**Attachment B1**

**Scope of Services Third Party Administrative Services for the**

**State employee medical plans – Statewide network**

1. **Duties of the Contractor.**
2. Incorporation by Reference
3. Exhibit A: Updated Plan Documents are attached hereto and incorporated herein.
4. Exhibit B: Indiana School Corporation Adoption and Binder Agreement for Indiana State Employee Medical Plans
5. Exhibit C: The Business Associate Agreement
6. Exhibit D: The Request for Proposals, pre & post-proposal inquiries and the responses thereto
7. Reference hereafter to certain of the subjects, topics, provisions, terms, obligations, rights, duties and other matters in the documents incorporated by reference are not meant to exclude the importance of other portions of said documents; rather, said references are intended to amplify upon or clarify the import, meaning and/or effect(s) thereof as same may relate to the rights, duties, and obligations of the parties to this Contract. The reference or non-reference to certain portions of the documents incorporated by reference shall not preclude the reasonable construction of the terms of said instruments which may be required from time to time during the tenure of this Contract; provided, that when the parties desire the clarifying construction of significant areas of dispute said construction shall be consistent with the terms expressly set forth in this Contract and shall be effectuated only by the written mutual agreement of the parties hereto, or as otherwise provided in this Contract.
8. The parties acknowledge that the Plans, as contained in Exhibit A, may be subject to approval of the Indiana Department of Insurance pursuant to and in the manner prescribed by law and/or regulation. The parties agree that subsequent additions or modifications to, or deletions from, said Plan shall be effectuated in accordance with the terms of this Contract; and the written acceptance or endorsement of all signatories to this Contract shall be required to make said additions, modifications, or deletions effective in accordance with Article 9.
9. Contractor will:

(1) Administer the State’s self-funded PPO medical plan and CDHPs for eligible employees, officers, and early retirees. Prescription drug benefits and related pharmacy benefit management of services have been “carved out” and are performed by a pharmacy benefits manager that may not be affiliated with Contractor. The Contractor does not insure or underwrite the liability of the State, participating School Corporations, Direct Billed entities, or individuals for these plans. The State retains the ultimate responsibility for claims made under theses plans and all expenses incident to those plans, except for the performance of Contractor duties which shall be performed by the Contractor at the contract prices set forth herein.

(2) Expand coverage as may be directed by the Indiana General Assembly.

(3) Except to the extent of Contractor duties as specified herein, the State retains full and final authority and responsibility for the Plans. The Contractor is empowered to act on behalf of the State in connection with the Plans only as expressly stated under this contract or as mutually agreed to in writing by the parties.

(4) Each party shall notify the other party of any legal actions against either party, which involves the Plan, or this Contract.

C. Administrative Responsibilities

1. The State of Indiana Personnel Department or State related organizations are responsible for the following functions:
   1. Enrollments (new and changed);
   2. Payroll deductions;
   3. Reimbursement of claims paid by the Contractor and payment of administrative charges as specified for the self insured plans;
   4. In accordance with the requirements under COBRA, timely notification of the availability of continuation coverage to eligible Enrollees or dependents. However, each School Binder Agreement will provide that Contractor will administer specified COBRA requirements for the school corporation;
   5. Establishment of open enrollment periods;
   6. To provide to the Contractor, accurate information concerning employees newly eligible for enrollment, termination of enrollees, address changes and family status changes affecting enrollment, within 30 days of the event.
2. The Contractor, or its authorized Subcontractors, will perform the following functions in support of the health plans:

Claims Administration

* 1. Accurate processing of claims - Medical claims are received directly from enrollees and service providers and network discounts are applied. The Contractor will obtain and maintain all additional service provider or coordination of benefits information directly from service providers or other carriers. Payments and explanation of benefits forms (EOB's) are to be distributed directly to enrollees and service providers. Contractor will pay claims according to the terms of this Contract and Contractor’s provider contracts;
  2. Preparation of medical identification cards, which will include information about the State’s pharmacy benefit manager;
  3. Preparation of claim forms that are available through mail or online format;
  4. Provision of detailed explanation of benefits paid to each claimant;
  5. Notification to claimants of rejected claims and the reason for rejection;
  6. Investigation of claims;
  7. Performance of internal and external audits on a random sample basis of claim payments with results reported to State Personnel Department;
  8. Delivery of information as necessary regarding coordination of benefits;
  9. Application of claims control procedures necessary for the effective implementation of the Plan;
  10. Preparation of standard quarterly reports including, but not limited to, paid claims, membership, employee cost share, utilization by setting, utilization of Contractor programs and services, network updates, and regulatory and compliance updates;
  11. Access to an online reporting portal with a suite of standard plan performance reports including at a minimum membership counts by type of enrollee and month, claims paid by setting, utilization by setting, large claims and lag reports;
  12. Explanation of payment made directly to claimants;
  13. Use the pay and pursue method of Coordination of Benefits;
  14. Provide notice to the Enrollee and Provider if claim is pended and not adjudicated for more than thirty (30) days;
  15. Maintain toll free telephone lines for pre-certification and to answer enrollee questions and assist with problems;
  16. Make use of Contractor's health and legal consultants in handling claims and defending the propriety of Contractor’s performance of its claims administration;
  17. Make refund of contributions paid in error by retirees or COBRA participants; or direct bill entities directly to the retiree or COBRA participantor entity;
  18. When possible, maintain all claim administration records by Social Security Number, as directed by the State;
  19. Use Contractor's funds to pay claims pending receipt of State remittances for the non-insured products;
  20. Provide onsite utilization review at hospitals within designated regional areas;
  21. Delegation by the State to Contractor of fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary to determine appeals of any adverse benefit determinations under the Plan. Contractor shall administer complaints, appeals and requests for independent review according to Contractor’s complaint and appeals policy, and any applicable law or regulation unless otherwise provided in the Benefits Booklet. In carrying out this authority, Contractor is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Contractor shall be deemed to have properly exercised such authority unless a Member proves that Contractor has abused its discretion or that its decision is arbitrary and capricious. Contractor is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action.
  22. Utilization review of procedures of participating providers for quality, efficiency, and elimination of vendor over-utilization.
  23. Contractor generally receives Member telephone numbers from the State through enrollment files or the online employer access portal.  Telephone numbers are provided directly to the State by Members with the understanding that Contractor may contact them, and the State does not obtain telephone numbers through a service or a third party.  Contractor may contact Members by telephone for clinical purposes, benefit related issues or to perform services under the Agreement.  Telephone numbers may be updated periodically by Members, and Contractor will honor do not call requests.  With regard to Contractor’s use of Member telephone numbers, the State agrees to retain Member enrollment records for a period of at least 4 years or as otherwise set forth in the Telephone Consumer Protection Act and, upon request, will provide such records to Contractor in a timely manner.
  24. The State acknowledges and directs Contractor to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that Members will be held harmless. Offsetting is the practice of Contractor recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of Contractor recovering overpayments made to a Network Provider for one Member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another Member, who receives benefits under a different group health plan for which Contractor pays the Claims on behalf of a different employer. If Contractor’s efforts to recover overpaid Claims by offsetting is unsuccessful, Contractor’s inability to offset does not relieve Contractor of its duty to recover overpayment of Claims by other means. The foregoing notwithstanding, nothing in this paragraph shall be deemed to require Contractor to guarantee overpaid Claims that are unrecoverable due to no fault of Contractor.

Contract Administration

1. Facilitate and administer the exchange of utilization information among vendors;
2. Standard direct claim system on medical benefits including:
   1. Toll-free direct enrollees counseling by Contractor's claim staff to handle questions and problems on a routine basis;
   2. Medical coverage verification by claim staff using information furnished by the State;
   3. Benefit Plan Descriptions;
   4. Prompt payment of proper claims;
3. Benefit Plan Descriptions, Benefit Summaries, and form letters tailored to the specifications of the State;
4. Maintenance of and reporting on eligibility records and eligibility listings by account.
5. Preparation and delivery of individual billings to the following:
   1. COBRA participants
   2. Quasi/Direct bill agencies
   3. Early retirees
   4. Participating School Corporations
6. Provide to the State upon request, back up claim documentation and method of adjudicating claims;
7. Billing Plan participants for continuing coverage when on various approved leaves, such as family medical leave, military leave and leave without pay;
8. Provide updates and analysis of state and federal legislation affecting the State Plan;
9. At least two (2) mailings to member’s homes per contract year will be provided to communicate plan benefits;
10. Provide representatives to meet quarterly with the State to review provider reports and resolve issues in the areas of claims, customer service, utilization, quality and others as may be requested by the State;
11. Contractor will respond to the merits of employee complaints brought through the Indiana Department of Insurance.
12. Administration of COBRA for plan participants, except that for State employees, the initial notification of COBRA rights and the notice of COBRA eligibility will be administered by the State. For school corporations, see the COBRA Administrative Service Agreement, Attachment X to the Exhibit B Adoption Agreement and Binder. The Contractor will be responsible for billing the COBRA participants as well as establishing and monitoring periods of eligibility, including duration of eligibility and secondary events.
13. Consultation on financial management, benefit design, and actuarial projections;
14. Periodic assistance with open enrollment, including on-site enrollment meetings for employees across the State of Indiana;
15. Contractor will provide State with Plan information and assistance necessary for the preparation of the Plan’s Summary of Benefits and Coverage (“SBC”) related to the elements of the Plan that Contractor administers. State is solely responsible for ensuring that the SBC accurately reflects the benefits State will offer and for finalizing and distributing the SBC to Subscribers.
16. Contractor will manage identification of early retiree and COBRA members who attain Medicare and terminate them as appropriate from the plans. The termination date of members who attain Medicare du to ESRD should extend out to the completion of their 30-month ESRD coordination period, even if age 65 is attained during this time.
17. Contractor will determine eligibility of disabled dependents, in accordance with the standard set forth in Exhibit XXX.
18. Administer rewards payments to individuals that are eligible under a Centers of Excellence program developed by the State;
19. Administer unclaimed funds associated with the State’s plans pursuant to unclaimed property or escheat laws.

Financial Administration

1. Benchmark medical plans to other employers by size, geography and industry and provide utilization reports;
2. Capability to break reporting into multiple groupings at the request of the State;
3. Accounting for rates and claims paid, claims denied, claims pending but not yet paid and administration services fees, for the fee for service plan, as indicated below:
   1. A detailed experience statement furnished no later than ninety days following the end of the Plan year. Administrative service fees are to be detailed as follows: total administrative fees, claim administration, contract administration, and other administrative costs;
   2. A lag study furnished annually on the medical plans;
   3. The State reserves the right to audit the claim files maintained by the Contractor or third party administrator at any time and without additional charge;
   4. Provide to the State quarterly reports reflecting network discount savings to include, at a minimum: total submitted charges, total ineligible charges, total eligible charges, total network discounts, total coordination of benefits amounts, total member costs share, net paid claims;
   5. A detailed financial accounting of all fees and charges related to fees and assessments related to out-of-network claims or inter-plan arrangements (as applicable). These fees may include, but are not limited to: access fees, administrative expenses allowance fees, and transaction fees;
   6. A detailed financial accounting of all fees and payments related to provider Performance Payments.
4. Underwriting/actuarial services including the rates (e.g. the suggestion of appropriate informational fees) and expected costs, benefit pricing for lag charges, calculation of incurred and unreported reserve liabilities, effects of changes in plan design, and annual experience report;
5. Use by the Contractor of its own funds to pay claims, pending receipt of remittances under this contract, for the fee for services plan.
6. Demonstrate application of accounting principles and claims cost controls that prevent loss of funds, abuse, fraud, and recovery of lost dollars.

Managed Mental Health Care Administrative Services

1. Inpatient and Outpatient Case Management for mental health and substance abuse;
2. Catastrophic (Individual) Case Management;
3. Network Development and management Services;
4. Full continuum of treatment services;
   1. Individual and group outpatient mental health treatment;
   2. Individual and group outpatient chemical dependency treatment;
   3. Intensive outpatient treatment;
   4. Partial hospitalization and day and night treatment programs;
   5. Residential care;
   6. Inpatient mental health and chemical dependency treatment;
   7. Other treatment modalities, as appropriate;
5. Coordination of care with the Employee Assistance Program (EAP);
6. Intensive chemical dependency after care/follow up ;
7. Eligibility and COB coordination with the PBM.

Prescription Drug Program

1. For the benefit of the enrollees and the State, coordinate with the carve-out Pharmacy Benefits Manager. These duties include activities such as:

(i) Providing the state’s Pharmacy Benefit Manager with up-to-date (daily at a minimum) eligibility data that includes coordination of benefit information;

(ii) Receiving prescription drug claims and accumulator data feeds and accurately administering accumulators for the State’s health plan participants;

(iii) Including the Pharmacy Benefit Manager name and customer service number on the member’s medical ID card.

(B) Pass through to the State 100% of rebates received from pharmaceutical manufacturers for claims for prescription drugs administered by Contractor and covered under the medical benefit portion of the Plan(s) (“Medical Drug Rebates”).

Integrated Care and Data Management

1. Safeguard data in motion and at rest consistent with industry standards and all applicable laws and regulations;
2. Exchange data as needed for care coordination and plan administration with Pharmacy Benefits Manager, Employee Assistance Program, Dental Plan Manager, Vision Plan Manager, Population Health Manager, Worker’s Compensation program, Disability program, and cafeteria plan administrator;
3. Electronically accept and integrate claim information as needed for care coordination and plan administration from , Pharmacy Benefits Manager, Dental Plan Manager, Vision Plan Manager, Population Health Manager, Worker’s Compensation program, Disability program, and Employee Assistance program;
4. Apply a quantifiable predictive model to member records to assess risk;
5. Use integrated data for identification of member specific disease conditions;
6. Provide monthly data files to the State’s data warehouse vendor in a mutually agreed upon file format including:
   * 1. Census data;
     2. Claims data;
     3. Clinical and disease management program participation;
     4. Lab data;

Disease Management

* + 1. Offer disease management programs for high prevalence disease states;
    2. Establish evidence-based practice guidelines for those conditions that will be managed;
    3. Outreach to members identified with targeted diseases for enrollment in the disease management program;
    4. Provide patient specific care recommendations and care gaps notifications to the member and their physician;
    5. Provide education materials and disease-specific coaching to enrolled members; Measure outcomes including cost of care per unit risk, cost of care by setting, utilization by setting, medication adherence, and key clinical outcomes;
    6. Provide enrollment, utilization and management reports to the State on a quarterly basis;
    7. Provide outcomes reports to the State on an annual basis;

Federal Compliance

1. Contractor agrees to comply with all applicable transparency rules and requirements.

Transparency

* + 1. Make available a provider search tool that is customized to the State’s benefit plan design;
    2. Integrate a provider search tool within the member portal that includes network status and quality data;
    3. Provide a procedure specific search tool within the member portal that includes cost and quality data by provider;
    4. Clearly designate all providers included in the State’s preferred provider tier within the provider search tool including any preferred providers.

Utilization Management (UM)

Provide concurrent and retrospective UM programs to including the following:

* + 1. Evaluate the appropriateness and medical necessity of health services, procedures and facilities according to evidence-based criteria or guidelines;
    2. Administer programs to redirect care to the most appropriate lowest cost setting;
    3. At a minimum, programs should be designed to address the following:
       1. Acute and Ancillary Care UM
       2. Behavioral Health UM
       3. Advanced Imaging UM
       4. Specialty Drug (j-code) UM

D. Claim Payment

(1) For benefits to be payable under the Plan, the Contractor must receive a claim with all information necessary to determine liability within 12 months following the date service was rendered. If the claim does not include enough information, the Contract shall ask for more details and it must be sent to the Contractor within 12 months or no benefits will be covered, unless otherwise required by law (e.g. Federal law allows exceptions for claims filed by the Veteran’s Administration up to a maximum 6 years from the date of service.)

(2) Often the provider of service will file the claim. If the servicing provider does not file, the Contractor will supply enrollees with claim forms.

(3) The Contractor will pay benefits due under the Plan to the enrollee, or, at its sole discretion, to the provider of the service from which benefits are claimed, or to both the enrollee and the provider of service jointly. No enrollee or dependent may assign such payment.

(4) If other parties have paid benefits due under the Plan, the Contractor may reimburse those other parties and be fully discharged from that portion of its liability. If any enrollee makes a material misrepresentation on a claim or application for this Plan’s benefits, the Contractor, on behalf of the State, may cancel his/her Plan coverage, effective on or anytime after the date of this claim.

(5) If the Contractor makes any payment on behalf of the State , that according to the terms of this Plan should not have been made, including payment made in error, the Contractor may recover that incorrect payment whether or not it was made due to Contractor’s own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to an enrollee, the Contractor may deduct it when making future payment directly to that enrollee.

(6) Paid Claims shall mean the amount charged to the State for covered services during the term of this Agreement. Paid Claims may also include any applicable interest passed through pursuant to the Medicare primary/secondary payment rules and any surcharges passed through pursuant to an assessment by a state or government agency (e.g., New York State facility use assessment).  In addition, Paid Claims shall be determined as follows:

1. Provider and Vendor Claims - Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Contractor actually pays the Provider or Vendor (without regard to whether Contractor reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology or whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply).
2. Payment Innovation Programs - If a Provider or Vendor participates in any Contractor payment innovation program, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by Contractor (“Payment Innovation Programs”), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to the State on a per claim, lump sum, per Subscriber, or per Member basis and shall be based on Contractor’s predetermined methodology for such Payment Innovation Program. The total monies charged to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, Contractor shall provide the State with a description of the Payment Innovation Program, the methodology that will be utilized to charge the State, and any reconciliation process performed in connection with such program. Contractor will provide the State with a report clearly reflecting the Payment Innovation Program Payments charged to the State.
3. Fees Paid to Manage Care or Costs - Paid Claims may also include fees paid to Providers or Vendors for managing the care or cost of care for designated Members, as set out specifically in Contractor’s XXXXXXXXXXX program and the Schedule of Financial Variables. The XXXXXXXXXX program and costs administered by Contractor for the State is the same program and at the costs as Contractor administers the XXXXXXXXXX program for Contractor’s own insured book of business.

As a condition precedent to the State’s participation in Contractor’s XXXXXXXXX program, the State asked Contractor to secure reasonable assurance from the Internal Revenue Service that payment of fees to Providers or Vendors for managing the cost of care under Contractor’s XXXXXXXXXXXX program does not disqualify the State’s High Deductible Health Plans or State employees’ tax qualified Health Savings Accounts. Contractor promises to indemnify the State and State employees for any tax consequences if the XXXXXXXXX program disqualifies the Health Savings Accounts. Should the State’s reliance on Contractor’s inducement to participate in the XXXXXXXXX program inure to the detriment of the State and/or employees, Contractor will pay the tax consequences.

1. Claims Payment Pursuant to Any Judgment, Settlement, Legal or Administrative Proceeding - Paid Claims shall include any medical Claim amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Plan and/or Contractor, or otherwise agreed to by Contractor, with respect to the decisions made by Contractor regarding the coverage of or amounts paid for services under the terms of the Plan, but not damages assessed against Contractor (e.g., for bad faith, abuse of discretion, or being arbitrary and capricious). Paid Claims also includes any amount paid as a result of Contractor's billing dispute resolution procedures with a Provider or Vendor.
2. Claims Payment Pursuant to Inter-plan Programs and Other Contractor Programs - Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Programs or for any amounts paid for Covered Services provided through another Contractor program (e.g. XXXXXXXXXX). More information about Inter-Plan Programs is found in Section 1.F. of the Agreement.

The propriety of amounts charged as Paid Claims per this section 1.D.(6) can be ascertained by audit. The details of each plan/program will be made available to the State. Plan/program administration and cost is the same for the State as for Contractor’s own insured book of business. Contractor will retain no margin on these payments to Provider or Vendor.

E. Subcontracting

1. The Contractor must obtain State Personnel Department and Department of Administration’s approval before subcontracting all or any portion of this Contract. Any subcontract must be submitted at least six (6) months prior to the effective date of the subcontract. “Subcontractor” as used in the section does not include agreements between Contractor and its providers or subcontracts expressly authorized elsewhere in this document.
2. The foregoing provisions shall not apply to the following undertakings and/or conditions:
   * 1. Any purchase, acquisition, or procurement by the Contractor of supplies, equipment, and materials in the normal course of the Contractor’s business.
     2. Any purchase, acquisition or procurement by the Contractor, the principle purpose of which does not directly involve the performance of obligations under this Contract.
     3. Any purchase, acquisition or procurement precipitated by or arising from urgent program requirements which, in the exercise of prudent business judgment, compel immediate action by the Contractor to preserve and/or enhance the program or the interest of enrollees with coverage hereunder; provided that the State Personnel Department and Department of Administration give prior written approval for any purchase, acquisition or procurement which exceeds a 30 day period; however, all purchases, acquisitions or procurements shall be reported wherever possible and prior notice shall be given.
3. The Contractor will be responsible for performance under the Contract, compliance with terms and condition of the Contract, and the requirements of federal and state equal opportunity and affirmative action statutes, rules, and regulations whether or not subcontractors are used.
4. F.  InterPlan ArrangementsOut of Area Services. Contractor has a variety of relationships with other Blue

Cross and/or Blue Shield Licensees refe1Ted to generally as "Inter-Plan

Programs." Claims for certain services may be processed through one of these

Inter-Plan Programs and presented to Contractor for payment in accordance

with the rules of the Inter-Plan Programs policies then in effect. The InterPlan

Programs available to Members under this Agreement are described

generally below. Typically, Members' Claims are processed through an InterPlan

Program when Members obtain care from health care Providers that have

a contractual agreement (i.e., are "Network Providers") with a local Blue

Cross and/or Blue Shield Licensee ("Host Blue"). In some instances,

Members may obtain care :from non-Network Providers. Contractor's payment

practices in both instances are described below.

1. BlueCard® Program. Under the BlueCard® Program, when Members access

Covered Services within the geographic area served by a Host Blue,

Contractor will remain responsible to the State for fulfilling Contractor's

conh·actual obligations. However, in accordance with applicable Inter-Plan

Programs policies then in effect, the Host Blue will be responsible for

providing such services as contracting and handling substantially all

interactions with its Network Providers. The financial terms of the BlueCard

Program are described generally below. Individual circumstances may arise

that are not directly covered by this description; however, in those instances,

Contractor's action will be consistent with the spirit of this description.

(a) Liability Calculation Method Per Claim. The calculation of the

Member liability on Claims for Covered Services processed through

the BlueCard Program will be based on the lower of the Network

Provider's Billed Charges or the negotiated price made available to

Contractor by the Host Blue.

The calculation of the State liability on Claims for Covered Services

processed through the BlueCard Program will be based on the

negotiated price made available to Contractor by the Host Blue.

Sometimes, this negotiated price may be greater than Billed Charges if

the Host Blue has negotiated with its Network Provider(s) an inclusive

allowance (e.g., per case or per day amount) for specific health care

services. Host Blues may use various methods to determine a

negotiated price, depending on the te1ms of each Host Blue's health care Provider conh·acts. The negotiated price made available to Contractor by the Host Blue may represent a payment negotiated by a Host Blue with a health care Provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without

any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment

reduced or increased by a percentage to take into account

certain payments negotiated with the Provider and other Claimand

non-Claim-related transactions. Such transactions may

include, but are not limited to, anti-fraud and abuse recoveries,

Provider refunds not applied on a Claim-specific basis,

retrospective settlements, and performance-related bonuses or

incentives, or

(iii) an average price. An average price is a percentage of Billed

Charges representing the aggregate payments negotiated by the

Host Blue with all of its health care Providers or a similar

classification of its Providers and other Claim- and non-Claimrelated

transactions. Such transactions may include the same

ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in

accordance with Inter-Plan Programs policies, prospectively increase

or reduce such prices to correct for over- or underestimation of past

prices (i.e., prospective adjustments may mean that a current price

reflects additional amounts or credits for Claims already paid to

Providers or anticipated to be paid to or received from Providers).

However, the amount paid by the Member and the State is a final

price; no future price adjustment will result in increases or decreases to

the pricing of past Claims. The BlueCard Program requires that the

price submitted by a Host Blue to Contractor is a final price

irrespective of any future adjustments based on the use of estimated or

average pricing. If a Host Blue uses either an estimated price or an

average price on a Claim, it may also hold some portion of the amount

that the State pays in a variance account, pending settlement with its

Network Providers. Because all amounts paid are final, neither

variance account funds held to be paid, nor the funds expected to be

received, are due to or from the State. Such payable or receivable

would be eventually exhausted by health care Provider settlements

and/or through prospective adjustment to the negotiated prices. Some

Host Blues may retain interest earned, if any, on funds held in variance

accounts.

A small number of states require Host Blues either (i) to use a basis for

determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim, or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Contractor would then calculate Member liability and the

State liability in accordance with applicable law.

(b) Return of Overpayments. Under the BlueCard Program, recoveries

from a Host Blue or its Network Providers can arise in several ways,

including, but not limited to, anti-fraud and abuse recoveries, health

care Provider/hospital audits, credit balance audits, utilization review

refunds, and unsolicited refunds. In some cases, the Host Blue will

engage a third pmiy to assist in identification or collection of recovery

amounts. The fees of such a third party may be netted against the

recovery. Recovery amounts determined in this way will be applied in

accordance with applicable Inter-Plan Programs policies, which

generally require correction on a Claim-by-Claim or prospective basis.

(c) This provision is intentionally omitted in its entirety.

1. Non-Network Providers Outside Contractor's Service Area.
   1. Member Liability Calculation. When Covered Services are provided

outside of Contractor's service area by non-Network Providers, the

amount a Member pays for such services will generally be based on

either the affiliated TPA's non-Network Provider local payment or the

pricing arrangements required by applicable state law. In these

situations, the Member may be responsible for the difference between

the amount that the Non-Network Provider bills and the payment

Contractor will make for the Covered Services as set forth in this

paragraph.

* 1. Exceptions. In some exception cases, Contractor may pay Claims from

non-Network Providers outside of Contractor's service area based on

the Provider's Billed Charges, such as in situations where a Member

did not have reasonable access to a Network Provider, as determined

by Contractor in Contractor's sole and absolute discretion or by

applicable state law. In other exception cases, Contractor may pay

such a Claim based on the payment it would make if Contractor were

paying a non-Network Provider inside of Contractor's service area, as

described elsewhere in this Agreement, where the affiliated TPA's

corresponding payment would be more than Contractor's in-service

area non-Network Provider payment, or in its sole and absolute

discretion, Contractor may negotiate a payment with such a Provider

on an exception basis. In any of these exception situations, the

Member may be responsible for the difference between the amount

that the non-Network Provider bills and the payment Contractor will

make for the Covered Services as set fotih in this paragraph.

1. Inter-Plan Program Fees and Compensation. the State understands and agrees

to reimburse Contractor for certain fees and compensation which it is

obligated under BlueCard or any other Inter-Plan Program, to pay to the Host

Blues, to the BCBSA, and/or to BlueCard or Inter-Plan Program vendors, as

described below. Fees and compensation under BlueCard and other Inter-Plan

Programs may be revised in accordance with the specific Program's standard

procedures for revising such fees and compensation, which do not provide for

prior approval by any groups. Such revisions typically are made annually as a

result of Program policy changes and/or vendor negotiations. These revisions

may occur at any time during the course of a given calendar year, and they do

not necessarily coincide with the Agreement Period. With respect to

Negotiated National Account An-angements, the participation with the Host

Blue may provide that Contractor must pay an administrative and/or network

access fee to the Host Blue. For this type of negotiated participation

arrangement, any such administrative and/or network access fee will not be

greater than the comparable fees that would be charged under the BlueCard

Program. Contractor will charge these fees as described in Schedule of

Financial Variables.

1. Value Based BCBSA Programs. This subsection l.F.(5) only applies to outof-

state Blue Card program participants of the Host Blue.

A. **Definitions.** For the purposes of this Section F.5., the following

definitions apply:

**1. Accountable Care Organization (ACO":** A group of healthcare

Providers who agree to deliver coordinated care and meet performance

benchmarks for quality and affordability in order to manage the total cost of

care for their member populations.

**2. Care Coordination:** Organized, information-driven patient care

activities intended to facilitate the appropriate responses to a Member's

healthcare needs across the continuum of care.

**3. Care Coordinator:** An individual within a Provider organization who

facilitates Care Coordination for patients.

**4. Care Coordinator Fee:** A fixed amount paid by a Blue Cross and/or

Blue Shield Licensee to Providers periodically for Care Coordination under a

Value-Based Program.

**5. Global Payment/Total Cost of Care:** A payment methodology that is

defined at the patient level and accounts for either all patient care or for a

specific group of services delivered to the patient such as outpatient,

physician, ancillary, hospital services, and prescription drugs.

**6. Negotiated National Account Arrangement:** An agreement negotiated

between a Home Licensee and one or more Host Licensees for any National

Account that is not delivered through the BlueCard Program.

**7. Patient-Centered Medical Home (PCMH):** A model of care in which

each patient has an ongoing relationship with a primary care physician who

coordinates a team to take collective responsibility for patient care and, when

appropriate, arranges for care with other qualified physicians.

**8. Provider Incentive:** An additional amount of compensation paid to a

healthcare Provider by a Blue Cross and/or Blue Shield Licensee, based on the

Provider's compliance with agreed-upon procedural and/or outcome measures

for a particular population of covered persons.

**9. Shared Savings:** A payment mechanism in which the Provider and

payer share cost savings achieved against a target cost budget based upon

agreed upon terms and may include downside risk.

**10. Value-Based Program (VBP):** An outcomes-based payment

arrangement and/or a coordinated care model facilitated with one or more

local Providers that is evaluated against cost and quality metrics/factors and is

reflected in Provider payment.

**B. BlueCard® Program**

Value-Based Programs Overview

In some cases, Members may access Covered Services from certain Host Blue

participating Network Providers that have entered into specific, Value-Based

Programs with a Host Blue. These Value-Based Programs consist of

Accountable Care Organizations, Global Payment/Total Cost of Care

arrangements, Patient Centered Medical Homes and Shared Savings

arrangements.

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching

agreed-upon cost/quality goals in the following ways: retrospective

settlements, Provider Incentives, a share of target savings, Care Coordinator

Fees and/or other allowed amounts. The Host Blue may pass these Provider

payments to Contractor, which Contractor will pass on to Employer in the

fonn of either an amount included in the price of the Claim or an amount

charged separately in addition to the Claim. When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods:

• Actual Pricing

o Claim Based (Actual Pricing): The charge to accounts for ValueBased

Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed via an enhanced fee schedule.

• Estimated/ Average Pricing

o Claim Based (Estimated Pricing): The charge to accounts for Value-Based Programs incentives/Shared-Savings settlements is included in the Claim as an amount based on a supplemental factor.

o In such cases, Contractor will pass any supplemental amounts on to Employer as follows: it will be included as pati of the Claims charge on the invoice.

When such amounts are billed in addition to the Claim, they may be billed as

follows:

o Per Member Per Month (PMPM) Billings: Per Member Per Month billings for incentives/Shared-Savings settlements to accounts are outside of the Claim system. Contractor will pass these Host Blue charges through to Employer as a separately identified amount on the invoice. The amounts used to calculate either the supplemental factors or PMPM billings are estimates. This means that Host Blues cannot determine final amounts for these a1Tangements at the time when Members incur Claims for Covered Services. Consequently, Host Blues may hold some portion of the amounts Employer pays under such arrangements until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

• Use any surplus in funds to fund Value-Based Program payments or reconciliation amount in the next measurement period.

• Address any deficit in funds through an adjustment to the per-membe rper-

month billing amount or the reconciliation billing amount for the

next measurement period. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement. Such surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings

in the case of Value-Based Programs. Note: Members will not bear any portion of the cost of Value-Based Programs except when Host Blues use either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

For certain Value-Based Programs, Host Blues may also bill Contractor for

Care Coordinator Fees which we will pass on to Employer. Based on the

methods that Host Blues use to pass these fees on to Contractor, Contractor

will invoice Employer through:

Or

(1) PMPM billings

(2) Individual Claim billings through applicable care coordination

codes from the most current editions of either *Current Procedural*

*Terminology* (CPT) published by the American Medical

Association (AMA) or *Healthcare Common Procedure Coding*

*System* (HCPCS) published by the US Centers for Medicare and

Medicaid Services (CMS).

Contractor and Employer will not impose Member cost sharing for Care

Coordinator Fees.

**2. Consideration and Premiums.**

A. Charges and Payment Terms

1. Administrative Charge
   * 1. To compensate the Contractor for administrative services provided for State employees and Early Retirees, the State will pay administrative charges monthly to the Contractor. The administrative charge is computed by multiplying the number of Subscribers covered, times the rate specified below:

STATE OF INDIANA

SCHEDULE OF FINANCIAL VARIABLES

EFFECTIVE January 1, 2022

MONTHLY ADMINISTRATIVE CHARGES

|  |  |  |
| --- | --- | --- |
|  | | |
| Administrative Fee | $ | subject to performance guarantees |
| Network Access Fee | $ |  |
| Disease Management Fee | $ |  |
| Additional rows added for programs as necessary | $ |  |
|  | $ |  |

The administrative fee, equivalent to $XXXX PSPM, will be offered to the Indiana State Police Department and Conversation/Excise Plans. [No other terms or portions of this Contract applies to the Indiana State Police Department and Conversation/Excise Plans.]

**Additional School Corporation COBRA Fee (Per Subscriber Per Month) $XXX**

(B) The State is paying Contractor to administer the State’s health care plans. The State is not paying Contractor to have its employees and agents criticize the State plan design or administration of the plan. A commitment to loyal customer service is guaranteed under this agreement in that if an occurrence of criticism is credibly reported to the State executives responsible for the plans the State will deduct from the administrative fee XXXXXXXXX dollars ($XXXXX) for each such criticism reported to the State. This clause canot not be invoked more than one hundred (100) times per year.

(2) Claims Expense Weekly Payments

The Contractor will deliver to the State a summary invoice and accompanying reconciled data file detailing the amount of authorized claims paid under the terms of the Plan on the State's behalf during the prior week and monthly administrative charges. The State must receive this billing by 9:00 a.m. to release the funds for payment three (3) working days after receipt of this billing information.  The payment will be transmitted to the bank account identified in writing by the Contractor and accepted by the State.

1. State Account

The State and Enrollee contributions will be retained in a State account from which the weekly billings are paid.Only employee/employer contributions from School Corporations, direct bill agencies, employees on worker's compensation leave, leave of absence, COBRA and Retiree fees are remitted directly to the Contractor. These fees are credited back to the State on the first billing in each month following the month that Contractor receives such amounts.

1. Post Active Retention Charge

Should this agreement terminate for any reason, the Contractor will process all claims incurred prior to the date of termination and any extended liability claims payable in accordance with the benefit provisions of the plan. Contractor will continue to bill the State weekly for self-insured claims incurred and paid under the State plan plus the Post Active Retention Charge. The Post Active Retention charge will be based upon the (a) the average number of State Subscribers for the month immediately preceding the termination (Base Subscribers) and (b) seventy-five percent (75%) of the Monthly Administrative fee Component of the Administrative Charge in effect for the month preceding the date of termination. The Post Active Retention Charge will be the product of the Base Subscribers and seventy-five percent (75%) of the Monthly Administrative Fee Component. The Post Active Retention Charge will be included in the billings for a period of six (6) weeks after termination. The weekly claims reimbursement billings will continue for a period of twelve (12) months from the termination date. The Contractor will then prepare a final billing comprising its estimate of the future cost of unpaid claims incurred under the Contract. This final billing, if agreed to by the State, is payable by the State within thirty (30) days of receipt.

1. Prescription Drug Rebates
   1. Contractor shall pass through 100% of Prescription Drug rebates and any other payments received directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by the Contractor and covered under the medical benefit portion of the Plan(s) (“Medical Drug Rebates”), on a quarterly basis, within 180 days after the end of the calendar quarter.

(B) Contractor will pass through additional collections from prior quarters in subsequent quarterly disbursements.

(C) Contract will reconcile each calendar year and submit reconciliation to the State within 10 months following the end of the calendar year, and any resulting additional value will be paid by the Contractor within 30 days following the reconciliation.

1. Performance Payments

Contractor is not retaining any difference between the amount the State is invoiced and the amount paid for Performance Payments to Providers or Vendors.

1. Fees to Manage Care

Contractor is not retaining any difference between the amount the State is invoiced and the amount paid for Fees to Manage Care to Providers or Vendors.

1. If CMS causes an offset of federal revenue to a State agency because of an unresolved coordination of benefits issue resulting from Contractor’s action or inaction, Contract will indemnify the impacted State agency for that loss by causing a credit to be issued against amounts owed Contractor for third party administration services or claims paid under the Agreement. In the event, the State agency later recovers the offset amount, the State will reimburse Contractor for the amount so indemnified. This is not be construed as a preclusion of or limitation on remedies for the failures to perform.

B. Self Insured Informational Fees

STATE OF INDIANA

SCHEDULE OF INFORMATIONAL FEES

EFFECTIVE 01/01/22 TO 12/31/22

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insert State of Indiana Rates |  |  |  |  |

For purposes of the School Corporation Adoption Agreement and Binder, Exhibit XXXXX , the 2022 SCHEDULE OF INFORMATIONAL FEES is as follows:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Insert State of Indiana Rates for School Corporations |  |  |  |  | | |
|  | |

The additional school corporation COBRA fee (per subscriber per month) is $XXX.

1. Direct Bill Informational Fees

The State has requested the Contractor to bill certain enrollees, agencies, and School Corporations on a direct basis for administrative fees, claims reimbursement, or Information Fees. Coverage for these Enrollees is contingent upon receipt by the Contractor of the applicable monies. Continued coverage for those directly billed is subject to the grace period, during which the claims are accepted, processed for payment, and then when premiums have been received, are released for payment. The Contractor is responsible for exercising best efforts to collect informational fees up to but not including litigation. State accepts no liability for the submission of these fees. It is hereby agreed that the Contractor will bill these individuals and agencies for Information Fees on a bi-weekly, monthly, or semi-annual basis, as specified. Any Information Fees received by the Contractor under this provision will be credited to the State’s billing on a monthly basis on the first billing each month following the month the Contractor receives such amounts. The amount to be credited on COBRA will exclude the 2% billing fee included in the Informational Fees for COBRA given above. The Contractor will retain the 2% billing fee.

D. The charges contained in the contract are the total of all charges by type and amount made under the Contract. Unless specifically provided elsewhere to be contrary to the terms hereof, no additional charges shall be claimed by the Contractor for the delivery, installation, utilization, and usage of the services provided herein, or any element thereof. All payments by the State will be made in arrears and shall be made in accordance with the Contract and the laws of Indiana.

E. There is a thirty-five (35) day grace period within which the administrative charges, claims expense payments or other fees must be paid as provided herein. The State will in any case be liable for the full amount of claims appropriately paid on its behalf and the applicable administrative charge for services rendered. The nonpayment, within the grace period, by the State of the administrative charges and weekly claim expense payments constitutes an event of default, with notice of default and a sixty (60) day period for cure, subsequent to the grace period, as a condition precedent to termination.

F. The Contractor warrants that no person or selling agency has been employed or retained by the Contractor to solicit or secure this Agreement upon an agreement or understanding for commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the Contractor for the purpose of securing business. For Breach or violation of this warranty the State shall have the right to terminate this Agreement in accordance with the Termination clause and, in its sole discretion, to deduct from the Agreement price and consideration or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fees.