30 calendar days unless additional time is requested from and granted by the member.

5) The Contractor's Customer Service team must log and manage all incoming and outgoing member calls and correspondence.

   In addition, notes on an inquiry will be attached to the member's record to ensure history can be reviewed at a later date.
6) The Contractor must use the information captured in the communication tracking system to target improvement opportunities (e.g., reducing call volume, providing online capabilities, identifying issues, etc.).

7) The Contractor must record incoming and outgoing member calls and review for quality monitoring purposes.

   Quality will be evaluated through listening to random samples of live calls, call recordings or side-by-side evaluations. Calls will be monitored for call authentication, accuracy of information provided, accuracy and thoroughness of documentation, customer service skills while on a call, including call opening, understanding of an issue presented, keeping the caller informed of actions, and call closure. For referral calls, audits will specifically focus on whether the Contractor's clinical staff member responded to the member's requests for provider type, location, specialty, and any cultural requests (e.g., gender, language). The quality coordinator will conduct call calibration sessions to verify consistency in evaluation of performance by managers, team leads and the quality coordinator, as well as identification of coaching opportunities and star performance. Call calibration will include a review of calls in a group setting with the managers and team leads. The call will be scored as a team and variance in scoring is discussed and a scored for each element is agreed to by all parties.

   Contractor intake staff will receive individualized monthly reports which include quality scores and performance metrics. Managers will utilize these reports for coaching and identifying top performers. Monthly rates for trending and identification of performance improvement

opportunities are also tracked and presented to the Contractor's Quality Management Committee.

8) The Contractor must retain all call recordings for a minimum of one year from the date of the call. Calls related to an appeal or grievance must be preserved until final disposition of the appeal or grievance by the Plan Sponsor.

G. Member Communications Materials and Meetings

1) Member Communication Materials

a. All communication materials must be provided in a web-ready format and reviewed and approved by Plan Sponsor in advance of distribution. All communication materials presented to Plan Sponsor for approval must allow for 10 business days for review and editing. 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 including, but not limited to the following:

1. The Contractor must create both a brief Guide to Accessing Care and a detailed Plan Booklet for members which accurately aligns with Plan Sponsor's Plan Design.

2. The Contractor must provide reimbursement and claim forms which have been reviewed and approved by Plan Sponsor.

3. The Contractor must prepare and distribute, at its own cost, all communication materials, including but not limited to announcements, letters, notices, brochures, forms, postage, and other supplies and Services for distribution to Members.

4. Customized Member communications must be provided, by the Contractor to Members, at no additional charge and are subject to the Plan Sponsor's approval. This also includes co-branding materials with the name of Contractor and Plan Sponsor, where desired by Plan Sponsor. Materials must be customized and Plan Sponsor approved. Open enrollment materials must be available by June 1st of each year.

5. The Contractor must provide Explanation of Benefits (EOB) that details charges, copays, outstanding benefit limits, and contact information for following up with questions or Appeal in easy-to-read language. Any denial of claims must have a detailed, understandable explanation of reason for denial.

2) Meetings:

a. The Contractor must provide speakers at meetings designated by Plan Sponsor at no additional charge to the Plan Sponsor. Meeting requests may vary from year-to-year.

b. In addition to Plan Sponsor designated meetings, the Contractor may receive requests for speakers from Member support organizations (i.e.: State Employees Retiree Association or state employee unions). All requests for meetings must be channeled through the Plan Sponsor and accommodated upon request. If the Contractor is unable to accommodate a meeting request, the Contractor must seek and obtain Plan Sponsor approval for excusal.

c. The Contractor must agree to participate in health fairs for State of Michigan members in a frequency mutually agreed to by the Contractor and Plan Sponsor.

3) Member Satisfaction: The Contractor must send a Plan specific member satisfaction survey, that is mutually agreed upon between the Plan Sponsor and Contractor on an annual basis. The Contractor must report results of the survey to the Plan Sponsor. All areas where Member satisfaction levels are low must be remedied by the Contractor within a timeframe acceptable to the Plan Sponsor. Sample sizes of responses must be sufficient to produce statistically valid results.

The Contractor will compile and review results on a monthly basis.

The Contractor will survey a population of members whom have had at least one behavioral health unit in the prior 12 months. A service unit is defined as a member who has an authorized visit with a provider and/or contact with the Contractor. The survey will be fielded in the fall of each year, via postal mail, using a two-wave approach. In the event there is no reply to the first mailing, a second survey will be mailed.

Objectives for the member satisfaction study include:

- Measurement of the member experience with the Contractor, including overall satisfaction
- Measurement of the member's health status and perceived improvement in their health, as compared to the previous twelve months
- Measurement of the members' experience with his/her behavioral health provider, access and overall rating of behavioral health care treatment
- Assessment of the members' perception of medical/behavioral integration around their plan of care (e.g., communication between behavioral health and primary care providers)
- Insight into the members' experience with the Contractor and the services received, such as customer service or case management
- Member perceptions as to how their ability to function in daily life has changed within the last twelve months
- Determination as to how well members' cultural and linguistic needs and preferences were accommodated

Member survey data will be reviewed by the Contractor Quality Management Committee. Year-over-year data and key driver analyses will be compared to identify areas where the Contractor has improved and areas where there are opportunities to improve upon. Action plans are then developed to improve member satisfaction with our services.

In addition to the annual member satisfaction surveys and after-call surveys, program surveys will also be conducted to measure member satisfaction and gather feedback on specific programs and services. Members in our case management program will be offered a survey of their experience with case management upon completion of the case management program. Results will be compiled and reviewed on a monthly basis.

4) The Contractor must supply a hyperlink to an electronic Provider directory to the Plan Sponsor for placement on the Plan Sponsor's website.

H. Enrollment and Eligibility

1) Eligibility includes active State employees, retirees, dependents, and COBRA participants. The Plan Sponsor is responsible for transmitting eligibility and enrollment information for covered active employees, COBRA participants, and their Dependents. The Office of Retirement Services (ORS) is responsible for transmitting eligibility and enrollment information for the State Employee Retirement System (SERS), State Police Retirement System (SPRS), Judges Retirement System (JRS), and the Military Retirement System (MRS) members. ORS is also responsible for transmitting eligibility and enrollment information for some of the Defined Contribution former qualified participants. ORS submits two separate files, one for Medicare eligible and one non-Medicare. Payment of Administrative Fees to the Contractor is predicated on the enrollment records of the Plan Sponsor and ORS (See also Section 6.1.B).

   The Contractor must maintain a system for enrollment and eligibility and be prepared to accept, and coordinate, multiple data files from two separate State Agencies (MCSC and ORS), as indicated in **Schedule E, HIPAA 834 File Layouts** document.

2) The Contractor must provide the Plan Sponsor with secure online access to the Contractor's enrollment and eligibility system in order to review and update member eligibility at or near real time.

3) Data for active and COBRA members will be supplied through the Human Resource Management Network (HRMN). Eligibility information will be transferred, by the Plan Sponsor, via File Transfer Service (FTS) (or another method selected by the State). The State sends an 834 HIPAA compliant "changes only" file on a weekly basis and a "full file" quarterly.

   Eligibility information for members who are enrolled retirees will be transferred by ORS using FTS (or another method selected by the State). ORS sends an 834 formatted "changes only" file

weekly and a “full file” semi-annually. Data for retirees and their dependents is supplied from the retirement account management system, Clarety.

The Contractor must maintain and update the enrollment system based on weekly eligibility files received by the State.

Contractor’s processing capability in regard to eligibility:
The Contractor will conduct a full automated audit comparison of each record on the file against each record on the membership system; identify the changes, drop records etc. Full files and changes will be conducted through the same process; however, for change only files, the audit comparison will be performed only on the records provided on the change files.

4) The State requires use of its FTS (or another method selected by the State) for all file transmissions. Electronic transmission of identifiable data must be protected by passwords and a Secure File Transfer Protocol (SFTP) method.

   The Contractor transmits files to and from the Contractor using SFTP via EDDI (Contractor’s data exchange Platform). This platform requires a login ID and password.

5) The Contractor must accept, load, store and maintain 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. The Contractor must not make any changes to Member information that would lead to Contractor and Plan Sponsor having different information for the same Member.

6) The Contractor must be able to accept the Plan Sponsor’s electronic eligibility files in the file format indicated in the file layouts identified in **Schedule E, HIPAA 834 File Layouts** document.

   Programming will be complete by 10/1/19. Blue Cross will work with the Plan Sponsor to accommodate data elements that are not currently used or stored during the implementation period.

7) The Contractor must be able to process change transactions to maintain up-to-date information for eligibility certification.

8) The eligibility files must be processed and Member eligibility and/or enrollment update completed, upon notification from the Plan Sponsor or its designee, with confirmation of changes submitted to the Plan Sponsor and number of records loaded.

9) The Contractor must accept a full file on a quarterly basis (or other frequency designated by the State) for audit purposes. See Section 1.J for service level requirement regarding file timing.

10) Upon written or verbal notification by the Plan Sponsor, urgent member eligibility and/or enrollment updates must be completed in real-time by the Contractor during the hours of 7:00AM and 3:00 PM EST. The Plan Sponsor will update membership via Contractor’s online tools if an emergency update is required after 3:00 PM EST.

11) The Contractor must have accessible and experienced information technology professionals to provide timely programming who are capable and authorized to implement system changes and produce reports.

12) The Contractor must use a system similar to a Secure Sockets Layer (SSL) Message Center for all administrative communications concerning individual Members.

13) The Contractor must maintain a Member’s enrollment in the Plan unless otherwise notified by Plan Sponsor, regardless of notifications from any other source.

14) No participant will lose eligibility for benefits through pre-existing condition exclusions as a result of a change in carrier at transfer or during the duration of the Contract. The Plan Sponsor has the sole authority to determine the effective date of Member coverage, including retroactive adjustments.

15) The 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 and eligibility files. The Contractor must work with the Plan Sponsor to develop a timeline for implementation and testing of any system changes. The Contractor must maintain a testing environment for such purposes.

16) Eligibility files received by 8:00 a.m. Monday-Friday will be processed within one business day. Errors resulting from processing the file will be completed within 3 days for a total of 4 business days for the entire process. The Contractor must have validation edits in place to ensure, for each data load, that all fields transmitted are properly uploaded, read, and populated in their system. Any records that do not pass Contractor's validation tests must be reported to Plan Sponsor within two business days after the file has been uploaded. Eligibility file discrepancy reports will be created in a Contractor's standard report format.

I. Audits

1) During Implementation and throughout the duration of the Contract, Plan Sponsor and its consultants may conduct site visits, interviews, and chart and facility evaluation. The Contractor must comply with and participate in these audits as requested by the Plan Sponsor. Any audits will be completed with no additional cost to State of Michigan and can occur with a 30-day notice from the State of Michigan to the Contractor. The Plan Sponsor intends to periodically (at least once every two years) perform on-site audits of the Contractor. The Plan Sponsor's current approach has been to audit two Plan Years at one time, conducted within 12 months of the end of the second year audited. The Plan Sponsor reserves the right to change this approach without prior notice. Claims included in the previous audited periods or claims paid prior to the last 24-months will be excluded from the audit.

   a. The Contractor must allow Plan Sponsor, or Plan Sponsor's consultant, the right to review the internal testing completed for Plan Sponsor's BH/SA Plan, if applicable, prior to the effective date of the plan and on an annual basis if there are plan design changes.

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

   c. The Contractor must cover the cost for and allow a pre-implementation audit by Plan Sponsor's consultant of the BH/SA Plan to confirm correct interpretation and programming of the plan specifications and accurate claim adjudication and customer service. The audit will include:
      1. Desktop review of plan documents.
      2. Claim testing
      3. Evaluation of plan reference materials
      4. Written report and presentation of findings.

2) The Plan Sponsor reserves the right to audit through authorized agents to determine the Contractor's compliance with the Contract or terms of agreement. This includes a chart review or other mechanism to determine the quality of services provided.

3) The Contractor must make records associated with the administration of the State's Plans available to, and must cooperate with, such auditors and audits as the Plan Sponsor may designate.

4) The Contractor must allow a sample size of 250 claims to be audited at no additional charge to Plan Sponsor, including, but not limited to, onsite pre-implementation audit, annual claims audit and annual benefit audit, etc. The Contractor is willing to discuss with the Plan Sponsor increasing the sample size if there is a valid need determined.

5) The Contractor must provide any 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.

6) The 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.

7) 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 must develop, agree upon and monitor an action plan to address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

8) If the audit demonstrates any errors in the documents provided to the State, then the amount in the agreed upon error must be reflected as a credit or debit on the next invoice once the appropriate signatures are obtained within 45 days, and on subsequent invoices until the amount is paid or refunded in full. However, a credit or debit may not be carried for more than four (4) invoices. If a balance remains after four (4) 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. See also Section 36 of Standard Contract Terms.

9) In addition to other available remedies as approved by the Plan Sponsor, if the difference between the payment received and the correct payment amount is greater than 10.00%, then the Plan Sponsor and Contractor will negotiate in good faith if the Contractor will pay all or a portion of the costs of the audit up to $25,000.

10) The Contractor must allow onsite auditability but will limit areas the group/auditor can have access to for instances where the information is housed in an area that works on PHI that is not specific to the State. In those instances, any State data would be pulled to be accessible for the audit.

11) The Contractor must not offset audit recovery overpayments by any potential underpayments identified by the audit.

12) The Contractor must not 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.

13) The Contractor must agree to pass through to Plan Sponsor 100% recovery of audit recoveries and overpayments.

J. Performance Guarantees / Service Level Agreements (SLAs)

1) The Contractor must ensure that the SLAs are measurable using the Contractor's standard management information systems. 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 under Standard Contract Terms.

2) Within the time specified after the end of each reporting period, the Contractor must provide the Plan Sponsor with a report assessing the Contractor's performance under each SLA and provide payment for any applicable penalties to the Plan Sponsor annually via invoice credit. The SLAs relate to on-going Services and will apply throughout the duration of the Contract, including any optional renewal periods (if exercised).

3) SLA Reports: Any metric that is reported must be accompanied by supporting documentation upon request of the Plan Sponsor and retained by Contractor for a mutually agreed-upon timeframe. SLAs without a corresponding report will be deemed unmet and subject to the credits. SLA Reporting Format must be mutually agreed-upon by the Plan Sponsor and Contractor.

4) SLAs are for all Services provided under this Contract for the Plan Sponsor as detailed in the table below:

SLA #1A & 1B: Eligibility Files
Guarantee

A.) The Contractor must upload and accurately process eligibility files (i.e., additions, deletions, corrections of addresses, names, social security numbers, etc.) within one business day of receiving them from the State.

B.) Discrepancies must be reported in the Contractor's standard report format within two business days after the eligibility files have been uploaded.

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

Credit

The credit for failure to meet the requirement for the Eligibility Upload SLA (#1A) is 2% of the monthly administrative fees for each month missed.

The credit for failure to meet the requirement for the Discrepancy Reporting SLA (#1B) is 2% of the monthly administrative fees for each month missed.

SLA #2A & 2B: Identification (ID) Cards

Guarantee

A.) 100% of ID cards must be created and distributed through the U.S. Mail within 10 business days of receipt of the Plan Sponsor's eligibility file. Performance must be substantiated by documentation providing proof of receipt date and mailing date.

B.) ID Cards must have an accuracy rate of 99% or higher.

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

Credit

The credit for failure to meet the requirement for the Identification Card Timeliness SLA (#2A) is 1.0% of the monthly administrative fees for each month missed.

The credit for failure to meet the requirement for the Identification Card Accuracy SLA (#2B) is 1.0% of the monthly administrative fees for each month missed.

SLA #3A – #3B: Average Claims Turnaround

Guarantee

A.) 94% of all claims must be processed within 14 calendar days; assumes that the claims are filed completely and with valid information.

B.) 99% of all claims must be processed within 30 calendar days; assumes that the claims are filed completely and with valid information.

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

Credit

The credit for failure to meet the requirement for SLA #3A is 1.0% of the monthly administrative fees for each month missed.

The credit for failure to meet the requirement for SLA #3B is 1.0% of the monthly administrative fees for each month missed.

SLA #4: Claims Processing Accuracy (Non-financial Error Rate)
Guarantee
The non-financial error rate (as defined as the number of claims with a non-financial error divided by the total number of claims) must not exceed 2.0%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #4) is 1% of the monthly administrative fees for each month missed.
SLA #5: Payment Incident Accuracy
Guarantee
The financial error (as defined as the number of claims containing a financial error divided by the total number of claims) must not exceed 3%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #6) is 1% of the monthly administrative fees for each month missed.
SLA #6: Financial Payment Accuracy
Guarantee
Financial Accuracy measures the percentage of benefit dollars paid correctly. The financial accuracy rate calculation is the total dollars paid in the sample, less the absolute value of overpayments and underpayments, divided by the total dollars paid in the sample. The acceptable error rate for each year of the Contract will be 0.7%. The Contractor must measure monthly and report its performance on this SLA on a quarterly basis.
Credit
The credit for failure to meet this requirement (SLA #6) is 1% of the monthly administrative fees for each month missed.
SLA #7A – 7B: Customer Service Response Time to Written Inquiries (Applicable beginning Year 2)
Guarantee
A.) Contractor must resolve 90% of all Written Inquiries within 14 calendar days of receipt. Written inquiries mean any inquiry other than telephonic. They include mail, email, fax, or web portal inquiries and include those submitted to the Contractor by the Plan Sponsor. The receipt date will be considered the date the Written Inquiry is received by the Contractor. B.) 100% of all Written Inquiries must be resolved within 30 calendar days.

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

Credit

The credit for failure to meet the requirement for SLA #7A is 1.0% of the monthly administrative fees for each month missed.

The credit for failure to meet the requirement for SLA #7B is an additional 1.0% of the monthly administrative fees for each month missed.

This SLA is effective beginning with year 2 of the contract.

SLA #8: Customer Service Call – Average Speed of Answer (Applicable beginning Year 2)

Guarantee

On a monthly basis, calls must be answered within an average of 30 seconds. The average speed of answer is the average length of time a caller waits in queue prior to the call being answered by a customer service representative.

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

Credit

The credit for failure to meet this requirement (SLA #8) is 1.0% of the monthly administrative fees for each month missed.

This SLA is effective beginning with year 2.

SLA #9: Customer Service Response Time - Percent of Calls Abandoned

Guarantee

The monthly call abandonment rate must not exceed 2.0% (determined by the number of calls abandoned divided by the total number of calls). A call will be considered abandoned if the Member hangs up at any time after initiating a transfer out of the Interactive Voice Response (IVR) system.

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

Credit

The credit for failure to meet this requirement (SLA #9) is 1% of the monthly administrative fees for each month missed.

SLA #10: Participating Provider List Audit

Guarantee

Contractor must perform a random audit of 3% of the Michigan based In-Network participating provider list to assure accuracy of identified providers accepting new patients and guaranteeing appointment availability.

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

Credit

The credit for failure to meet this requirement (SLA #10) is 1% of the monthly administrative fees for each month missed.

SLA #11: Network Accessibility

Guarantee

99% of provider appointments must be offered within the following timeframes:

- Immediate for Emergency (Life-threatening)
- 6 hours for Emergency (Non-Life-threatening)
- 48 hours for urgent
- 10 calendar days for routine

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

Credit

The credit for failure to meet this requirement (SLA #11) is 4% of the monthly administrative fees for each month missed.

SLA #12: Network Access Standards

Guarantee

Network Access is at least 95% of the standards outlined in Section 1.D.2; calculation of access will exclude any providers operating with income dependent access restriction (e.g., community mental health facilities/providers) or those not accepting new patients.

The following is not subject to this SLA: Network Access in rural areas where there is a shortage of MD/DO specializing in child/adolescent psychiatry and where there is a shortage of ABA board certified providers.

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

Credit

The credit for failure to meet this requirement (SLA #12) is 4% of the monthly administrative fees for each month missed.

SLA #13A – 13C: Timely Production of Complete Management Reports

Guarantee

A.) Contractor must provide complete monthly reports on the 15th of the second subsequent month (e.g., October reporting is due December 15th).

B.) Contractor must provide complete quarterly reports on the following dates:
Q1: 02/15 of the next calendar year
Q2: 05/15 of the current calendar year
Q3: 08/15 of the current calendar year
Q4: 11/30 of the current calendar year.

C.) Contractor must provide complete annual reports on 11/30 of the current calendar year.

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

Credit
The credit for failure to meet the monthly reporting requirement (SLA #13A) is 2% of the monthly administrative fees for each month missed. The credit for failure to meet the quarterly reporting requirement (SLA #13B) is 2% of the combined monthly administrative fee for the months in that quarter. The credit for failure to meet the annual reporting requirement (SLA #13C) is 2% of the full annual administrative fee.
SLA #14: Implementation Readiness (Applicable Year 1 only)
Guarantee
Readiness for launch of year 1 will be determined by assessing that the following areas are met 30 days before go live: • Phone lines implemented and operational, with Client approved language and call tree routing. • Financial responsibility for mixed service protocols clearly defined, reviewed, and agreed upon by appropriate stakeholders (ex. Client, Contractor, Medical Carrier). • Client benefits loaded in accordance with agreed upon project plan to support annual enrollment. • Process mapping of current internal and external vendor interaction completed. • Testing to confirm data feeds and requested information is provided accurately and reliably completed. The Contractor must measure and report their performance on this SLA by the end of the first quarter (12/31/19) post-launch.
Credit
The credit for failure to meet to meet this requirement (SLA #14) is 3% of the full annual administrative fee. This SLA is applicable only for Year 1.

K. Technology and Support

1) IT Policies, Standards and Procedures (PSP):
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.

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

Contractor data is stored in physical primary and secondary data centers, in Detroit and New Hudson, Michigan. Data is replicated nightly and stored in a hosted data center, in Boulder, Colorado. Membership and eligibility data is provided to external third-party partners, only as specifically-required for contracted services delivery.

Blue Cross utilizes a mainframe-based system (NASCO) for eligibility and to process the Plan Sponsor's claims. The physical data center is in Lexington, Kentucky in an IBM hosted facility. NASCO deploys a full physical security controls and HiTrust certification covering this facility. This is attested to in the SOC1 and SOC2 reports and Contractor will provide them annually to the Plan Sponsor. For data reporting, the Contractor uses both a cloud-based Informatics Environment for storing data as well as an Enterprise Data Warehouse. The cloud-based Informatics Environment is HITRUST certified. The Enterprise Data Warehouse is on Contractor's premises.

Subcontractor AccumTech provides accumulator services. Plan Sponsor data is hosted within AccmuTech's SOC/HIPAA-Compliant data center. AccumTech is migrating to a hosted cloud solution. This will be an ongoing solution throughout 2019. The cloud solution involves both the database server that stores any data relevant to the accumulation or integration of cost share data, in addition to the application servers that run the backend architecture and the outward facing webserver from which the file transmission occurs.

Subcontractor New Directions provides care management services for behavioral health and substance abuse services. This care management system must be available 99.5% of the time and the service availability performance must be at least 99.5%. The Web Pass Provider Portal must be available 99.5% of the time with service performance of at least 99.5%. New Directions stores backup data in a secure AWS storage environment. All data is encrypted at rest as well as in transit. New Directions leverages a secure DirectConnect for data transmission to AWS. The region that they store the data is FedRamp and HIPAA certified. In addition, New Directions are in a multi-phase project to implement Office 365, which will move many internal technology delivery services, such as; email, SharePoint and OneDrive for business collaboration. They will leverage a robust DLP solution to ensure all data meets HIPAA requirements prior to being made available externally.

Subcontractor myStrength provides interactive, individually-tailored applications for members. myStrength data is hosted in the cloud using ClearDATA, a HITRUST certified cloud service provider. All data is contained in the United States, within Amazon Web Services US-EAST-1 and US-WEST-2 regions.

a. ADA Compliance:
The State is required to comply with the Americans with Disabilities Act of 1990 (ADA), and has adopted a formal policy regarding accessibility requirements for websites and software applications. The State is requiring that Contractor's proposed Solution, where relevant, comply with level AA of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) 2.0. Contractor may consider, where relevant, the W3C's Guidance on Applying WCAG 2.0 to Non-Web Information and Communications Technologies (WCAG2ICT) for non-web software and content.
http://www.michigan.gov/documents/dmb/1650.00_209567_7.pdf?20151026134621

2) User Type and Capacity:

Contractor's Member Portal is certified to support 50,000 secured visits per hour. Systems capacity will be monitored regularly to ensure that they are sized appropriately to changes in usage patterns.

3) End User Operating Environment
The Contractor must provide current minimum browser requirements and the Contractor must publish the minimum browser requirements on the Contractor's proposed system solution for member access.

Contractor's Member Portal and sites are tested and certified on internet browsers that have a market share of 5% or above in the U.S. Browser and device trends will be regularly monitored to ensure that the services offered are compatible and function optimally for the Members/Consumers.

4) Software Licensing/User Agreement: A licensing/user agreement is not required for any portal or solution being provided by the Contractor under this Contract.

5) The Contractor must maintain and keep a documented Disaster Recovery Plan that will be made available to the State or Plan Sponsor upon request.

Contractor Disaster Recovery Plan is attached as **Schedule L, Disaster Recovery Plan**.

6) All State data must be stored, maintained and managed within the contiguous 48 states.

L. SSAE Audit

1) The Contractor must have a Statement on Standards for Attestation Engagements (SSAE) SOC 1 and SOC 2 Type II, conducted annually.

2) Reserved.

3) The Contractor must supply the Plan Sponsor with an annual electronic copy of the results of this audit within 45 Days of completion of the report.

4) Reserved.

5) The Contractor must provide the Plan Sponsor with a corrective action plan on all items determined by the Plan Sponsor to be actionable within 30 days from delivery of the report to the Plan Sponsor (or as mutually agreed upon between Contractor and Plan Sponsor) and provide regular updates on those items until they are resolved.

M. Training

1) The Contractor must provide on-site training, documentation and training materials, covering provider network, systems, access, overall product offering, etc. to the Plan Sponsor, Call Center or ORS, depending on Plan Sponsor's need at the time (over the duration of the Contract) and at no cost to the Plan Sponsor.
The Contractor will customize training and materials for the Plan Sponsor, Call Center and ORS based on specific needs. The training will consist of but not limited to Contractor's online tools for updating membership, eBookshelf which contains information on the Plan Sponsor's payment invoices and detailed claim reports, Whyzen, Contractor's online cost and use reporting platform, and the online tools available through subcontractor New Directions. The appropriate subject matter expert will accompany the Contractor's Representative to provide this training. The Contractor's Representative will facilitate the appropriate training relating to care management programs.

2. Acceptance

2.1. Acceptance, Inspection and Testing

The State will use the following criteria to determine acceptance of the Contract Activities provided under this SOW: see Standard Contract Terms, Section 21.

3. Staffing

3.1. Contractor Representative

The Contractor must appoint individuals, specifically assigned to State of Michigan accounts, who will respond to State inquiries regarding the Contract Activities, answering questions related to provision of services:

A. The Contractor's appointed Senior Account Manager (SAM) will serve as the Contractor Representative. This representative must be specifically assigned to State of Michigan accounts, and is responsible for responding to State inquiries regarding the Contract Activities.

Contractor SAM:
Arva Overton
Phone: (313) 448-5912
Email: aoverton@bcbsm.com.

B. SAM must be proactive and respond within one business day to Plan Sponsor inquiries or member escalations.

3.2. Customer Service Toll-Free Number

The Contractor must specify its toll-free number for the Plan Sponsor to make contact with the Contractor Representative. The Contractor Representative must be available for calls during the hours of 7 am to 5 pm EST.

3.3. Technical Support, Repairs and Maintenance

The Contractor must specify its toll-free number for the Plan Sponsor to make contact with the Contractor for technical support, repairs and maintenance. The Contractor must be available for calls and service during the hours of 7 am to 5 pm EST. Issues must be resolved promptly.

3.4. Key Personnel

A. The Contractor must appoint 5 dedicated key personnel positions to work with Plan Sponsor benefits and employee assistance program (ESP) staff, and 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 1 business day.

Contractor may identify personnel and positions in addition to the list of the required Key Personnel positions below which includes:

Key Personnel	Minimum Experience Recommended
Senior Account Manager (SAM)	-Five (5) years of Account Management with accounts of similar size and scope to Plan Sponsor's.
Back-Up to the SAM	- Five years of Account Management.
Implementation Manager	- At least three prior implementations of size and scope comparable to Plan Sponsor's.
Data/Eligibility Specialist	At least three years of eligibility file upload and integration experience.
Clinical Expert	No minimum experience recommended

The Contractor must identify all Key Personnel who will be assigned to this contract including the following for each individual:

1. Name of staff designated.
2. Years of experience and title, in their current classification.
3. Which of the 5 required key personnel positions they are fulfilling.
4. Key Personnel's roles and responsibilities for this Contractor
5. Identify if Key Personnel is a direct, subcontract, or contract employee.
6. Identify if Key Personnel is employed full-time, part-time or temporarily.
7. Length of employment or affiliation with the Contractor's organization.
8. Identify Key Personnel's percentage of work time devoted to this Contract versus Key Personnel's staff member's total overall workload.
9. Identify where Key Personnel staff member will be physically located (city and state) during the Contract performance.

1. Name	*3. Position*	4. Role(s) / Responsibilities	5. Direct/ Subcontract / Contract	6. FT/ PT/T	8. % of Work Time	9. Physical Location
Arva Overton	SAM	Responsible for overseeing all aspects of the Plan Sponsor's contract; functioning as the single point of accountability to ensure the group's servicing expectations are met.	Direct	FT	100%	Detroit, MI
Kevin Kihn	Back-Up SAM	Back up SAM in servicing Plan Sponsor when needed	Direct	FT	25 – 50% - allocated accordingly	Detroit, MI
Michele Avis (BCBSM)	Implementation Manager	Planning, coordination, and oversight throughout implementation progress	Direct	FT	75%	Detroit, MI
Marie Reese	Implementation Manager	Planning, coordination, and oversight	Direct	FT	50-75%	Kansas City, MO

		throughout implementation progress				
Holly Blundo	Data/Eligibility Specialist	Process member eligibility updates from the weekly 834-member eligibility files along with completing enrollment updates	Direct	FT	75%	Detroit, MI
J. Lyndon Good, M.D.	Clinical Expert	Peer reviews, case rounds, interface with BCBSM Medical Director	Subcontract or	FT	20%	Plymouth, MI

B. Reserved.

C. 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 Program 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.

D. Contractor must 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"):

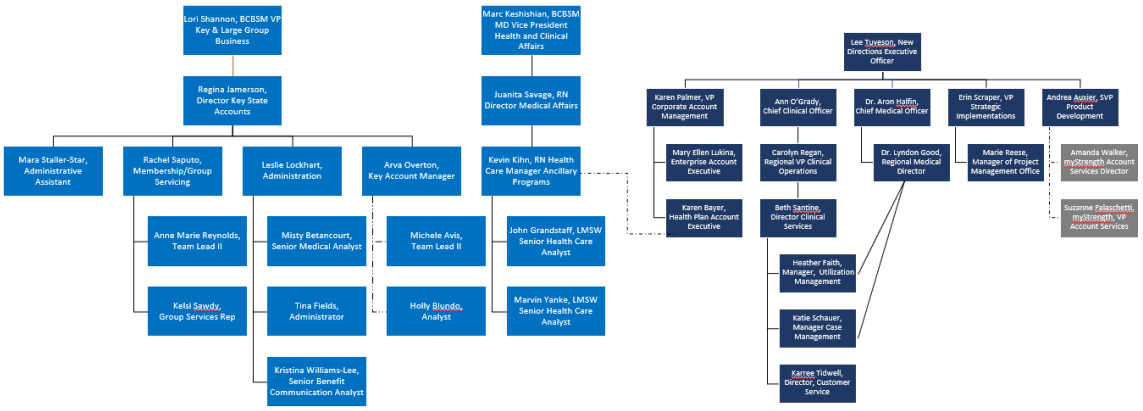
(i) For the Unauthorized Removal of any Key Personnel designated in the applicable Statement of Work, the credit amount will be $25,000.00 per individual if Contractor identifies a replacement approved by the State and assigns the replacement to shadow the Key Personnel who is leaving for a period of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

E. 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 and which includes the individuals or work units responsible for work for the Plan Sponsor.



3.6. Disclosure of Subcontractors

If the Contractor intends to utilize subcontractors, the Contractor must disclose the following:

1. The legal business name; address; telephone number.
2. A description of subcontractor's organization and the services it will provide.
3. Information concerning subcontractor's ability to provide the Contract Activities.
4. The relationship of the subcontractor to the Contractor.
5. Whether the Contractor has a previous working experience with the subcontractor.
6. If yes, provide the details of that previous relationship.
7. A complete description of the Contract Activities that will be performed or provided by the subcontractor.

Legal business name and full address.	**New Directions Behavioral Health, LLC** 8140 Ward Parkway Suite 500 Kansas City, Missouri 64114
Phone number.	(816) 237-2300
Description of the Contract Activities that will be performed or provided by the subcontractor.	Customer service; behavioral health/substance abuse care management program, including care transitions, case management, and utilization management.
The relationship of the subcontractor to the Contractor.	Blue Cross Blue Shield of Michigan partnered with New Directions in 2015 and has 10% ownership of New Directions Behavioral Health, LLC with Board of Directors representation.
Legal business name and full address.	**myStrength, Inc. (myStrength.com)** 1875 Lawrence St. Suite 550 Denver, CO 80202
Phone number.	(720) 593-8200
Description of subcontractor's organization and the services it will provide.	New Directions offers digital behavioral health self-care resources through its partnership with myStrength, Inc. (mystrength.com), headquartered in Denver, Colorado. myStrength, Inc. is a recognized leader in digital behavioral health.
Description of the Contract Activities that will be performed or provided by the subcontractor.	myStrength provides interactive web and mobile applications myStrength's evidence-based resources offer digital interactive exercises, self-care modules and daily wellness inspiration, which is personalized to each member. myStrength's Integrated, guided experience offers depth and breadth to build resiliency, manage stress, improve

	mood, sleep better or simply find daily inspiration, empowering users with individualized pathways incorporating multiple programs to help manage and overcome co-occurring challenges. The myStrength experience is based in clinical models such as cognitive behavioral therapy, acceptance and commitment therapy, positive psychology, mindfulness, and motivational interviewing. The platform includes clinically-reviewed wellness resources for diabetes, smoking cessation, nutrition, depression, pregnancy and postpartum mental health, anxiety, stress, substance use (including opioid management and addiction recovery), chronic pain, insomnia, and LGBTQ+ resources..
Legal business name and full address.	**American Well (americanwell.com)** 75 State Street 26th Floor Boston, MA 02109
Phone number.	(617) 204-3500
Description of the Contract Activities that will be performed or provided by the subcontractor.	American Well provides Contractor's white-labeled Blue Cross Online Visits solution which includes the BCBSM Online Visits app and the BCBSMOnlineVisits.com website for medical, therapy, and psychiatry online visits. Online Care Group, provides 24/7/365 coverage via a combination of full-time employed and part-time contracted physicians, psychologists, master's-level counselors, psychiatrists, registered dietitians, lactation consultants, and pediatricians. In all, Online Care Group employs a pipeline of over 2,000 credentialed providers.
Legal business name and full address.	**Accumulation Technologies, LLC d/b/a AccumTech** 17199 N Laurel Park Dr Suite 110 Livonia, MI 48152
Phone number.	734-237-5100
Description of the Contract Activities that will be performed or provided by the subcontractor.	AccumTech will perform data integration on behalf of BCBSM with any third parties requiring cost share integration or accumulator services.

3.7. Security
The Contractor will be subject to the Data Security requirements in **Schedule J, Data Security Requirements.**

4. Project Management

4.1. Project Plan

A. The Contractor must carry out this project under the direction and control of the Plan Sponsor. All transition and implementation plans are subject to the approval of the Program Manager.

B. There must be continuous liaising between the Plan Sponsor and Contractor during the implementation period and over the course of this Contract, particularly during any process involving MCSC partners or the Plan Sponsor. The Plan Sponsor will meet with the Contractor's SAM/Implementation Manager for initial review of the Contractor's work plan prior to beginning service delivery and then periodically, as needed. The meetings will provide for reviewing progress and providing necessary guidance to the Contractor regarding the timing of activities and solving issues or problems.

C. The Contractor must provide an Overall Implementation Plan (also referred to as the project plan or the work plan) for the period between May 1, 2019 and September 30, 2019 in order to commence Services, which will begin on October 1, 2019. The implementation plan must describe in detail:
   1) All major project milestones.
   2) The anticipated outcomes for each milestone.
   3) A detailed corresponding calendar/timeline/schedule for the Implementation Period.
   4) A detailed discussion on how to manage a possible transition process from the current Contractor, if applicable.
   5) All tasks, duties, or responsibilities associated with implementation and complete Contract

administration on October 1, 2019.

6) The Contractor's project management approach, including identifying methods, tools, and processes intended for oversight and completion of the implementation.
7) Any anticipated issues/changes, when they may arise, and how those issues will be conveyed to the appropriate State staff, and include suggested resolution or risk mitigation strategies to the issue(s).
8) A detailed protocol and escalation communication process; the plan must also provide escalation procedures and contact information for issues that may need to be escalated above the SAM.
9) A Final Disruption Analysis and a plan for averting disruptions and communicating any disruptions to affected members.
10) Any additional information or considerations for Services to begin October 1, 2019 and continue thereafter for the Contract term.

Contractor's Draft Plan:

1) **All major project milestones.**
The table below is a high-level draft of the implementation plan which identifies key milestones and their deadlines for completion. The organizations which will have a role in these milestones is indicated in the organizations' columns.

- "A" indicates the organization accountable, or the owner of the milestone.
- "R" indicates the organization is responsible for completing one or more deliverables within the milestone.
- "C" references the organization that will be consulted to complete the milestone and will be required to provide feedback.
- "I" references that the organization will be informed of the outcome/output of a milestone.
- "A/R" indicates the organization is both the owner and responsible.
- If a cell is blank, we do not expect the organization to be involved in the milestone.

Key Implementation Milestones	Subcontractor NDBH	BCBSM	SOM	Start	Complete
Project Management: Form Project Teams	A/R	A/R		Apr 1	Apr 30
Project Management: Hold Cross-Org Kickoff	A/R	A/R		May 1	May 7
Project Management: Establish recurring touchpoint meetings	A/R	A/R		May 1	May 14
Contracting: Obtain draft SOW	I	A/R		May 1	May 14
Contracting: Obtain fully executed Contract	I	A/R	C	May 15	May 31
Finance: Update claims payment procedures to include SOM		A/R	C	May 15	Aug 30
Finance: Establish vendor billing processes	R	A/R		Jun 1	Jun 30
Compliance: Review contract; Join appropriate workgroups	A/R	I		May 1	May 31
Communications: Support BH-related communications to members (i.e. Benefits Books)	I	A/R	C	Jul 1	Aug 30
Communications: Develop and execute Provider Communications Plan	C	A/R		Jun 1	Aug 30
Communications: Develop Employee Communications Plans	A/R	A/R		Jul 1	Jul 31
Benefits: Verify covered services and authorization requirements	R	A/R		May 1	Jun 30
Benefits: Incorporate SOM benefits and accumulations with BCBSM systems		A/R	C	May 1	Aug 30
UM and CM: Verify scope of services	R	A/R		May 1	Jun 14
UM and CM: Create UM workflows, and establish processes	A/R	R		Jun 15	Aug 14

UM and CM: Create CM and Co-CM workflows, and establish processes	A/R	R		Jun 15	Aug 30
UM and CM: Verify/Establish Medical Necessity Criteria	A/R	A/R		Jun 1	Jul 14
UM and CM: Establish Active BH Cases Transition Plan	A/R	A/R	I	Jun 15	Jul 31
UM and CM: Transition designated active BH cases to NDBH	A/R	C	I	Aug 15	Sep 30
ABA: Verify ABA services requirements	R	A/R		May 1	Jun 14
ABA: Create ABA workflows, and establish processes	A/R	R		Jun 15	Aug 14
ABA: Establish ABA Case Transitions Plan	A/R	A/R	I	Jun 15	Jul 31
ABA: Transition designated active ABA cases to NDBH	A/R	C	I	Aug 15	Sep 30
Customer Service: Verify operational requirements	A/R	R		May 1	Jun 30
Customer Service: Train CS staff on the SOM contract	A/R			Aug 15	Sep 30
Telecom: Set up dedicated SOM phone number and call flows	A/R	C	C	Jun 1	Jun 30
Telecom: Establish phone activation schedule	A/R	I	I	Jun 1	Jun 30
Letters: Create and automate UM and CM letters inventories	A/R	R	C	May 15	Aug 31
Reporting: Develop sample reports based on contract requirements	A/R	R	C	June 15	Jul 31
Reporting: Finalize reports	A/R	C	C	Aug 1	Sep 30
Quality: Review requirements; Incorporate SOM into NDBH QM processes	A/R	R		Jun 1	Jul 31
Appeals: Review requirements; Confirm processes with BCBSM	R	A/R		May 15	Jul 14
HR: Recruit and onboard any additional required staff	A/R			May 1	Sep 14
Training: Conduct SOM-specific training	A/R	R		Sep 1	Sep 21
IT Data: Set up file exchanges for Eligibility, Provider, Authorization, and Claims data	A/R	A/R		May 15	Aug 14
IT Data: Obtain historic SOM Claims data	R	A/R		Jul 1	Sep 30
Website: Update to include SOM		A/R	I	Jun 1	Aug 30
Info Security: Review contract; Ensure IS requirements are met	A/R	A/R		Jul 1	Aug 31
Project Management: Conduct Readiness Review	A/R	R		Sep 1	Sep 14
Go-Live	A/R	A/R	I	Oct 1	Oct 1
Complete Post Implementation Work	A/R	A/R	I	Oct 1	Oct 31

2) **The anticipated outcomes for each milestone.**
The table above (#1) is a high-level draft of the implementation plan which identifies key milestones and their deadlines for completion. The organizations which will have a role in these milestones is indicated in the organizations' columns.

3) **A detailed corresponding calendar/timeline/schedule for the Implementation Period.**
The table above (#1) is a high-level draft of the implementation plan which identifies key milestones and their deadlines for completion. The organizations which will have a role in these milestones is indicated in the organizations' columns.

4) **A detailed discussion on how to manage a possible transition process from the current Contractor, if applicable.**

- The previous contractor will be responsible for administering all prior auth and concurrent review for all higher levels of care for admission dates/dates of service prior to October 1st, 2019;
- The previous contractor will transition any active case management cases to the new program administrator on October 1st, 2019

The Contractor is committed to our members experiencing a seamless transition from their prior behavioral health contractor to their new behavioral health contractor. In planning for these transitions, collaboration between all parties will be imperative to ensure continuity of care. The Contractor will respectfully request professionalism and cooperation between all parties, including the previous contractor to ensure the best experience for the member. The Contractor will remain committed to this when transitioning at the beginning and end of the Contract.

To avoid any disruption in service and care for the members and providers during the transition of vendors, the Contractor requests that the previous contractor provide a list of those members with an active authorization in higher levels of care during the last week of September, in order to provide assistance with care transitions and discharge planning to provide support as the member returns to their community and receives outpatient care.

For members in case management or service coordination at the end of contract, the Contractor will request a list of members approximately two weeks prior to the transition. The Contractor will recommend coordinating 3-way case conferences including the member and the incumbent vendor to review active cases to better prepare the case managers/service coordinators to assume case management/service coordination responsibilities without having to have the member start from the beginning.

The Contractor believes that the key to success for transition is to obtain full support from the previous contractor to collaborate with the Contractor for smooth transition.

5) All tasks, duties, or responsibilities associated with implementation and complete Contract administration on October 1, 2019.

The table above (#1) is a high-level draft of the implementation plan which identifies key milestones and their deadlines for completion. The organizations which will have a role in these milestones is indicated in the organizations' columns.

6) The Contractor's project management approach, including identifying methods, tools, and processes intended for oversight and completion of the implementation.

The Contractor will collaborate closely with its subcontractors to ensure that the transition of the behavioral health program is seamless to your members.

The Contractor will provide a dedicated implementation project manager responsible for coordinating all of the operational aspects of the implementation and be the primary point of contact between the Contractor and its subcontractors.

The project manager will use the project management tool "SmartSheet" to plan, execute, and monitor the implementation effort. Contractor project teams will have direct access to the web-based implementation plan on smartsheet.com to understand deliverable timelines and view task assignments.

The Contractor will break out the implementation work into workstreams that focus on specific functional areas involved with the implementation, such as Clinical, Customer Service, Reporting, and Letters. Each workstream will be led by subject matter experts who will be responsible for completing the workstream deliverables. Early on when the workstream leads are identified, the project manager will meet with them to identify, document, and plan out the workstream requirements. These requirements will be the foundation of the implementation plan.

The Contractor exercises open communication between organizations and clear delineation of roles, responsibilities, and timelines are key elements of a successful implementation, and assists the State in proactively communicating the Contractor change to members and other stakeholders. The Contractor will establish weekly implementation status update meetings to discuss the status of in-progress deliverables, key decisions, open items, delays, roadblocks, and next steps. In addition to the weekly cross-org meeting, the Contractor will set up recurring or ad hoc workstream-specific

meetings depending on the complexity and workload requirements of the given workstreams. The Contractor will also set up recurring internal meetings to ensure continuity across workstreams.

In the weeks leading up to go-live, the Contractor will conduct a readiness review where the project manager meets with the workstreams to review for operational readiness, identify any gaps and remaining open items, and develop a plan to ensure the workstream is prepared for go-live. The Contractor will set up frequent touchpoints during the first few weeks of go-live verify operations are running according to plan, and to identify and address any questions or concerns identified to date. The project manager work with the account manager to plan the project closure, and the handoff from implementation to operations.

7) **Any anticipated issues/changes, when they may arise, and how those issues will be conveyed to the appropriate State staff, and include suggested resolution or risk mitigation strategies to the issue(s).**
The Contractor supports a systematic approach to escalating issues and changes identified during the implementation. When an issue or change is identified, the project manager will immediately inform the account manager and project owner. The project manager will investigate the impact of the issue or change, including identifying who is impacted and any resulting delays, rework, or new requirements. These details will also be communicated during the escalation process. The project manager will work with the account manager, project owner, and subject matter experts to develop a contingency plan to respond to the issue or delay and develop mitigation tactics as necessary. The issue or change, its impact, and the contingency plan will be communicated to the project team members and organization staff as soon as possible. These details will also be communicated during the next weekly implementation status update meeting.

The Contractor and their subcontractors will inform each other of identified issues and changes and work together to develop responses when both organizations are impacted. The Contractor will escalate issues and changes to the Plan Sponsor when the impact is significant enough to warrant the Plan Sponsors awareness or input. Two weeks prior to implementation, the frequency of transition meetings will increase and, on the go-live date the command center will be launched and will meet daily until all issues are resolved.

8) **A detailed protocol and escalation communication process; the plan must also provide escalation procedures and contact information for issues that may need to be escalated above the SAM.**
The Contractor's process is identified in Section 7 of their draft project plan, above.

9) **A Final Disruption Analysis and a plan for averting disruptions and communicating any disruptions to affected members.**

10) **Any additional information or considerations for Services to begin October 1, 2019 and continue thereafter for the Contract term.**
The Contractor has addressed all information and considerations.

D. The Contractor must meet to discuss the Implementation Plan with Program Manager and Plan Sponsor within five State-business days from Contract award date. The Overall Final Implementation Plan must be submitted to Program Manager within five State business days from the initial Implementation meeting and must include items 1-10 in Section 4.1.C above, 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 October 1, 2019. The Program Manager will provide final approval of the Implementation Plan within 14 days after submission.

4.2. Meetings
All agendas and meeting materials created by the Contractor for meetings as required below must be provided to Plan Sponsor at least 5 Days prior to the meeting.

The Contractor must attend the following meetings:

A. The Contractor must participate in any meetings requested and deemed appropriate by the Plan Sponsor. Meeting frequency will change over the course of the Contract. During these meetings, the

Contractor must review all open projects and present the status, progress and results of each project. The Contractor must provide data and cost analysis upon request.

B. **Quarterly Plan Review Meetings:** These meetings must be held at a location as determined by the Plan Sponsor (these meetings may be conducted via teleconference as authorized by the Plan Sponsor), and additional meetings may be held each year, for the purpose of reviewing:
   1) Contractor's performance on SLA's (See Section 1.J). The Contractor must meet with the Plan Sponsor to review plan performance, report on progress, and identify improvement opportunities.
   2) Contractor's comprehensive review of the cost and utilization experience of the Plan, including, but not limited to:
      a. Proposed solutions to performance variances (such as cost, utilization, and administrative performance and their root causes).
      b. Data analysis with commensurate recommendations and cost-benefit analysis to provide support for proposed plan modifications and for subjects of bargaining.
      c. Review of changes in the market and identification of emerging trends.
      d. The fourth quarter meeting will also include the annual plan review.

C. **Strategic Planning Sessions:** The Contractor must participate in strategic planning sessions to provide the following:
   1) Data analysis with commensurate recommendations and cost-benefit analysis to provide support for proposed plan modifications and for subjects of bargaining.
   2) Review of changes in the market and identification of emerging trends.

   These meetings are estimated to be annual, however they may be needed based on demand and in conjunction with bargaining or Executive Office requests.

D. **Strategic Planning Seminars:** The Contractor must provide seminars on related topics from the Strategic Planning Sessions for the Plan Sponsor.

4.3. Reporting

A. The Contractor must submit to the Program Manager, proper and timely reporting and analysis including their standard cost and use reporting, at no additional cost to the Plan Sponsor. Failure to adhere to the timeframes indicated in this section will result in penalties identified in Section 1.J.

   This reporting will include comprehensive annual cost and use reporting across all medical and behavioral health claims as well as quarterly cost and use dashboard reporting for key metrics. In addition, the Contractor will provide the Plan Sponsor with access to Whyzen Analytics, Contractor's online cost and use reporting platform. Using Whyzen Analytics, the Plan Sponsor can access over 100 standard cost and use reports are available to run/export each month.

B. All reports must include the relevant BOB (Book of Business), and the peer comparator group.

   The Contractor will partner with the Plan Sponsor to define an appropriate peer comparator group to determine the feasibility of providing peer comparisons in reporting and analysis. Comparisons can be made to the Contractor's Book of Business, or a segmented BOB such as a plan, product, industry, or geography.
   In addition, Whyzen Analytics includes –
   - Concurrent and Prospective Risk Scores developed by Blue Health Intelligence (BHI).
   - Medical Episode Grouper (MEG), a proprietary episode grouping methodology of Truven Health Analytics, now IBM WatsonHealth
   - New York University (NYU) Emergency Department (ED) visit algorithm to retrospectively classify ED visits

   The Contractor will also access the Blue Cross Blue Shield Association's National Data Warehouse (NDW) as needed for national and regional benchmarks using the largest healthcare database in the country.

C. The Contractor must have online or electronic reporting capabilities. Training and ongoing support must be provided at no additional cost.

   The Contractor will provide online access to Whyzen Analytics. Plan Sponsor and any delegated access they may provide to consultants will be able to access Whyzen themselves and is available

24/7 via a web browser. Paid claim data will be sent to Whyzen Analytics monthly, and the tool will contain the most recent 39 months of incurred data, updated each month. The user can customize a run-out period for paid claims between 0 and 3 months.

The recommended browser is Google Chrome; however, it can also be used in Internet Explorer 11, Safari, and Firefox. The web browser supporting the tool is HTML5 compliant. The solution is secured via penetration testing. Member-identifying information such as name, address, social security number, etc. is restricted for external users. Members will be identified using an encrypted member ID so that external users are not able to access a member's Protected Health Information (PHI).

The Contractor will also provide the Plan Sponsor and any of their delegated consultants, with training on use of the tool monthly and as needed. The Contractor will also provide limited consultative support and support for report generation to the Plan Sponsor and any of their delegated consultants as needed.
Additional reporting functionality of Whyzen:

- "At a glance" flexible time views of summary cost and utilization key metrics
- Continuum of care (segment population)
- Site of care (steering care to less-intensive sites, if appropriate)
- ACO metrics (ER, readmissions, etc.)
- Quality of care metrics
- Drugs (generic substitution, mail order usage, specialty drugs, etc.)

The Plan Sponsor will also have access to eBookshelf, an online portal that includes weekly invoices, claims listings, and various monthly reports on membership and will also be able to grant access to their consultant, as needed.

D. The Contractor must provide their standard report package in addition to the required reports below. See **Schedule H Sample Claims Report and Invoice Format**. Failure to adhere to the timeframes indicated will result in penalties.

Monthly reports are due on the 15th of the second subsequent month, for example, reports for October are due December 15th. Quarterly and annual reports are due on the following schedule:

Quarter designation	Date Range (inclusive)	Report Due Date
First Quarter	October 1-December 31	February 15
Second Quarter	January 1-March 31	May 15
Third Quarter	April 1-June 30	August 15
Fourth Quarter, to include year-end.	July 1- September 30	November 30

1) **Monthly reports.** These reports must be split between Actives, COBRA and Retirees:
   a. Monthly Dashboard
      1. A brief summary of significant activities, issues or problems identified or addressed during the month, or anticipated in subsequent months, including fraud detection and remedy (i.e. Executive Summary).
      2. Claims reporting, showing number of claims paid in the month, total number of subscribers who obtained services, and the total plan paid and member paid dollars, and split by In-network and Out of Network.
      3. Number of subscribers and dependents covered.
   b. Claims Lag report, separated by Actives, COBRA participants, and Retirees (broken out by retirement system, SERS, SPRS, JRS & MRS), updated monthly for year-to-date claims.
   c. Service Availability report. The Service Availability Report must include all systems/solutions utilized to service this Contract. See **Schedule M, Service Availability Report** for the required Service Availability Report format.

2) **Quarterly reports.**
   a. Quarterly and YTD summaries of Claims Reporting to include:
      1. Claim volume
         - Claims cost per contract
         - Claims cost per member

- Number of members utilizing services

2. Financial reporting of Plan Sponsor and member cost share
   - By provider level
   - By Current Procedural Terminology (CPT) code
3. Performance Standard Guarantee Report detailing the Service Level Agreements with supporting documentation provided upon request of Plan Sponsor.
4. Utilization review and case management summaries, which provide the following items:
   - Response time in days to practitioner's request for authorization of admission and continued care.
   - Time in days from the day of admission or referral to the day reviewed.
   - Admits per thousand and Average Length of Stay (ALOS) for adults and adolescents for claims under case management.
   - Number of reconsideration claims submitted and length of time in days to make reconsideration.
   - Reversal rate for medical necessity decisions for internal reconsideration and external appeals.
   - Case management information, including the number and cost of case management activities, referencing the type of provider utilized, focus of task, and amount of savings achieved.
   - Number and percent of total cases in case management that resulted in alternative treatments.
   - Percentage of members terminating treatment prior to completion of treatment plan.
5. Network and Utilization Management report, including the following items:
   - Number of providers identified as requiring further investigation.
   - Number of providers for which more details were requested and are currently pending, with number concluded with no adverse recommendations.
   - Percent of providers reviewed in monitoring patterns of abuse.
   - Average time from identification of the problem to conclusion of the investigation.
   - Number of complaints made and the number unresolved.
   - Summary of all reconsiderations and appeals.
   - Number of providers and ratio of providers to claims.
6. Professional reviews and/or audits conducted during the period.
7. Grievance and Appeal reporting that details the count, issue, date received and responded to, and outcome.

3) **Annual Reports.**
   a. Annual attestation for HIPAA privacy and security compliance. (See also Section 1.C.3).
   b. Management summary: Full financial and enrollment experience, including the items shown in monthly and quarterly reports, summarized to an annual basis.
   c. Claims coordinated, split by claims coordinated with the State-sponsored health plans, and by spouse's employer-sponsored medical or MHSA plans.
   d. Results of member and provider satisfaction surveys
   e. Annual SSAE SOC 1 and SOC 2 Type II (or other applicable report) with applicable bridge report.

The Contractor will provide access to standard reporting through Whyzen Analytics. Over 100 standard reports will be available in the tool. These reports will include all types of services, such as inpatient, outpatient, professional, and pharmacy claims, and also sorted by product categories such as PPO, HMO, etc. Included in these reports will be standard reports, such as use, cost, trends, and episodes of care.

Reports will be updated monthly on the most recent rolling 39 months. Standard reports will have a 1 month run-out for incurred claims, however run-out periods can be adjusted between 0 and 3 months. Users can also create their own standard reports and schedule them to update on a routine basis.

All reporting can be obtained through the Contractor or via self-service. Standard reporting will be available monthly, quarterly, and annually (calendar and rolling). Reports can be scheduled to be run automatically with each update or can be run manually anytime.

The Contractor will work with the Plan Sponsor's technical team to provide Cobra reporting by October 1, 2019. The Plan Sponsor will provide the proper COBRA indicators to the Contractor. In addition, the Contractor will partner with the Plan Sponsor to develop any new standard reporting as needed for monthly, quarterly, or annual reporting.

5. Ordering

5.1. Authorizing Document

The appropriate authorizing documents for the Contract will be a signed Master Agreement as well as an Agency Issued Delivery Order (DO).

6. Invoice and Payment

6.1. Invoice Requirements

A. All invoices submitted to the State must include but is not limited to: (a) date; (b) description of the Contract Activities and supporting documentation; and (c) total price. See **Schedule H Sample Claims Report and Invoice Format**.

B. Payment of Administrative Fees to the Contractor is predicated on the enrollment records of the Plan Sponsor and ORS (See also Section 1.H.1).

The Plan Sponsor self-bills their administrative fees, emailing the amounts to put on a future invoice.

6.2. Payment Methods

The State will make payment for Contract Activities via Electronic Funds Transfer (EFT).

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE B
PRICING

1. The pricing table below reflects pricing with ABA fee rolled into the Administrative Fee.
2. Reserved.
3. Reserved.
4. Pricing 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.
5. The Contractor must provide Pass-Through Pricing to Plan Sponsor. The 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.
6. Reserved.
7. The Contract pricing reflects a 39-month period with service commencing October 1, 2019 and ending December 31, 2022.

Self-Insured Pricing (1)	
Contract Term FY2020-2022 (39 Months)	**Rate**
Administrative Fee (2) **(Per Contract Per Month Administration Fee)**	**$ 1.77**
Implementation Credit	**$200,000**
Prompt Payment	none

Notes:
(1) The State of Michigan does not guarantee a minimum or maximum volume of services, claims and conversions.

STATE OF MICHIGAN

Contract No. 190000000755

Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE C

PLAN DESIGN AND CLAIMS PAYMENT RULES

Description	Detail
Reimbursement and Allowed Amount – Out of Network	Usual & Customary Rate based on FairHealth or Medicare rates or billed charges, or In Network allowed amount; (whichever is less).
Claims Filing Limitation	12 months from date of service for all providers
Pre-existing conditions	No pre-existing condition clause applies.
Certification	Preauthorization of services where required for full provider reimbursement at network rates.
Coordination of benefits	• Birthday Rule • Lesser of A. balance of the service, or B. amount that would have been paid if SHP PPO was primary • Medicare coordination is in accordance with Medicare primacy rules
Lifetime Maximum	None
Year	Plan Year for enrollment and benefit changes begins first full pay period in October. Deductibles and Maximums reset with the Calendar Year. Plan includes 4th quarter carryover: Any amount accumulated toward in-network deductible for dates of service from October 1-December 31 will carry over and be applied toward the in-network deductible the following year. Calculations made by Health Plan Accumulator Contractor.
Plan Deductible	In Network $400 Individual/$800 Family. Out-of-Network $800 Individual/$1,600 Family. Shared with other carriers to track Out of Pocket Maximum (OOPM) Calculations made by Health Plan Accumulator Contractor.
Out of Pocket Maximum (OOPM)	In Network $2000 individual/$4000 Family. Out-of-Network $3000 individual/$6000 Family Shared with other carriers.
Autism Spectrum Disorders Including Applied Behavioral Analysis (ABA)	Covered 90% of allowed amount In Network after deductible Covered 80% of allowed amount Out of Network after deductible Annual Maximums $50,000 through 6 years of age $40,000 for ages 7 through 12 $30,000 for ages 13 through 18
Tele-behavioral health	Covered In-Network only Member charged the lesser of $10 Copay or 10% of allowed amount. except active members or persons who retired from the State Police

	Enlisted bargaining unit on or after October 1, 1987 where member is charged the lesser of $20 Copay or 10% of allowed amount. Medicare Enrolled individuals not eligible.	
Outpatient BH	In-Network	Covered 90% of allowed amount
	Out of Network	Covered 50% of allowed amount
Outpatient SA Includes Office Based Opioid Treatment & Methadone Maintenance - $3500 calendar year maximum benefit for services for chemical dependency	In-Network	Covered 90% of allowed amount with certification
	Out of Network	Covered 50% of allowed amount with certification
Detox	• Substance abuse/Sub-acute detox is covered and is included in the normal annual limits. • All detox services are covered under Inpatient benefits, including ambulatory and outpatient detox and paid at 100%. • Acute detox is covered under the medical benefits.	
Inpatient BH – 365 days/year	• 365 days per calendar year for both INN and OON	
	In-Network	• Covered 100% of allowed amount with or without a certification
	Out of Network	• Covered 50% (allowed amount or billed charges; whichever is less)
Inpatient SA	• Up to 28 days per treatment period; maximum of two periods per calendar year • SA treatment periods must be separated by at least 60 days (either in or out of network). If a member relapses soon after discharge a second inpatient may be included as the same treatment period but combined cannot exceed the 28 day total. Second SA treatment period is renewable after 60 days from the date of discharge. • Prior Plan Sponsor approval required to waive 60-day separation.	
	In-Network	• $0 copay with or without a certification
	Out of Network	• Covered 50% (allowed amount or billed charges; whichever is less)
Bridge Appointments	In-Network	• Covered 100% of allowed amount with or without certification
	Out of Network	• Not covered
Alternative Levels of Care	• Residential – 1:1 to inpatient (Substance Abuse Only) • Halfway House– 2:1 to inpatient (only if clinical services are provided) • Partial Hospital – 2:1 to inpatient • IOP –2:1 to inpatient	
Psychological Testing	• Covered 90% of allowed amount with prior certification • Covered 50% if not certified (of allowed amount or billed charges, whichever is less) • No distinction between in/out of network	
Neuropsychological Testing	• If resultant diagnosis is mental health pay as above. If diagnosis is medical, not covered or paid.	

Electro-Convulsive Therapy (ECT)	• Outpatient (OP) ECT will pay as one partial hospital day at 100% of the allowed rate, with prior certification. • Anesthesiology – covered at 100% of allowed amount. • Hospital, psychiatrist and other associated costs covered 100% of allowed amount, with certification
Emergency Room	• $200 Copay (waived if admitted to same facility with a BH or SA diagnosis) • All others are processed by medical carrier.
Laboratory Expense:	• Covered 90% after deductible
Ambulance	Medically necessary ambulance charges, covered 90% after deductible.
Excluded Services	• Residential Mental Health • rTMS • Biofeedback • Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide. • Hypnotherapy • Marital counseling • Psychodrama • Art therapy • Recreation therapy • Counseling for vocational, academic, or education purposes • Court-ordered psychotherapy, including substance abuse • Services received at private residences • Phone consultations or therapeutic phone questions • Music therapy • Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member. • Serviced provided while the member is not covered for this benefit. • Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice. • Claims deemed fraudulent which, through the exercise of due diligence by contractor could have been prevented • Completion of any insurance form • Medical services or drugs not administered for BH/SA treatment.
Diagnosis Codes:	Mixed Service Protocol with ICD-10 codes for included and excluded services will be discussed by Plan Sponsor and Contractor, and any questions resolved prior to implementation.

SCHEDULE D – RESERVED

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE E
HIPAA 834 FILE LAYOUTS

Select the hyperlinks below to view each document:

MCSC 834 Companion Guide
ORS 834 File Layout
ORS 834 File User Guide

SCHEDULE F - RESERVED

SCHEDULE G - RESERVED

STATE OF MICHIGAN

Contract No. 190000000755

Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE H – SAMPLE CLAIMS REPORT AND INVOICE FORMAT

Regular Invoicing Sample Format

Invoice date	**11/15/2018**	**(must date invoice and include range covered, weekly, bi-weekly or monthly, as appropriate)**
Invoice period	**11/4/2018-11/10/2018**	

Invoicing	Total Claims	Total Admin	Total Tax*
Actives	$ -	$ -	$ -
COBRA (includes Active & Retiree COBRA)	$ -	$ -	$ -
SERS	$ -	$ -	$ -
SPRS	$ -	$ -	$ -
JRS	$ -	$ -	$ -
MRS	$ -	$ -	$ -
Total	$ -	$ -	$ -

*** Claims taxes must be reported separately where applicable. These must then roll up to quarterly and year-end reports.**

Sample SOM Insurance Quarterly and Year-end Claims Invoice Report

Reporting period

Paid Claims	Total Invoiced 10/1/17 - 9/30/18
Actives	$ -
COBRA (includes Active & Retiree COBRA)	
SERS	$ -
SPRS	$ -
JRS	$ -
MRS	$ -
Total	$ -
	(should match invoice totals billed and paid for the period)

Administrative Fees	Total Admin 10/1/17 - 9/30/18
Actives	$ -
COBRA (includes Active & Retiree COBRA)	
SERS	$ -
SPRS	$ -
JRS	$ -
MRS	$ -
Total	$ -
	(should match admin totals on invoices for the period)

Claims Taxes	Total Tax 10/1/17 - 9/30/18
Actives	$ -
COBRA (includes Active & Retiree COBRA)	
SERS	$ -
SPRS	$ -
JRS	$ -
MRS	$ -
Total	$ -
	(should match applicable tax totals on invoices for the period)

(For year end only) Estimated Liability for Incurred but Unpaid Claims as of September 30, 2018	Claims less than one year	Claims greater than one year
Actives	$ -	$ -
COBRA (includes Active & Retiree COBRA)	$ -	$ -
SERS	$ -	$ -
SPRS	$ -	$ -
JRS	$ -	$ -
MRS	$ -	$ -
Total	$ -	$ -

Sample Claim Lag Report
Incurred Claims 10/01/17 through 09/30/18

Vendor:

Actives and Retiree data must be submitted monthly in two separate sections or tabs
Shaded area to include applicable values

		Incurred Date												
Paid Date	**Prior Period**	10/01/16 10/31/16	11/01/16 11/30/16	12/01/16 12/31/16	01/01/17 01/31/17	02/01/17 02/28/17	03/01/17 03/31/17	04/01/17 04/30/17	05/01/17 05/31/17	06/01/17 06/30/17	07/01/17 07/31/17	08/01/17 08/30/17	09/01/17 09/30/17	Total Paid
10/01/16 - 10/31/16			$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11/01/16 - 11/30/16				$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12/01/16 - 12/31/16					$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
01/01/17 - 01/31/17						$0	$0	$0	$0	$0	$0	$0	$0	$0
02/01/17 - 02/28/17							$0	$0	$0	$0	$0	$0	$0	$0
03/01/17 - 03/31/17								$0	$0	$0	$0	$0	$0	$0
04/01/17 - 04/30/17									$0	$0	$0	$0	$0	$0
05/01/17 - 05/31/17										$0	$0	$0	$0	$0
06/01/17 - 06/30/17											$0	$0	$0	$0
07/01/17 - 07/31/17												$0	$0	$0
08/01/17 - 08/31/17													$0	$0
09/01/17 - 09/30/17														$0
10/01/17 - 10/31/17														$0
11/01/17 - 11/30/17														$0
12/01/17 - 12/31/17														$0
01/01/18 - 01/31/18														$0
02/01/18 - 02/28/18														$0
03/01/18 - 03/31/18														$0
04/01/18 - 04/30/18														$0
05/01/18 - 05/31/18														$0
06/01/18 - 06/30/18														$0
07/01/18 - 07/31/18														$0
08/01/18 - 08/31/18														$0
09/01/18 - 09/30/18														$0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

SCHEDULE I – RESERVED

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE J – DATA SECURITY REQUIREMENTS

1. Definitions. For purposes of this Schedule, the following terms have the meanings set forth below. All initial capitalized terms in this Schedule that are not defined in this **Section 1** shall have the respective meanings given to them in the Contract.

"**Contractor Security Officer**" has the meaning set forth in **Section 2** of this Schedule.

"**Contractor Systems**" has the meaning set forth in **Section 5** of this Schedule.

"**FedRAMP**" means the Federal Risk and Authorization Management Program, which is a federally approved risk management program that provides a standardized approach for assessing and monitoring the security of cloud products and services.

"**Hosted Services**" means the hosting, management and operation of the computing hardware, ancillary equipment, Software, firmware, data, other services (including support services), and related resources for remote electronic access and use by the State and its Authorized Users, including any services and facilities related to disaster recovery obligations.

"**PSP**" means the State's IT Policies, Standards and Procedures located at: http://michigan.gov/dtmb/0,4568,7-150-56355_56579_56755---,00.html

2. Contractor will appoint a Contractor employee to respond to the State's inquiries regarding the security of the Contractor Systems who has sufficient knowledge of the security of the Contractor Systems and the authority to act on behalf of Contractor in matters pertaining thereto ("**Contractor Security Officer**"). The Contractor Security Officer will be considered Key Personnel under the Contract.

3. Protection of the State's Confidential Information. Throughout the Term and at all times in connection with its actual or required performance of the Services, Contractor will:

3.1. Obtain and maintain HITRUST certification and maintain its current levels of controls established in its SOC2 Type 2 Report for the Hosted Services throughout the Term. In the event the Contractor is unable to obtain and maintain HITRUST certification and the SOC2 Type 2 Report with its current level of controls, the State may terminate the Contract in accordance with the termination provisions in the Contract. When obtained, Contractor is required to submit SOC2 Type2 audit reports and HITRUST certifications to the State on an annual basis. For any cloud-based hosting solution provided by the Contractor and any of their subcontractors that has State Data that contains PII and PHI as defined in Standard Contract Terms Section 36, FedRAMP or HITRUST certification is required. HITRUST certification must be obtained within one year of the Contract effective date;

3.2. Ensure that the Software is securely hosted, supported, administered, and accessed in a data center that resides in the continental United States, and minimally meets Uptime Institute Tier 3 standards (www.uptimeinstitute.com), or its equivalent;

3.3. Maintain and enforce an information security program including safety and physical and technical security policies and procedures with respect to its Processing of the State's Confidential Information that comply with the requirements of the State's data security policies as set forth in the Contract, and must, at a minimum, remain compliant with the requirements as mentioned in Schedule J, Section 3.1.

3.4. Provide technical and organizational safeguards against accidental, unlawful or unauthorized access to or use, destruction, loss, alteration, disclosure, transfer, commingling or processing of such information that ensure a level of security appropriate to the risks presented by the processing of the State's Confidential Information and the nature of such Confidential Information, consistent with best industry practice and standards;

3.5. Take all reasonable measures to:

(a) Secure and defend all locations, equipment, systems and other materials and facilities employed in connection with the Services against "hackers" and others who may seek, without authorization, to disrupt, damage, modify, access or otherwise use Contractor Systems or the information found therein; and

(b) Prevent (i) the State and its Authorized Users from having access to the data of other customers or such other customer's users of the Services; (ii) the State's Confidential Information from being commingled with or contaminated by the data of other customers or their users of the Services; and (iii) unauthorized access to any of the State's Confidential Information;

3.6. Ensure that State Data is encrypted by Contractor in transit and at rest using AES 256bit or higher encryption. Contractor must provide confirmation that they have successfully migrated to this standard within 30 days of Contract award;

3.7. Ensure the Contractor's Hosted Services support Identity Federation/Single Sign-on (SSO) capabilities using Security Assertion Markup Language (SAML) or comparable mechanisms;

3.8. Ensure the Contractor's Hosted Services have multi-factor authentication for privileged/administrative access implemented no later than December 31, 2019; and

3.9. Contractor must work with the State staff in creating the State's system security plan and risk assessment or provide enough information and evidence to the State staff (i.e. SOC 2 Type II, Independent audit report when available, to enable completion of the system security plan and risk assessment for this Contract).

4. Unauthorized Access. Contractor may not access, and shall not permit any access to, State systems, in whole or in part, whether through Contractor's Systems or otherwise, without the State's express prior written authorization. Such authorization may be revoked by the State in writing at any time in its sole discretion. Any access to State systems must be solely in accordance with the Contract and this Schedule, and in no case exceed the scope of the State's authorization pursuant to this **Section 4**. All State-authorized connectivity or attempted connectivity to State systems shall be only through the State's security gateways and firewalls and in compliance with the State's security policies set forth in the Contract as the same may be supplemented or amended by the State and provided to Contractor from time to time.

5. Contractor Systems. Contractor will be solely responsible for the information technology infrastructure, including all computers, software, databases, electronic systems (including database management systems) and networks used by or for Contractor in connection with the Services ("**Contractor Systems**") and shall prevent unauthorized access to State systems through the Contractor Systems.

6. Security Audits. During the Term, Contractor will:

6.1. Maintain complete and accurate records relating to its data protection practices, IT security controls, and the security logs of any of the State's Confidential Information, including any backup, disaster recovery or other policies, practices or procedures relating to the State's Confidential Information and any other information relevant to its compliance with this Schedule;

6.2. Upon the State's request, make all such records, appropriate personnel and relevant materials available during normal business hours for inspection and audit by the State or an independent data security expert that is reasonably acceptable to Contractor, provided that the State: (i) gives Contractor at least five (5) Business Days prior notice of any such audit; (ii) undertakes such audit no more than once per calendar year, except for good cause shown; and (iii) conducts or causes to be conducted such audit in a manner designed to minimize disruption of Contractor's normal business operations and that complies with the terms and conditions of all data confidentiality, ownership, privacy, security and restricted use provisions of the Contract; Including, the Contractor agrees to regularly perform vulnerability scans of Contractor's systems/applications and will promptly remediate vulnerabilities revealed by the routine scans. Contractor will provide written confirmation quarterly to the State that such scans and remediation have occurred.

7. Nonexclusive Remedy for Security Compliance. Any failure of the Services to meet the requirements of this Schedule with respect to the security of any State Data or other Confidential Information of the State, including any related backup, disaster recovery or other policies, practices or procedures, is a material breach of the Contract for which the State, at its option, may terminate the Contract immediately upon written notice to Contractor without any notice or cure period, and Contractor must promptly reimburse to the State any Fees prepaid by the State prorated to the date of such termination

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE K – HIPAA BUSINESS ASSOCIATE AGREEMENT

HIPAA Business Associate Agreement begins on next page.

HIPAA BUSINESS ASSOCIATE AGREEMENT

The parties to this Business Associate Agreement ("Agreement") are the State of Michigan State Health Plan PPO ("Covered Entity") and Blue Cross Blue Shield of Michigan ("Business Associate").

RECITALS

A. Under this Agreement, Business Associate will collect or receive certain information on the Covered Entity's behalf, some of which may constitute Protected Health Information ("PHI"). In consideration of the receipt of PHI, Business Associate agrees to protect the privacy and security of the information as set forth in this Agreement.

B. Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI collected or received by Business Associate under the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HIPAA Rules, as amended.

C. The HIPAA Rules require the Covered Entity to enter into an agreement containing specific requirements with Business Associate before Business Associate's receipt of PHI.

AGREEMENT

1. Definitions.

   a. The following terms used in this Agreement have the same meaning as those terms in the HIPAA Rules: Breach; Data Aggregation; Designated Record Set; Disclosure; Health Care Obligations; Individual; Minimum Necessary; Notice of Privacy Practices; Protected Health Information; Required by Law; Secretary; Security Incident; Security Measures, Subcontractor; Unsecured Protected Health Information, and Use.

   b. "Business Associate" has the same meaning as the term "business associate" at 45 CFR 160.103, and as used in this agreement refers to Blue Cross Blue Shield of Michigan.

   c. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR 160.103 and regarding this Agreement means the State of Michigan State Health Plan PPO.

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

2. Obligations of Business Associate. Business Associate agrees to:

   a. use and disclose PHI only as permitted or required by this Agreement or as required by law.

   b. implement and use appropriate safeguards, and comply with Subpart C of 45 CFR 164 regarding electronic protected health information, to prevent use or disclosure of PHI other than as provided in this Agreement. Business Associate must maintain, and provide a copy to the Covered Entity within 10 days of a request from the Covered Entity, a comprehensive written information privacy and

security program that includes security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI relative to the size and complexity of Business Associate's operations and the nature and the scope of its activities.

c. report to the Covered Entity within five calendar days of any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.410, and any Security Incident of which it becomes aware. If Business Associate is responsible for any unauthorized use or disclosure of PHI, it must promptly act as required by applicable federal and State laws and regulations. Covered Entity and Business Associate will cooperate in investigating whether a breach has occurred, to decide how to provide breach notifications to individuals, the federal Health and Human Services' Office for Civil Rights, and potentially the media.

d. ensure, according to 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate regarding such information. Each subcontractor must sign an agreement with Business Associate containing substantially the same provisions as this Agreement. Business Associate must implement and maintain sanctions against subcontractors that violate such restrictions and conditions and must mitigate the effects of any such violation.

e. make available PHI in a Designated Record Set to the Covered Entity within ten days of a request from the Covered Entity to satisfy the Covered Entity's obligations under 45 CFR 164.524.

f. within ten days of a request from the Covered Entity, amend PHI in a Designated Record Set under, 45 CFR § 164.526. If any individual requests an amendment of PHI directly from Business Associate or its agents or subcontractors, Business Associate must notify the Covered Entity in writing within five days of the request and amend the information within ten days of the request. Any denial of amendment of PHI maintained by Business Associate or its agents or subcontractors is the responsibility of Business Associate.

g. maintain, and within ten days of a request from the Covered Entity make available, the information required to provide an accounting of disclosures to enable the Covered Entity to fulfill its obligations under 45 CFR §164.528. Business Associate is not required to provide an accounting to the Covered Entity of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 CFR § 164.506; (ii) to individuals of PHI about them as set forth in 45 CFR § 164.502; (iii) under an authorization as provided in 45 CFR § 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR § 164.510; (v) for national security or intelligence purposes as set forth in 45 CFR § 164.512(k)(2); (vi) to correctional institutions or law enforcement officials as set forth in 45 CFR § 164.512(k)(5); (vii) as part of a limited data set according to 45 CFR 164.514(e); or (viii) that occurred before the compliance date for the Covered Entity. Business Associate agrees to implement

a process that allows for an accounting to be collected and maintained by Business Associate and its agents or subcontractors for at least six years before the request, but not before the compliance date of the Privacy Rule. At a minimum, such information must include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or a copy of the written request for disclosure. If the request for an accounting is delivered directly to Business Associate or its agents or subcontractors, Business Associate must, within ten days of the receipt of the request, forward it to the Covered Entity in writing.

h. to the extent Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity when performing those obligations.

i. make its internal practices, books, and records relating to Business Associate's use and disclosure of PHI available to the Secretary for purposes of determining compliance with the HIPAA Rules. Business Associate must concurrently provide to the Covered Entity a copy of any PHI that Business Associate provides to the Secretary.

j. retain all PHI throughout the term of the Agreement and for a period of six years from the date of creation or the date when it last was in effect, whichever is later, or as required by law. This obligation survives the termination of the Agreement.

k. implement policies and procedures for the final disposition of PHI and the hardware and equipment on which it is stored, including but not limited to, removal of PHI before re-use.

l. within ten days of a written request by the Covered Entity, Business Associate and its agents or subcontractors must allow the Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI under this Agreement. Business Associate and the Covered Entity will mutually agree in advance upon the scope, timing and location of such an inspection. Covered Entity and Business Associate will execute a nondisclosure agreement, if requested by the other party. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Business Associate of its responsibility to comply with this Agreement. Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices, does not constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this Agreement.

3. Permitted Uses and Disclosures by Business Associate.

   a. Business Associate may use or disclose PHI:

      (1) for the proper management and administration of Business Associate or to carry out its legal responsibilities; provided, however, either (A) the disclosures are required by law, or (B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

      (2) as required by law;

      (3) for Data Aggregation services relating to the health care operations of the Covered Entity;

      (4) to de-identify, consistent with 45 CFR 164.514(a) – (c), PHI it receives from the Covered Entity. If Business Associates de-identifies the PHI it receives from the Covered Entity, Business Associate may use the de-identified information for any purpose not prohibited by the HIPAA Rules; and

      (5) In conformance with the provisions and requirements set forth in HIPAA, Business Associate may use PHI to create De-Identified Health Information and Limited Data Sets containing the minimum necessary amount of PHI reasonably needed for Research, Public Health or Health Care Operations activities; and

      (6) may use and disclose a Limited Data Set for Research, Public Health or Health Care Operations purposes. Business Associate may make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of the underlying agreement between Business Associate and Covered Entity.

   b. Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

   c. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity except for the specific uses and disclosures described above in 3(a)(i) and (iii).

4. Covered Entity's Obligations Covered Entity agrees to:

   a. use its Security Measures to reasonably and appropriately maintain and ensure the confidentiality, integrity, and availability of PHI transmitted to Business Associate under this Agreement until the PHI is received by Business Associate.

   b. provide Business Associate with a copy of its Notice of Privacy Practices and must notify Business Associate of any limitations in the Notice of Privacy Practices of the Covered Entity under 45 CFR 164.520 to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

c. notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose the individual's PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

d. notify Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Term. This Agreement continues in effect until terminated or is replaced with a new agreement between the parties containing provisions meeting the requirements of the HIPAA Rules, whichever first occurs.

6. Termination.

a. Material Breach. In addition to any other provisions in the Agreement regarding breach, a breach by Business Associate of any provision of this Agreement, as determined by the Covered Entity, constitutes a material breach of the Agreement and provides grounds for Covered Entity to terminate this Agreement for cause. Termination for cause is subject to 6.b.:

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

(2) Business Associate's Duties. Notwithstanding termination of the Agreement, and subject to any directions from the Covered Entity, Business Associate must protect and preserve property in the possession of Business Associate in which the Covered Entity has an interest.

(3) Erroneous Termination for Default. If Covered Entity terminates this Agreement under Section 6(a) and after such termination it is determined, for any reason, that Business Associate was not in default, then such termination will be treated as a termination for convenience, and the rights and obligations of the parties will be the same as if the Agreement had been terminated for convenience.

b. Reasonable Steps to Cure Breach. If the Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under the provisions of this Agreement or another arrangement and does not terminate this Agreement under Section 6(a), then Covered Entity must notify Business Associate of the pattern of activity or practice. Business Associate must then take reasonable steps to cure such breach or end such violation, as applicable. If the Business Associate's efforts to cure such breach or end such violation are unsuccessful, Covered Entity may either (i) terminate this Agreement, if feasible or (ii) report Business Associate's breach or violation to the Secretary.

c. Effect of Termination. After termination of this Agreement for any reason, Business Associate, with respect to PHI it received from the Covered Entity, or PHI created, maintained, or received by Business Associate on behalf of the Covered Entity, must:

(1) retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(2) return to Covered Entity (or, if agreed to by the Covered Entity in writing, destroy) the remaining PHI that Business Associate still maintains in any form;

(3) continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

(4) not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3(a)(1) which applied before termination; and

(5) return to Covered Entity (or, if agreed to by Covered Entity in writing, destroy) the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

7. No Waiver of Immunity. The parties do not intend to waive any of the immunities, rights, benefits, protection, or other provisions of the Michigan Governmental Immunity Act, MCL 691.1401, *et seq*., the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq*., or the common law.

8. Data Ownership. Business Associate has no ownership rights in the PHI. Covered Entity retains all ownership rights of the PHI.

9. Disclaimer. Covered Entity does not warrant or represent that compliance by Business Associate with this Agreement, HIPAA, or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

10. Certification. If Covered Entity determines an examination is necessary to comply with Covered Entity's legal obligations under HIPAA relating to certification of its security practices, Covered Entity or its authorized agents or contractors may, at Covered Entity's expense, examine Business Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to Covered Entity the extent to which Business Associate's security safeguards comply with HIPAA, the HIPAA Rules or this Agreement.

11. Amendment. Upon the compliance date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of electronic PHI, or other aspects of HIPAA applicable to this Agreement or to the ASC, this Agreement will automatically amend such that the obligations imposed on Covered Entity and Business Associate remain in compliance with such regulations.

12. Assistance in Litigation or Administrative Proceedings. Business Associate must make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to Covered Entity at no cost to Covered Entity to testify as witnesses, or otherwise, if litigation or administrative proceedings are commenced against Covered Entity, its directors, officers or employees, departments, agencies, or divisions based upon a claimed violation of HIPAA or the HIPAA Rules or other laws relating to Business Associate's or its subcontractors' use or disclosure of PHI under this Agreement, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

13. No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer upon any person other than the Covered Entity, Business Associate, and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

14. Interpretation and Order of Precedence. Any ambiguity in this Agreement must be interpreted to permit compliance with the HIPAA Rules. In the event of any conflict between the mandatory provisions of the HIPAA Regulations and the HITECH Act and the provisions of this Agreement, the HIPAA Regulations and the HITECH Act shall control. Where the provisions of this Agreement differ from those mandated by the HIPAARules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement control.

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

16. Survival of Certain Agreement Terms. Notwithstanding any contrary provision in this Agreement, Business Associate's obligations under Section 6(c) and record retention laws ("Effect of Termination") and Section 13 ("No Third Party Beneficiaries") survive termination of this Agreement and are enforceable by Covered Entity.

17. Representatives and Notice.

    a. Representatives. The individuals listed below are designated as the parties' respective representatives for purposes of this Agreement. Either party may from time to time designate in writing new or substitute representatives.

    b. Notices. All required notices must be in writing and must be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

Covered Entity Representative:

Bethany C. Beauchine
Director, Bureau of Benefits Administration
Michigan Civil Service Commission
P.O. Box 30002
Lansing, MI 48909
(517) 284-0086
beauchineb@michigan.gov

with copy to:

Mary Ostrowski
Category Specialist
DTMB, Central Procurement 525
W. Allegan St.
Lansing, MI 48913
(517) 249-0438
ostrowskim@michigan.gov

Business Associate Representative:

Lori Shannon VP
Key Accounts
600 E. Lafayette Blvd – Mail Code 517A
Detroit, MI 48226-2998
(313) 448-5912
lshannon2@bcbsm.com

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

Covered Entity **State Health Plan PPO**	**Business Associate** **Blue Cross Blue Shield of Michigan**
By: _____	By: _____
Date: _____	Date: _____
Print Name: Bethany C. Beauchine	Print Name: _____
Director, Bureau of Benefits Administration Michigan Civil Service Commission	Title: _____

STATE OF MICHIGAN

Contract No. 190000000755

Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE L – DISASTER RECOVERY PLAN

Contractor has provided the State with a copy of its Disaster Recovery Plan (DR Plan), which is incorporated herein by reference. The DR Plan is statutorily exempt from disclosure through FOIA request for security reasons.

STATE OF MICHIGAN

Contract No. 190000000755

Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE M – SERVICE AVAILABILITY REPORT

Reporting Month	Hosted Service	Service Availability Requirement	Service availability performance	Corrective action of service failure
	BCBSM Provider Portal			
	BCBSM Member Portal			
	New Directions Optamum (Care Management)			
	New Directions Web Pass (Provider Portal)			
	Claims system (BCBSM)			
	Accumulation Technologies, LLC, - AccumTech			
	Reporting Platform			

	Whyzen Analytics			
	Reporting Platform **eBookshelf**			
	Online Visits App (American Well)			

STATE OF MICHIGAN

Contract No. 190000000755
Behavioral Health and Substance Abuse Benefits for the State Health Plan PPO

SCHEDULE N – Sample Provider Survey

Sample Provider Survey begins on the next page.

BCN Questions

Utilization Management Practitioner Satisfaction Survey

Blue Cross Blue Shield of Michigan and Blue Care Network would like your feedback on our utilization management programs and processes to help us improve our services. We value your opinion. If your office of facility participates with both Blue Cross and BCN, you'll be asked to answer questions based on your experiences with one of the health plans, but not both. Your responses are confidential.

Does your office or facility participate with Blue Care Network?

- ◯ Yes
- ◯ No

Please answer the following questions based on your experiences with the Blue Care Network health plan and patients, excluding Blue Cross Blue Shield of Michigan experiences.

First, please tell us about your role and your office or facility.

What best describes your position? (Please check one.)

- ◯ Physician
- ◯ Behavioral health provider
- ◯ Behavioral health office manager/administrator
- ◯ Physician assistant
- ◯ Nurse or nurse manager
- ◯ Office manager
- ◯ Biller, billing manager or billing coordinator
- ◯ Medical assistant or secretary
- ◯ Referral coordinator
- ◯ Group or office administrator
- ◯ _____ Other (Specify)

Which best describes your office or facility? (Please check one.)

- ◯ Primary care
- ◯ Specialist
- ◯ Medical care group administration
- ◯ Behavioral health
- ◯ Hospital
- ◯ Nonhospital facility
- ◯ _____ Other (Specify)

Please identify your team's managed care group. Select from one of the drop-down lists below, based on your geographic region. If your team isn't part of a managed care group, select 'Not part of a Managed Care Group' within your region.

Note: McLaren is shown in each list, but should only be selected once in the appropriate region.

Southeast Michigan

▼

East Michigan

West Michigan

Mid Michigan

Referral process

At BCN, we strive to make referral decisions as quickly as possible. Routine requests submitted through e-referral usually approve automatically. Requests that require clinical review also may approve automatically if they're submitted with the clinical information required. When more information is needed to make the decision, we'll send a Request for Information letter that lists the clinical information we need to review your request. Please answer a few questions about how you use e-referral and what we can do to improve your experience with it.

Do you use the e-referral online tool to submit?

- Yes
- No

Do you use the e-referral online tool to view requests?

- Yes
- No

How satisfied are you with BCN's online e-referral process?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied

Have you completed the e-referral online training?

- Yes
- No

How useful was the online training?

Extremely useful	Very useful	Moderately useful	Slightly useful	Not at all useful

How satisfied are you with BCN's referral intake staff?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied

Tell us what we can do to improve our referral process.

Clinical review process

Specific medical and behavioral health services require clinical review depending on the product line and group. BCN has a work group that meets regularly to review and analyze utilization data and make recommendations regarding those services that should be added or removed from the Clinical Review Program. We also consider new medical policies or new applications of existing medical policies for clinical review.

Does your office ever submit services for clinical review by BCN?

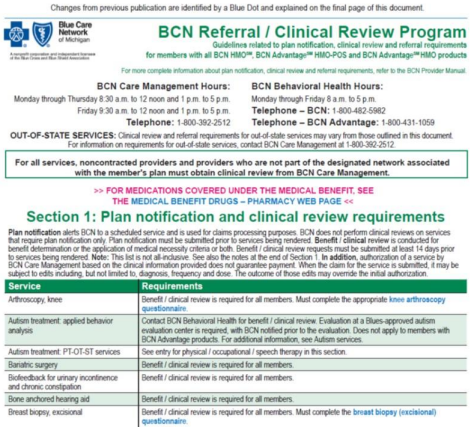
- Yes
- No

- ◯ Unsure

How well do you understand which services require BCN clinical review?

Extremely well	Very well	Moderately well	Slightly well	Not well at all
◯	◯	◯	◯	◯

Do you use the BCN Referral and Clinical Review Program guidelines (image below)?



Changes from previous publication are identified by a Blue Dot and explained on the final page of this document.

Blue Care Network of Michigan

BCN Referral / Clinical Review Program

Guidelines related to plan notification, clinical review and referral requirements for members with all BCN HMO℠, BCN Advantage℠ HMO-POS and BCN Advantage℠ HMO products

For more complete information about plan notification, clinical review and referral requirements, refer to the BCN Provider Manual.

BCN Care Management Hours:
Monday through Thursday 8:30 a.m. to 12 noon and 1 p.m. to 5 p.m.
Friday 9:30 a.m. to 12 noon and 1 p.m. to 5 p.m.
Telephone: 1-800-392-2512

BCN Behavioral Health Hours:
Monday through Friday 8 a.m. to 5 p.m.
Telephone – BCN: 1-800-482-5982
Telephone – BCN Advantage: 1-800-431-1059

OUT-OF-STATE SERVICES: Clinical review and referral requirements for out-of-state services may vary from those outlined in this document. For information on requirements for out-of-state services, contact BCN Care Management at 1-800-392-2512.

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain clinical review from BCN Care Management.

>> FOR MEDICATIONS COVERED UNDER THE MEDICAL BENEFIT, SEE THE MEDICAL BENEFIT DRUGS – PHARMACY WEB PAGE <<

Section 1: Plan notification and clinical review requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical reviews on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Benefit / clinical** review is conducted for benefit determination or the application of medical necessity criteria or both. Benefit / clinical review requests must be submitted at least 14 days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition**, authorization of a service by BCN Care Management based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Service	Requirements
Arthroscopy, knee	Benefit / clinical review is required for all members. Must complete the appropriate knee arthroscopy questionnaire.
Autism treatment: applied behavior analysis	Contact BCN Behavioral Health for benefit / clinical review. Evaluation at a Blues-approved autism evaluation center is required, with BCN notified prior to the evaluation. Does not apply to members with BCN Advantage products. For additional information, see Autism services.
Autism treatment: PT-OT-ST services	See entry for physical / occupational / speech therapy in this section.
Bariatric surgery	Benefit / clinical review is required for all members.
Biofeedback for urinary incontinence and chronic constipation	Benefit / clinical review is required for all members.
Bone anchored hearing aid	Benefit / clinical review is required for all members.
Breast biopsy, excisional	Benefit / clinical review is required for all members. Must complete the breast biopsy (excisional) questionnaire.

- ◯ Yes
- ◯ No
- ◯ I'm not aware of the guidelines

What types of services do you or your office typically submit for clinical review? Select all that apply.

- ◯ Behavioral health
- ◯ Cosmetic surgery
- ◯ Joint surgery
- ◯ Pain management
- ◯ Radiology
- ◯ Radiation oncology
- ◯ Sleep studies
- ◯ Therapy
- ◯ [ ] Other (Specify)

Are you responsible for finding and providing BCN medical policies to those in your office or team regarding clinical review?

- ◯ Yes, I alone am responsible
- ◯ Yes, but I share the responsibility with other staff
- ◯ No, I'm not responsible

Do you know where to find BCN medical policies online?

- ◯ Yes
- ◯ No

How satisfied are you with the clinical review process?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	No experience
◯	◯	◯	◯	◯	◯

Tell us what we can do to improve our clinical review process.

Admission and concurrent review process

All inpatient admissions are reviewed by clinical staff. If the clinical information given to us by the facility meets our criteria, the nurse reviewer approves the admission. BCN medical directors review admissions that don't meet criteria for approval. We consider concurrent admission reviews as urgent and strive to make a decision as quickly as possible, but no later than 72 hours after the request is received. Our nurse reviewers assist with discharge planning and identification of continuity of care needs for our members.

Are you a physician who admits patients to inpatient facilities?

- ◯ Yes

- ◯ No

Which of the following types of admissions requests does your office usually submit? Select all that apply.

- ◯ Medical admissions
- ◯ Behavioral health admissions

How satisfied are you with the timeliness of our inpatient admission decisions?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

Are you an employee of an acute care facility that provides admission review requests to BCN?

- ◯ Yes
- ◯ No

How satisfied are you with the timeliness of our admission review decisions?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	NA/No experience
◯	◯	◯	◯	◯	◯

Tell us what we can do to improve our admission review process.

Plan medical director

BCN plan medical directors:

- Make clinical coverage determinations in accordance with BCN programs and policies
- Have peer-to-peer discussions with rendering providers regarding UM decisions

- Work with affiliated practitioners to ensure appropriate care and service for BCN members
- Are a resource for affiliated practitioners and providers
- Adjudicate claims payment appeals

Do you have experience with our peer-to-peer review process for clinical determinations, such as prior authorization or inpatient admissions?

- ◯ Yes
- ◯ No

How satisfied were you with the overall timing to conduct a peer-to-peer review?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

If you've had clinical requests remain denied after the peer-to-peer discussion, did a BCN medical director explain remaining appeal options?

- ◯ Yes
- ◯ No
- ◯ Not applicable

For administrative, non-clinical issues (e.g. billing, payment, quality, etc.), how satisfied are you with the medical directors' overall accessibility?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	NA/No experience
◯	◯	◯	◯	◯	◯

For administrative, non-clinical issues (e.g. billing, payment, quality, etc.), how satisfied are you with the medical directors' overall consideration of your problems?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	NA/No experience
◯	◯	◯	◯	◯	◯

Provider appeal process

Several types of provider appeals are processed by BCN's Care Management department:

- Clinical editing appeals
- Clinical review appeals
- Inpatient admission appeals

Have you requested an appeal of a denied service using any of Care Management's provider appeal processes?

- ◯ Yes
- ◯ No

How easy is it to understand the appeal instructions in the denial notification letters and in BCN's Provider Manual for the following?

	Extremely easy	Somewhat easy	Neither easy nor difficult	Somewhat difficult	Extremely difficult	NA/Don't know
Clinical editing appeals	◯	◯	◯	◯	◯	◯
Clinical review appeals	◯	◯	◯	◯	◯	◯
Inpatient admission appeals	◯	◯	◯	◯	◯	◯

Tell us what we can do to improve your experience with BCN's provider appeal process.

Contact information (optional):

As a token of our appreciation, we'll enter all respondents and those who provide their contact information into a drawing to win one of two $250 gift cards. All survey responses must be received *no later* than December 31, 2018, to be eligible for the random drawing.

Two winners will be selected in a random drawing at the end of the survey. Each winner will receive a $250 gift certificate. No participation is necessary. The drawing will take place approximately one week following the closure of the survey. The winner will be notified by telephone or email.

This drawing is open to all contracted Blue Cross and BCN providers. Those who don't wish to participate in the survey, but wish to be included in the drawing, may enter by emailing **BCBSMandBCNPhysicianSurvey@bcbsm.com** with an entry request. All requests must include applicant's name, physician's name (if different from applicant), office name, physician's NPI and office address. All requests must be received no later than December 31, 2018.

- ◯ _____ Name of physician in your office or facility (first, last)
- ◯ _____ NPI of physician named above
- ◯ _____ Practice/facility name:
- ◯ _____ Practice/facility street address (including city, state, zip):
- ◯ _____ Your name (first, last)
- ◯ _____ Your phone number
- ◯ _____ Your email address:

May we contact you regarding your responses or comments?

- ◯ Yes
- ◯ No

Does your office or facility participate with Blue Cross Blue Shield of Michigan?

- ◯ Yes
- ◯ No

Blue Cross Blue Shield of Michigan Authorizations

Please answer the following questions based on your experiences with Blue Cross Blue Shield of Michigan health plan and patients, excluding Blue Care Network experiences.

First, please tell us about your role and your office or facility.

What best describes your position? (Please check one.)

- ◯ Physician
- ◯ Behavioral health provider
- ◯ Behavioral health office manager/administrator
- ◯ Physician assistant
- ◯ Nurse or nurse manager
- ◯ Office manager
- ◯ Biller, billing manager or billing coordinator
- ◯ Medical assistant or secretary
- ◯ Referral coordinator
- ◯ Group or office administrator
- ◯ _____ Other (Specify)

Which best describes your office or facility? (Please check one.)

- ◯ Primary care
- ◯ Specialist
- ◯ Medical care group administration
- ◯ Behavioral health
- ◯ Hospital
- ◯ Nonhospital facility
- ◯ _____ Other (Specify)

Please select the physician organization associated with your office. Select 'Not applicable' if your office isn't part of a physician organization.

Authorization process

At Blue Cross, we strive to make authorization decisions as quickly as possible. Some requests submitted through e-referral approve automatically. Requests that require clinical review may approve automatically in the e-referral system if they're submitted with the clinical information required. When more information is needed to make the decision, we'll send a Request for Information letter that lists the clinical information that we need to review your request. Please answer a few questions about the authorization process and what we can do to improve your experience with it.

Do you use the e-referral online tool to submit?

- ◯ Yes
- ◯ No

Do you use the e-referral online tool to view requests?

- ◯ Yes
- ◯ No

How satisfied are you with Blue Cross' online e-referral process?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

Have you completed the e-referral online training?

- ◯ Yes
- ◯ No

How useful was the e-referral online training?

Extremely useful	Very useful	Moderately useful	Slightly useful	Not at all useful
◯	◯	◯	◯	◯

How satisfied are you with Blue Cross' referral intake staff?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

Tell us what we can do to improve our authorization process.

Clinical review -Blue Cross

Clinical review process

Specific medical and behavioral health services require clinical review depending on the product line and group. Some services require prior authorization and other services are reviewed once the claim is submitted. Blue Cross has a work group that meets regularly to review and analyze utilization data and make recommendations regarding those services that should be added or removed from the Clinical Review Program. We also consider new medical policies or new applications of existing medical policies for clinical review.

Does your office ever submit services for authorization by Blue Cross?

- ◯ Yes
- ◯ No
- ◯ Unsure

How well do you understand which services require Blue Cross clinical review?

Extremely well	Very well	Moderately well	Slightly well	Not well at all

Which of the following best describes when you or your office usually conducts clinical reviews?

- Pre-service (before the service is performed)
- Post-service (after the service is performed and billed)
- Varies by type of case

What type of services do you or your office typically submit for clinical review? Select all that apply.

- Behavioral Health
- Cosmetic surgery
- Genetic testing
- Joint surgery
- Oral surgery
- Pain management
- Radiation oncology
- Radiology
- Sleep studies
- Therapy
- [ ] Other (Specify)

Are you responsible for finding and providing Blue Cross medical policies to those in your office or team regarding clinical review?

- Yes, I alone am responsible
- Yes, but I share the responsibility with other staff
- No, I'm not responsible

Do you know where to find BCBSM medical policies online?

- Yes
- No

How satisfied are you with with the clinical review process?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	No experience
◯	◯	◯	◯	◯	◯

Tell us what we can do to improve our clinical review process.

Admission - Blue Cross

Admission and concurrent review process

All inpatient admissions require an authorization number. Some inpatient admissions are reviewed by clinical staff based on product line and Group requirements. If the clinical information given to us by the facility meets our criteria, the nurse reviewer approves the admission. BCBSM medical directors review admissions that don't meet criteria for approval. We consider concurrent admission reviews as urgent and strive to make a decision as quickly as possible but no later than 72 hours after the request is received. Our nurse reviewers may assist with discharge planning and identification of continuity of care needs for our members.

Are you a physician who admits patients to inpatient facilities?

- ◯ Yes
- ◯ No

Which of the following types of admissions requests does your office usually submit? Select all that apply.

- ◯ Medical admissions
- ◯ Behavioral health admissions

How satisfied are you with the timeliness of our inpatient admission decisions?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
○	○	○	○	○

Are you an employee of an acute care facility that provides admission review requests to BCBSM?

- ○ Yes
- ○ No

How satisfied are you with the timeliness of our admission review decisions?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	NA/No experience
○	○	○	○	○	○

Tell us what we can do to improve our admission review process.

Blue Cross Medical Director

Plan medical director

Blue Cross plan medical directors:

- Make clinical coverage determinations in accordance with Blue Cross programs and policies
- Work with affiliated practitioners to ensure appropriate care and service for Blue Cross members
- Have peer-to-peer discussions with rendering providers regarding UM decisions
- Are a resource for affiliated practitioners and providers
- Adjudicate claims payment appeals

Do you have experience with our peer-to-peer review process for clinical determinations, such as prior authorization post-service review or inpatient admissions?

- ◯ Yes
- ◯ No

How satisfied were you with the overall timing to conduct a peer-to-peer review?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

If you've had clinical requests remain denied after the peer-to-peer discussion, did a BCBSM medical director explain remaining appeal options?

- ◯ Yes
- ◯ No
- ◯ Not applicable

Blue Cross Appeals

Provider appeal process

Several types of provider appeals are processed by Blue Cross' Care Management department:

- Clinical editing appeals
- Clinical review appeals
- Inpatient admission appeals

Have you requested an appeal of a denied service using any of Care Management's provider appeal processes?

- ◯ Yes
- ◯ No

How easy is it to understand the appeal instructions in the denial notification letters and in Blue Cross' Provider Manual for the following?

	Extremely easy	Somewhat easy	Neither easy nor difficult	Somewhat difficult	Extremely difficult	NA/Don't know
Clinical editing appeals	◯	◯	◯	◯	◯	◯
Clinical review appeals	◯	◯	◯	◯	◯	◯
Inpatient admission appeals	◯	◯	◯	◯	◯	◯

Tell us what we can do to improve your experience with Blue Cross' provider appeal process.

Drawing

Contact information (optional):

As a token of our appreciation, we'll enter all respondents and those who provide their contact information into a drawing to win one of two $250 gift cards. All survey responses must be received *no later* than December 31, 2018, to be eligible for the random drawing.

Two winners will be selected in a random drawing at the end of the survey. Each winner will receive a $250 gift certificate. No participation is necessary. The drawing will take place approximately one week following the closure of the survey. The winner will be notified by telephone or email.

This drawing is open to all contracted Blue Cross and BCN providers. Those who don't wish to participate in the survey, but wish to be included in the drawing, may enter by emailing **BCBSMandBCNPhysicianSurvey@bcbsm.com** with an entry request. All requests must include applicant's name, physician's name (if different from applicant), office name, physician's NPI and office address. All requests must be received no later than December 31, 2018.

- ◯ _____ Name of physician you work with (first, last)
- ◯ _____ NPI of physician named above
- ◯ _____ Practice/facility name:
- ◯ _____ Practice/facility street address (including city, state, zip):
- ◯ _____ Your name (first, last)
- ◯ _____ Your phone number
- ◯ _____ Your email address:

May we contact you regarding your responses or comments?

- ◯ Yes
- ◯ No

FOR THE CONTRACTOR:

Company Name

Authorized Agent Signature

Authorized Agent (Print or Type)

Date

FOR THE STATE:

Signature

Jared Ambrosier, Sourcing Director
Name & Title

DTMB- Central Procurement
Agency

Date