Amendment 2

Attached to and made a part of the Master Services Agreement MSA-863728

an agreement between

Aetna Life Insurance Company
(hereinafter referred to as Aetna)

and the Customer

State of Delaware

Nothing contained in this amendment shall be held to alter or affect any of the terms of the Services Agreement other than as herein specifically stated.

It is understood and agreed as follows:

1. The Self-Insured HMO Administrative Fee shall be $41.20 PEPM
2. The PPO Medical; CDHP Administrative Fee shall be $38.41 PEPM
3. The fee guarantee for both the HMO and PPO Medical shall be as follows:

Fee Guarantee: Aetna guarantees that the fees for the 7/1/14 – 6/30/15 period will increase over the fees for the 7/1/13 – 6/30/14 period by 3%. Aetna guarantees that the fees for the 7/1/15 – 6/30/16 period will increase over the fees for the 7/1/14 – 6/30/15 period by 3%. Aetna also guarantees that the fees for the 7/1/16 – 6/30/17 will increase over the 7/1/15 – 6/30/16 by 3%.

In Witness Whereof, Aetna has signed this amendment at **Hartford, Connecticut,** to become effective July 1, 2013 and continue through June 30, 2014 unless otherwise agreed to in writing between the Parties.

Signed by Aetna May 31, 2013.

Original on File

By:

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Original on File

Financial Verification: _____

Signed by the Customer 7-18-13
Date

Original on File

Director, HRM & SBO
Signature Official Title

MSA Amend

P.O. Box 1991
Wilmington, DE 19899.1991
highmarkbcbsde.com

AMENDMENT #2
To the
ADMINISTRATIVE SERVICES AGREEMENT
Between
HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
And The
STATE OF DELAWARE, OFFICE OF MANAGEMENT AND BUDGET (OMB)

Effective July 1, 2014, the Adminstrative Service Agreement (State – Administrative Services Agreement – 07/01/12) is amended as follows:

I. DUTIES AND RESPONSIBILITIES OF THE PLAN SPONSOR

The following are added as Sections III.G and III.H

G. Tax and PPACA Reporting

Plan Sponsor assumes all tax reporting obligations relative to the reimbursement of any benefit to members of its Plan. Plan Sponsor further assumes all reporting responsibilities relative to its obligations (or those of the Plan) arising under PPACA; including, but not limited to: (a) the filing of Form 720, *Quarterly Federal Excise Tax Return,* for payment of the Patient Centered Outcomes Research Institute (PCORI) under Section 4376 of the Internal Revenue Code; (b) the information reporting requirements applicable to self-insuring employers, and certain other providers of minimum essential coverage under Section 6055 of the Internal Revenue Code; and (c) the information reporting requirements applicable to large employers under Section 6056 of the Internal Revenue Code.

H. Internal Revenue Code Requirements and PPACA Fee Requirements.

Unless otherwise specifically delegated herein, compliance with any requirement of the Internal Revenue Code or PPACA fee requirement applicable to the Plan shall be the sole responsibility of the Group. These shall include, but are not limited to: (a) the non-discrimination requirements of Section 105(h) of the Internal Revenue Code; (b) the welfare benefit fund requirements of Sections 419 and 419A of the Internal Revenue Code; (c) withholding and reporting requirements for any taxable Plan benefits; (d) payment of the employer shared responsibility obligation under Section 4980H of the Internal Revenue Code; and (e) payment of the PCORI fee.

II. DUTIES AND RESPONSIBILITIES OF HIGHMARK DELAWARE

The following is added to the Agreement as Sections IV.G and IV.H, and the sections following are renumbered accordingly:

G. Subrogation

Unless otherwise directed by Plan Sponsor, Claims Administrator is hereby delegated full authority to pursue Subrogation and related third party recovery rights as agent for Plan Sponsor. To that end, Claims Administrator may engage the services of a subrogation management firm to assist with the identification and management of Subrogation cases and fees of not more than twenty-five percent (25%) of any recovery shall be deducted in connection with the Subrogation efforts. Claims Administrator (directly or through its subrogation management firm) shall have full and complete authority and discretion to settle any Subrogation claim.

H. Financial Settlements

Plan Sponsor acknowledges and agrees that Claims Administrator may, from time to time, enter into financial settlements with providers for, among other reasons, routine claims adjustments, delayed rate adjustments, cost rate adjustments and incentive program adjustments. As such, the outcome of these settlements could result in an additional charge or credit being issued to Plan Sponsor during or after the applicable Contract Term. The parties understand and agree that any such charge or credit shall not result in a corresponding adjustment to amounts paid or not paid by Members in connection with claims relating to the settlement.

III. LEGAL ACTION; INDEMNIFICATION; CONFLICT OF INTEREST

A. Section VI.B.3 is deleted from the Agreement and the rest of the section is renumbered accordingly. This modification is deemed to be effective retroactive to July 1, 2012.

B. Secton VI.B.4 (renumbered as VI.B.3 based on the action above) is revised to read:

3. Highmark Delaware shall indemnify and hold the Plan Sponsor harmless from and against any and all loss, cost expense or liability arising out of claims by third parties for actual or alleged breach of duty, neglect, error, misstatement, misleading statement or other act of commission or omission committed by Highmark Delaware in the selection, administration or implementation of the Health Care Benefits Plans defined in this Contract; provided, however, that this section shall not apply to claims related to determinations made by the Plan Sponsor or with the Plan Sponsor's explicit consent, nor to claims alleging fraud or personal gain.

C. Secton VI.B.5 (renumbered as VI.B.4 based on the actions above) is deleted from the Agreement.

IV. EXHIBIT A – QUALIFIED GROUP HEALTH PLAN

The Qualified Group Health Plan is modified as follows:

A. The Qualified Group Health Plan

1. "A Guide to Your Health Care Benefits" State of Delaware First State Basic Plan (Print date 05/01/14)
2. "A Guide to Your Health Care Benefits" State of Delaware Comprehensive PPO Plan (Print date 05/01/14)
3. "A Guide to Your Health Care Benefits" State of Delaware Blue Care® HMO Plan (Print date 05/01/14)
4. "A Guide to Your Health Care Benefits" State of Delaware Consumer-Directed HealthGold Plan with Health Reimbursement Arrangement (HRA) Fund (Print date 05/01/14)
5. "A Guide to Your Health Care Benefits" State of Delaware Diamond State Port Corporation Blue Select® POS Plan (Print date 05/01/14)
6. "A Guide to Your Health Care Benefits" State of Delaware Group Special Medicfill Plan (Print date 05/01/14)

Section B.1., ProgenyHealth℠ Neo-Natal Care Program, is deleted, and the rest of the section is renumbered accordingly.

A copy of the revised Exhibit A is attached to this amendment.

V. EXHBIT B – FINANCIAL INFORMATION

A. The Self-Funded Financial Appendix (State – Self Funded Fin. Appx. – 07/01/12) is revised as follows:

1. Section II, *Definitions* is revised as follows:

   Administrative Expense is the amount charged to the Plan Sponsor by Highmark Delaware to cover reasonable and normal expenses associated with administering programs delivered under this Contract (including claims administration, overhead, etc.). Such expenses shall also include taxes, assessments or any other amounts imposed against Highmark Delaware based on the terms of this Agreement, under the authority of any federal, state, or local taxing jurisdiction, and with this provision continuing in effect after termination of this Agreement for any reason. Expenses associated with special, non-routine functions will be evaluated on a case-by-case basis to determine if a separate charge is required.

2. Section VIII, *BlueCard Program*, is deleted and replaced with the following:

   VIII. BlueCard Program

   Out-of-Area Services. Highmark Delaware has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside the geographic area Highmark Delaware serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Highmark Delaware for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this agreement are described generally below.

   Typically, Members, when accessing care outside the geographic area Highmark Delaware serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue

Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. Highmark Delaware payment practices in both instances are described below.

Applicable to HMO Plan Only

The HMO programs described in this Agreement cover only limited healthcare services received outside of Highmark Delaware's service area. As used in this context "Out-of-Area Covered Healthcare Services" include emergency care and urgent care obtained outside the geographic area Highmark Delaware serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by Insured's primary care physician ("PCP").

BlueCard Program

Under the BlueCard Program, when Members access covered healthcare services within the geographic area served by a Host Blue, Highmark Delaware will remain responsible to Group for fulfilling our contractual 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 participating healthcare 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, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Highmark Delaware by the Host Blue.

The calculation of Group's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to Highmark Delaware by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made

available to Highmark Delaware by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare 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 claim- and 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 covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related 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 Group 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 Highmark Delaware 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 Group pays in a variance account, pending settlement with its participating healthcare 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 Group. Such payable or receivable would be eventually exhausted by healthcare 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 healthcare 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 healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Highmark Delaware would then calculate Member liability and Group liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party 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.

Unless otherwise agreed to by the Host Blue, Highmark Delaware may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or healthcare provider contracts or would jeopardize its relationship with its healthcare providers.

BlueCard Program Fees and Compensation

Group understands and agrees to reimburse Highmark Delaware for certain fees and compensation which Claims Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any accounts. 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 Group's benefit period under this agreement.

Highmark Delaware will charge access fees as follows:

The access fee is currently limited to the lesser of percent of the savings that the BCBS organization has obtained from its providers, or $2,000 per claim. These percentages will apply to claims incurred during the contract period:

Market Segment Size		2014 Rates
Standard:	<1,000 Blue contracts and travelers	5.05%
Reduced:	1,000 to 9,999 Blue PPO contracts	2.81%
Jumbo:	10,000 to 49,999 Blue PPO contracts	2.61%

Only the BlueCard Program access fee may be charged separately each time a claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Highmark Delaware receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim.

All other BlueCard Program related fees are included in Highmark general administrative fee. See Exhibit B (Payment for Plan Benefits and Administrative Fees).

B. Financial Exhibit

The Financial Exhibit for the State of Delaware (State – Self Funded Fin. Exh. – 07/01/12), is replaced with the Financial Exhibit for the State of Delaware (State – Self Funded Fin. Exh. – 04/24/14). The replacement is attached to this Amendment.

C. Performance Guarantees

Performance Guarantees for the State of Delaware, is replaced with the Performance Guarantees for the State of Delaware (State – Perf. Guar. – 04/24/14). The replacement is attached to this Amendment.

VI. EXHBIT C - MASTER REPORT LIST

The Master Report list for the HBCBSD and Statewide Benefits Office FY 13 (July 1, 2012 to June 30, 2012) Revised 8-9-12 APS, is replaced with the Master Report list for for the HBCBSD and Statewide Benefits Office for FY 14.

VII. TABLE OF CONTENTS

Table of Contents, pages 2-3 of the Adminstrative Service Agreement (State – Administrative Services Agreement – 07/01/12) is revised and attached to this Amendment.

All the terms and conditions of the Agreement not inconsistent with the provisions and conditions of this Amendment remain applicable.

FOR: STATE OF DELAWARE

Original on File

BY: _____
Signature

NAME: Brenda Lakeman

FOR: HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE

Original on File

BY: _____
Signature

NAME: Margaret Eitl

TITLE:	Director of HR Mgt and Benefits Administration	TITLE:	Vice President, Sales and Client Management
DATE:	7/11/14	DATE:	7/24/14

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association.

ADMINISTRATIVE SERVICES AGREEMENT
TABLE OF CONTENTS

EXHIBITS

AMENDMENTS

EXHIBIT A

THE QUALIFIED GROUP HEALTH PLAN

QUALIFIED GROUP HEALTH PLAN

The entire Qualified Group Health Plan is attached hereto and made a part of this Agreement. The Qualified Group Health Plan is comprised of the following documents:

A. The Qualified Group Health Plan

1. "A Guide to Your Health Care Benefits" State of Delaware First State Basic Plan (Print date 05/01/14)
2. "A Guide to Your Health Care Benefits" State of Delaware Comprehensive PPO Plan (Print date 05/01/14)
3. "A Guide to Your Health Care Benefits" State of Delaware Blue Care® HMO Plan (Print date 05/01/14)
4. "A Guide to Your Health Care Benefits" State of Delaware Consumer-Directed HealthGold Plan with Health Reimbursement Arrangement (HRA) Fund (Print date 05/13/14)
5. "A Guide to Your Health Care Benefits" State of Delaware Diamond State Port Corporation Blue Select® POS Plan (Print date 05/01/14)
6. "A Guide to Your Health Care Benefits" State of Delaware Group Special Medicfill Plan (Print date 5/01/14)

B. The following programs are not discussed in the above documents, but constitute features of the Qualified Health Plan:

1. Juvenile Diabetes Case Management Program

   The Plan Sponsor's members under the age of 18 identified as having diabetes are targeted for case management by a Highmark Delaware case manager. A screening is conducted of available claims data prior to an outreach call being placed to the member and his or her guardian. During this call an overview of case management is provided and consent for enrollment in case management is sought.

2. Collaborative Case Management Activities with Alere

   Highmark Delaware Case Management staff and Alere clinical staff will hold a monthly conference call to review cases for the purposes of care collaboration, case referral and issue resolution. Representatives of the Plan Sponsor, Alere and Highmark Delaware will meet annually to review status of this on-going process.

EXHIBIT B

FINANCIAL EXHIBIT

For the

STATE OF DELAWARE

For the Contract Term July 1, 2014 through June 30, 2015

A. Access Fee Limit

Network Access Fees will be waived for claims incurred within the Contract Term if the Plan Sponsor's Employee[1] enrollment exceeds fifty thousand (50,000) during the Contract Term.

If the Employee[1] enrollment drops below fifty thousand (50,000), Network Access Fees may be charged for services rendered outside of the Delaware provider service areas. The Access Fee charged would be the lesser of 2.61 percent of the savings that BCBS Plans obtain from providers, up to a maximum of $2,000 per claim. Any Access Fee charged will be included in Claims Cost.

Irrespective of any waiver of Access Fees for claims incurred in the current Contract Term, Access Fees may be assessed for claims incurred prior to the start of the Contract Term at the rate applicable to the relevant Contract Term during which the claim was incurred.

C. Case Management Fee – Plan Sponsor shall pay Highmark Delaware for coordination services with Alere for case management. The parties agree that any changes to this fee after June 30, 2014 will not exceed the administrative fee rate cap of three percent (3%) from the previous Contract Term.

Fee (Per Covered Employee[1] Per Month; applies to all products except Special Medicfill) $0.36

D. NIA Advanced Radiology Review Charge (Per Covered Employee[1] Per Month; applies to all products except Special Medicfill) $0.62

B. Provider Discount

100% of the Provider Discount amounts generated on the Plan Sponsor's claims will be credited to the Plan Sponsor.

C. Monthly Retention Charge (Per Covered Employee[1] Per Month)

Monthly Retention Charges include charges disclosed in Sections C and D, above, except for Special Medifill, to which case management and advanced radiology review charges are inapplicable.

- First State Basic, Comprehensive PPO and Blue Select POS Plan $36.75
- CDH Gold HRA PPO Plan $37.77
- HMO Plan $35.31
- Special Medicfill Plan $15.32

D. Delaware Health Information Network (DHIN)

During Fiscal Year 2015, the State of Delaware's Group Health Insurance Program shall participate in the Delaware Health Information Network (DHIN). Effective May 23, 2013, and due

[1] Employee shall mean any Employee, elected or appointed official, retiree, pensioner or other covered person who is eligible for, and enrolled in, health benefit coverage under the State of Delaware Employee Health Care Plan (the Group Health Plan) and their enrolled spouses and children.

to the terms of a separate agreement signed by State of Delaware's Group Health Insurance Program and DHIN, a fee of $0.78 Per Covered Member Per Month shall be billed to Plan Sponsor as a DHIN Administrative Fee as a separate item on the monthly invoice identified in this Exhibit.

E. Programming

Highmark Delaware will provide fifty (50) hours of programmer time during the Contract Term as needed to support the report requirements described in Exhibit D, or such other requests as needed and mutually agreed upon by the parties. Programming required by the Plan Sponsor in excess of this limit will be charge to the Plan Sponsor, subject to the Plan Sponsor's approval of the scope of work, at a rate of $100 per hour.

Plan Sponsor will not be responsible for programming time necessitated by the move to the Highmark platform.

F. External Review Charges

Charges for external review of denied claim appeals will be charged to the Plan Sponsor as incurred, and will be supported by copies of invoices provided to Highmark Delaware by the reviewing body. Such charges apply only to reviews conducted on behalf of members enrolled in the CDH Gold plan.

G. Renewal Delivery Dates ..... December 31, 2014

H. Invoices and Payments

1. Highmark Delaware will invoice the Plan Sponsor as follows:

a) Highmark Delaware will send the weekly Claims Costs Invoice by electronic mail (e-mail) to the Plan Sponsor before 10:00 AM each Wednesday, with payment due by ACH Credit transfer to Highmark Delaware on Friday (that is, within two (2) days). Weekly Claims Costs Invoices sent after the 10:00 AM cutoff will be due for payment by ACH Credit transfer to Highmark Delaware within two (2) days from the next business day. Adjustments to the due dates for payment of the Claims Costs Invoice will be made to accommodate (i) State of Delaware holidays, (ii) instances of material inconvenience to Plan Sponsor as may be agreed upon in advance (for example, fiscal year close-outs), or (iii) such emergencies as may be mutually agreed upon by the Parties, and with written notice dependent upon the situation (potentially including, but not limited to, material technical difficulties). Plan Sponsor's contact information was provided to Highmark Delaware on May 7, 2013.

a) Highmark Delaware will invoice the Plan Sponsor weekly for the Claims Costs for claims processed in the preceding week. In addition, Highmark Delaware will provide a separate Invoice of all Claims Costs by month, based on the date of the claims payment. To comply with this requirement, Highmark Delaware will generate two (2) claims Invoices for each week that spans two (2) calendar months.

b) Monthly Retention and Other Administrative Fees

(1) Highmark Delaware will invoice the Plan Sponsor monthly for the following:

(a) Retention Charges

(b) Alere Coordination/Additional Case Management Fees

(a) NIA Advanced Radiology Review Charges

(b) Fees payable to the Delaware Health Information Network (DHIN)

(c) External Review Charges, if any (applies only to CDH Gold Plan)

(c) Programming Charges in Excess of Programming Allowance, if any

(d) Other State Taxes and Assessments, if any

(e) Other Administrative Charges as specified on the invoice and due under this Agreement, if any.

2. Highmark Delaware will generate the monthly invoice on or before the 15th of each month. The Plan Sponsor will pay the Monthly Retention Charge Invoice amount to Highmark Delaware by the later of the 15th of the month or two (2) working days after receipt of the Invoice.

3. For purposes of this Section K, invoices will be considered received on the day Highmark Delaware transmits, via electronic mail, a copy of the invoice to the Plan Sponsor.

I. Interest Charge is Prime Rate plus 1%, not to exceed amount specified in 29 Del Code, Sec 6516 (d) 4, currently 12% per annum.

J. Settlement - Annual

By September 30, 2015, Highmark Delaware will deliver to the Plan Sponsor a Settlement of the Claims Costs, Retention Charges, Interest Charges and any other financial information or charges due to/from the Plan Sponsor for the Contract Term. Any amount due to Highmark Delaware or to the Plan Sponsor will be invoiced or remitted at the time of the next Monthly Retention Charge Invoice, and is payable on the Invoice due date. Highmark Delaware reserves the right to impose and Plan Sponsor agrees to pay, an interest charge for late payment of the settlement balance due, at the rate specified above.

K. Settlement - Post Agreement Termination

After termination of this Agreement, the Preliminary Settlement is due within 180 days of the Contract termination date, and the Final Settlement is due within 30 months of the Contract termination date.

L. Claims Processing Upon Agreement Termination

Highmark Delaware's responsibility for claims processing ends on the date of the Agreement's termination, except for claims incurred while the Agreement was in effect. Highmark Delaware's responsibility for processing claims incurred while the Contract was in effect ends 12 months after the Agreement termination date. The Plan Sponsor is responsible for reimbursing Highmark Delaware for the Claims Cost for claims incurred prior to, but paid after, the Agreement termination date in the same manner as before that date.

EXHIBIT B

STATE OF DELAWARE

PERFORMANCE GUARANTEES

For the Contract Term July 1, 2012 through June 30, 2015; Revised effective July 1, 2013

Highmark Delaware agrees that, pursuant solely to the table set forth in this Exhibit, the retention charges it receives from the Plan Sponsor under this Agreement are "at risk" subject to Highmark Delaware not meeting the Performance Measure for each Standard. These Performance Guarantees will be measured over the course of a twelve-month Contract Term (July 1, 2012 through June 30, 2013, July 1, 2013 through June 30, 2014 and July 1, 2014 through June 30, 2015) and any amount owed to the Plan Sponsor will be part of the annual settlements.

Total at Risk: 27.0% of Retention Charge

and up to $12,000 for Implementation

Performance	Standard	Performance Measure	Frequency of Reporting	Percent of Fees at Risk
Claim Administration/Customer Service				
Turnaround Time for Claims	Percentage of Claims Processed in 30 days.	95% - 97%	Monthly	1.50%
Financial Payment Accuracy	Percentage of claims paid accurately (Total dollars of audited claims paid minus sum of absolute dollar value of all over/under payments] divided by the total dollars of audited claims paid.)	97% - 99%	Monthly	1.50%
Procedural Accuracy	Coding accuracy per month (Coding error that results in an incorrect payment of a claim. Formula = total number correct claims/total number of claims audited)	95%	Monthly	1.50%
Payment Incident Accuracy	Average year end accuracy (Number of correct audited payments/total number of payments audited)	97.5%	Annually	1.50%
Telephone Response Time	Maintain an average speed of answer of 30 seconds or less from the time of selection to speak to a live representative via the IVR system to the time a live person is on the line.	30 seconds or less	Monthly	1.00%
Call Abandonment Rate	Calculated automatically via	2%	Monthly	0.25%

EXHIBIT B

	automatic telephone call distribution system.			
Eligibility/Transfer Accuracy	Percentage of updates processed accurately	95% - 97%	Monthly	0.50%
Timely Submission of Data to Data Mining Vendor	Claims and eligibility sent by the 15th of the month	Claims and Enrollment files: 90% timely	Monthly	0.50%
ID Card Distribution (routinely throughout the plan year)	Percentage mailed within 10 days of data receipt	97% - 99%	Monthly	0.25%
ID Card Distribution (open enrollment)	Percentage mailed within 10 days of data receipt	97% - 99%	Annually	0.25%
Coordination of Benefits (weekly) No-Form List	Weekly list of all contract holders/spouses non-compliant as have not submitted S-COB form	95%	Weekly	Accuracy** 0.75% Timeliness 0.75%
Coordination of Benefits (weekly) Sanctioned Spouse List*	Weekly list of all contract holders whose spouses are sanctioned because non-compliant with S-COB policy	95%	Weekly	Accuracy** 0.75% Timeliness 0.75%
Coordination of Benefits (open enrollment)	List of contract holders effective 7/1 non-compliant (no form and sanctioned) with S-COB policy. If State provides all form electronically, due date is 6-15; if State provides both electronic and paper forms, due date is 6-22.	100%	Annually	Accuracy** 0.75% Timeliness 0.75%
Data Security	Regularly advise the State of any changes in status regarding implementation of required data security procedures	100%	On-going	1.00%
Timeliness of Responding to CMS Demands	Provide written response to CMS or third party vendor (MSPRC) within 45 days of date demand is issued	98%	On-going	0.25%
Member Satisfaction Survey	Positive Response Rate	85% or higher	Annually	0.25%
Enrollment Support for Open Enrollment	Accurate enrollment materials will be distributed to State employees in advance of open enrollment period. Highmark Delaware's participation		Annually	0.25%

	in benefit representative meetings, health fairs, etc., at State's request; Customer Service staff trained to respond to concerns regarding plan design, programs.			
Customer Service	Customer Service Center staff will be trained and available to respond to employee inquiries and will remain open and available 8:30 a.m. to 7:00 p.m. Monday through Friday, EST.	Customer Service Center staff will be trained and available to respond to employee inquiries and will remain open and available 8:30 a.m. to 7:00 p.m. Monday through Friday, EST. (Excludes: Emergency or Weather Related Office Closings)	On-going	0.50%
Reporting (See Exhibit C, Master Report List.)****	Complete and Timely Submission of accurate reports, as defined in Exhibit C, Master Report List.	Complete, accurate and timely submission of reports, as defined in Exhibit C, Master Report List, unless agreed to in writing by the State andHighmark Delaware.	Per Exhibit C, Master Report List	Accuracy** 1.00% Timeliness 1.00%
Account Management				
Account Management Satisfaction***	Score of 3.0 or higher on the State's Account Management Survey Form	2.9-2.5=.75% 2.4-2.0=1.5% <2.0=2.50%	Quarterly	2.50%
Network Management and Development				
Credentialing	Every network provider or facility must be re-credentialed at least every three years (Letter fromHighmark Delaware at the end of each contract year	Every network provider or facility must be re-credentialed at least every three years	Annually	2.00%

EXHIBIT B

	confirming compliance with credentialing requirements)			
Financial Guarantees				
Discount off Medical Charges	Provider Discounts as a percentage of Covered Charges (incurred July – June and paid July – August (incurred 12 and paid 14) plus an appropriate estimate for incurred but unpaid claim expense) for non-Medicfill contracts	43%	Annually	2.50%
In-Network Guarantee (PPO and CDHP)	Percentage of incurred claim payments (incurred July – June paid July – August (incurred 12 and paid 14) plus an appropriate estimate for incurred but unpaid claim expense) in-network, for non-Medicfill contracts	95%	Annually	2.50%
Implementation				
Implementation and Account Manager Performance	Implementation manager and account executive /manager will participate in every implementation call and will be prepared to lead call, based on detailed agenda sent to team in advance.		Open Enrollment	$2,000
Maintenance of detailed project plan	Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in advance of each implementation weekly call.		Open Enrollment	$1,000
Adherence to key deadlines	All key dates will be met to the extent Highmark Delaware has control and/or has notified State of risks of failure in advance of due date; State and Highmark Delaware will agree at		Open Enrollment	$2,000

EXHIBIT B

	the beginning of implementation on which deadlines are critical to program success			
Plan Design	Systems will be updated for accurate plan designs in time for State to conduct a pre-implementation audit		Open Enrollment	$2,000
Account Structure	Highmark Delaware will be prepared to replicate existing account structure, and conduct meeting with State to review current account structure to ensure it is adequate to meet current reporting needs		Open Enrollment	$1,000
Enrollment Support	Accurate enrollment materials will be distributed to State employees in advance of open enrollment period. To provide accurate information to members of the State of Delaware's Group Health Insurance Program, all standard communications prepared by Highmark Delaware shall contain clarification that not all Highmark Delaware's programs, processes, services, etc. pertain to members of the State of Delaware's Group Health Insurance Program. Additionally, the Plan Sponsor reserves the right to review in advance all print communications being mailed or available electronically to State of Delaware members. All communications related to State of Delaware annual Open Enrollment (specifically Plan Benefit Booklets, Summary of Benefits		Open Enrollment	$2,000

	and Coverage, Open Enrollment Booklets, plan information,.) shall be complete and delivered to the Plan Sponsor in advance of the annual Open Enrollment period, provided however, that the State of Delaware provides Highmark Delaware final decisions about its intended plan designs not less than 45 days prior to the first day of the Open Enrollment period.			
Initial ID Card Distribution	ID cards will be distributed at least 20 days in advance of effective date.		Open Enrollment	$1,000
Customer Service	Customer Service center will be trained and available to respond to employee inquiries prior to the open enrollment period and will remain open and available continuously from that point on.		Open Enrollment	$1,000

NOTES:

* Non-compliance with Spousal-Coordination of Benefits (S-COB) Policy is defined as State members who have not completed and returned the State's S-COB form. S-COB policy and S-COB form are available at http://ben.omb.delaware.gov/documents/cob.

** Accuracy with respect to the COB Guarantees shall be measured by terms mutually agreed to upon by the State andHighmark Delaware.

*** Overall Account Management performance will be measured quarterly, and the annual performance determination will be based on the arithmetic mean of the quarterly measurements.

**** Those items listed in Exhibit C, Master Report List, which also appear separately on this Performance Guarantee Exhibit, will be excluded from this specific standard.