

THIRD AMENDMENT TO MASTER SERVICES AGREEMENT-863728

This THIRD AMENDMENT OF THE MASTER SERVICES AGREEMENT-863728 (this "Amendment") is effective as of July 1, 2015 and is between Aetna Life Insurance Company, on behalf of itself and its affiliated health maintenance organizations (collectively, "Aetna") and State of Delaware ("Customer").

Aetna and Customer are parties to a Master Services Agreement effective as of July 1, 2012, (the "Agreement") and want to amend the Agreement as set forth below.

The parties therefore agree as follows:

1. The State of Delaware has agreed to add the following Disease Management and Wellness programs:

a. Aetna Health ConnectionsSM Disease Management:

Aetna Health Connections Disease Management is an enhancement to Aetna's medical/disease management spectrum and will target Plan Participants at risk for high cost who have actionable gaps in care, engage the Plan Participants at the appropriate level, and assist the Plan Participant to close gaps in care in order to avoid complications, improve clinical outcomes and demonstrate medical cost savings. The Aetna Health Connections Disease Management program will provide the following:

Disease management of over 35 chronic conditions:

- A vascular cluster consisting of diabetes (adult and pediatric), heart failure, coronary artery disease, cerebrovascular disease/stroke, hypertension (adult and pediatric), hyperlipidemia (high cholesterol) and peripheral artery disease
- A pulmonary cluster consisting of asthma (adult and pediatric) and COPD
- A cancer cluster including cancers such as breast, lung, prostate, colorectal, lymphoma/leukemia, and general cancer (as a comorbidity)
- A gastrointestinal cluster consisting of gastro esophageal reflux disease (GERD), peptic ulcer disease, chronic hepatitis, inflammatory bowel disease (Crohn's disease and ulcerative colitis)
- An orthopedic/rheumatologic cluster consisting of osteoporosis, osteoarthritis (as a comorbidity) rheumatoid arthritis, osteopenia (as a comorbidity), and chronic low back pain
- A neurological/geriatric cluster consisting of geriatrics, migraines, seizure disorders and Parkinsonism
- A renal cluster consisting of chronic kidney disease and end stage renal disease
- A comprehensive set of other conditions consisting of cystic fibrosis (adult and pediatric), HIV, hypercoagulable state (blood clots), weight management (adult and pediatric), sickle cell anemia (adult and pediatric), and depression (as a comorbidity) that vary in prevalence and severity across populations

Engagement of members identified for disease management in varying and progressive levels of intensity. The levels depend upon the severity of their condition(s) and the overall opportunity to impact their health status as measured by an opportunity score. Engagement levels include:

- **Supportive Monitoring:** Members receive a toll-free number to access an Aetna disease management nurse, use of our member website for self-directed learning, and bi-annual newsletters. Our staff will assist members to order a glucose meter according to their benefit plan.
- **Active Monitoring:** Members receive all of the above, plus an introductory letter, an invitation to call our toll-free number and speak with a disease management nurse for personalized education and action plans and educational materials as needed. Members may also receive peak flow meters and spacers if appropriate.
- **Active Monitoring with Nurse Engagement:** Members receive all of the above plus outreach to engage them with a disease management nurse for individualized coaching and education.

Identification of members for disease management intervention. We identify and score members using the Aetna Opportunity Score (AOS). The AOS uses a set of clinical identification and validation rules, scoring models and stratification algorithms to create a member-level score. We refresh scoring data on a monthly basis. We assign an overall opportunity score to each member. The score represents the degree to which disease management has an opportunity to impact each member's health status and clinical outcomes.

An attempt to reach members identified for nurse engagement by phone, letter or e-mail. Once a member agrees to participate, we assign a disease management nurse who acts as a personal health coach. The nurse provides one-on-one education and support, and helps the member understand his or her health needs, how to best leverage doctor visits through informed communication, and helps the member set health goals.

The creation of an action plan around the member's complete set of conditions and comorbidities that maximizes care, provides recommendations for care that are specific to a member's conditions and supports adherence to multiple providers' plans of care

The inclusion of our MedQuerySM Patient Safety program.

b. MedQuerySM

MedQuery is powered by our patented CareEngine[®] technology. The CareEngine applies over 1,100 clinical rule sets covering a broad range of conditions to a single, aggregated patient medical record, including medical claims, pharmacy, lab results, and self-reported data, to uncover opportunities to improve patient care.

For each opportunity identified, the system generates an alert we call a Care ConsiderationSM. The Care Consideration notes the clinical issue and suggests a change in treatment supported by evidence-based medical literature and treatment guidelines. We send the alerts to both members and their doctors. The CareEngine applies the rules on a continuous basis to all members.

The MedQuery program is a data-mining initiative, aimed at turning Aetna's data into information that physicians can use to improve clinical quality and patient safety. Through the program, Aetna's data is analyzed and the resulting information gives physicians access to a broader view of the Plan Participant's clinical profile. The data which fuels this program includes claim history, current medical claims, pharmacy, physician encounter reports, and patient demographics. Data is mined on a weekly basis and compared with evidence-based treatment recommendations to find possible errors, gaps, omissions (meaning, for example, that a certain accepted treatment regimens may be absent) or co-missions in care (meaning, for example, drug-to-drug or drug-to-disease interactions). When MedQuery identifies a Plan Participant whose data indicates that there may be an opportunity to improve care, outreach is made to the treating physician based on the apparent urgency of the situation. For customers who have elected the buy-up of MedQuery with Member Messaging feature, in certain situations outreach will be made directly to the Plan Participant by MedQuery, requesting that the Plan Participant discuss with their physician, specific opportunities to improve their care.

When available information reveals lack of compliance with a clinical risk, condition, or demographic-related recommendation for preventive care, a Preventive Care Consideration ("PCC") is generated. The PCC is a preventive/wellness alert sent to the Plan Participant electronically via the Plan Participant's Personal Health Record. Paper copies of a PCC, delivered via U.S. Mail, are also available as a buy up option.

Care Considerations are categorized into one of ten types, based on the identified opportunity for improved care:

Care Consideration type	Description
Add/intensify a medical treatment	Identification of patients in whom adding/intensifying a specific therapy (e.g., drug therapy, medical therapy with oxygen, electrolyte replacement) may benefit their condition.
Alternative medicine intervention (patient-derived)	Identification of patients, based on patient-derived information, taking over-the-counter medicines such as herbal medicine and supplements concomitantly with a drug or with a specific condition which may result in an adverse side effect.
Condition screening	Identification of patients who are candidates for screening for a specific condition.
Condition/drug monitoring	Identification of patients in whom monitoring (e.g., lab test, eye exam) may be indicated for either a condition or a drug.
Diagnostic work-up	Identification of patients in whom a diagnostic work-up (e.g., additional testing) may be indicated for either a condition or abnormality.

Care Consideration type	Description
Drug-drug interaction	Identification of patients in whom at least 2 drugs are being taken concomitantly which may result in an adverse side effect. Evaluation should be made with respect to the risks/benefits of continued use of the drugs. For specific Care Considerations, the literature may recommend monitoring parameters or the addition of other agents if both drugs have to be used concomitantly.
Food-drug interaction (patient-derived)	Identification of patients, based on patient-derived information, who are ingesting a specific food along with a drug which may result in an adverse side effect.
Modify lifestyle (patient-derived)	Identification of patients, based on patient-derived information, who are candidates for lifestyle modification (e.g., smoking cessation, diet, exercise).
Stop/modify a drug	Identification of patients in whom a drug should be avoided for a specific condition.
Vaccination	Identification of patients in whom vaccination may be indicated for a specific condition.

We determine how to communicate the Care Considerations to physicians based on severity. Each Care Consideration is assigned one of three levels of severity:

Severity Level	Description	Physician Communication
One	Clinically urgent: A potentially serious issue where communication with treating physician could have a significant impact and the situation should be addressed immediately.	Fax letter* to treating physician's office within 24 hours of Care Consideration generation.**
Two	Clinically important: A potentially serious, but non-urgent issue.	Mail letter to treating physician's office within 5 business days.
Three	Clinically notable: A less severe issue generally related to prevention and/or wellness. Not time sensitive.	Mail letter to treating physician's office within 5 business days.

c. Aetna Healthy Actions

Incentive rewards tracking is available as a buy-up option through Aetna Healthy Actions. This feature tracks eligible members who complete certain events over a specified time period. Currently, the Aetna Healthy Actions rewards tracking fee is \$0.15 PEPM. The fee covers the events-tracking process and report administration. Please consult with your underwriter on questions related to cost.

Our Aetna Healthy ActionsSM program includes an incentive component to help employees and their families take steps toward a healthier lifestyle. Eligible participants can view and track their incentives through the Healthy Actions page on our member website. The page displays all eligible, earned and applied incentives programs.

Members who are offered the health incentive credit reward feature will also be able to view details on credit dollars rolled over from previous years, dollars earned in the current year and claims for which incentive credit was used to pay member responsibility.

d. Healthy Lifestyle Coaching:

The Healthy Coaching Lifestyle program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach that utilizes incentives and rewards to encourage engagement and continued program participation. The program is designed to help Plan Participants quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness.

Our Healthy Lifestyle Coaching program is a high-touch, relationship-based wellness coaching program. We match participants with a coach to help them identify the wellness areas they want to focus on and the specific changes they want to make.

Our Healthy Lifestyle Coaching program is available to all of your employees and their dependents (18 and older), regardless of their risk level or whether they are enrolled in an Aetna medical plan.

Coaches and participants work together to identify which area of wellness to focus on. They use the health assessment or biometric screening results for their initial conversation to help determine which focus to select. However, this focus can change over time as both the coach and participant identify new opportunities for growth.

The six basic areas of focus are:

- Tobacco cessation
- Weight management
- Stress management
- Nutrition/Healthy eating
- Physical activity
- Well-being/Preventive health

Identification

We identify participants and assign their risk level based on the following:

- Health assessment results – this includes the Simple Steps To A Healthier Life® health assessment score, BMI, or indication that the individual uses tobacco
- ~~Claims data – we monitor claims for use of Chantix or Zyban (smoking cessation aids)~~
- Self-referral – individuals can refer themselves by telephone or through Aetna Navigator®, our secure member website
- Biometrics – this includes BMI, triglyceride levels, HDL level, blood pressure and blood glucose

Stratification and risk levels

Based on a participant's health assessment results and other data, we assign them to one of the following risk levels:

High opportunity

We identify members as high opportunity if their:

- Health assessment score is greater than 65
- Health assessment indicates a BMI equal to, or greater than, 30
- Health assessment indicates tobacco use
- Claim data shows use of either Chantix or Zyban (smoking cessation aids)
- Biometric data indicates three or more of the following:
 - BMI equal to, or greater than, 30 or large waist circumference (40 inches for men, 35 inches for women)
 - A raised triglyceride level (150 or higher)
 - A reduced HDL level (lower than 40 in men, lower than 50 in women)
 - Raised blood pressure (130/85 or higher)
 - Raised blood glucose (100 or higher) or previously diagnosed type 2 diabetes

Moderate opportunity

We identify members as moderate opportunity if their:

- Health assessment score is 56 to 65
- Health assessment indicates a BMI of 25 to 29.9
- Their health assessment score is less than 65 and their work limitations questionnaire score is greater than 11
- Biometric data indicates two of the following:
 - BMI equal to, or greater than, 30 or large waist circumference (40 inches for men, 35 inches for women)
 - A raised triglyceride level (150 or higher)
 - A reduced HDL level (lower than 40 in men, lower than 50 in women)
 - Raised blood pressure (130/85 or higher)
 - Raised blood glucose (100 or higher) or previously diagnosed type 2 diabetes

Low opportunity

We identify members as low opportunity if their:

- Health assessment score is less than 56
- Health assessment indicates a BMI of less than 25

Outreach and engagement

We engage members based on their assigned health risk:

High opportunity

Participants who have a higher risk of future health conditions receive proactive outreach and other support that includes:

- Initial proactive outreach from program
- One-to-one telephone coaching sessions, up to once a week
- Access to online or telephonic group coaching sessions
- Unlimited in-bound calls
- Self-directed online programs with Simple Steps to a Healthier Life
- Coach supported online lifestyle communities through CaféWell

Moderate opportunity

Participants who have a risk of future health conditions receive proactive outreach that includes:

- Initial proactive outreach from program
- One-to-one telephone coaching sessions, up to eight per year
- Access to online or telephonic group coaching sessions
- Unlimited in-bound calls
- Self-directed online programs with Simple Steps to a Healthier Life
- Coach supported online lifestyle communities through CaféWell

Low-opportunity

Participants who have a lower risk of future health conditions are invited to contact us to engage in the program, which consists of:

- Invitation e-mail to self-enroll in program
- One-to-One telephone coaching sessions, up to four per year
- Access to online or telephonic group coaching sessions
- Unlimited in-bound calls
- Self-directed online programs with Simple Steps to a Healthier Life
- Coach supported online lifestyle communities through CaféWell

e. Informed Health Line:

Our Informed Health® Line provides members with telephone and e-mail access to experienced registered nurses to help them make informed health care decisions.

Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week. We provide TDD service for speech impaired, deaf and hard of hearing members. We also offer foreign language translation for our non-English speaking members.

Additionally, members may e-mail a nurse by clicking on the "Talk to a Nurse" link within Aetna Navigator®, our secure member website. Nurses respond to inquiries within 24 hours.

	AHF PPO	HMO
Disease Management (Aetna Health Connections) with Patient Safety (Medquery)	\$3.90	\$3.90
RX Integration	\$ 0.28	\$0.28
Total Per Employee Per Month Disease Management Fee	\$4.18	\$ 4.18
Wellness Programs		
Aetna Health Actions	\$ 0.09	\$ 0.09
Healthy Lifestyle Coaching	\$1.82	\$1.82
total per employee per month wellness fee	\$ 1.91	\$ 1.91
Optional Services		
Online DM	\$0.20	\$0.20

2. Except as amended, the Agreement remains in full force and effect. All references to the Agreement in any other agreement or document shall hereinafter be deemed to refer to the Agreement as amended.

AETNA LIFE INSURANCE COMPANY

State of Delaware
Original on File

By: _____

By: _____

Name:

Name: Brenda L. Lakeman

Title:

Title: Director, Human Resource
Management and Benefits Administration

Date:

Date: 9-30-15



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AMENDMENT #3
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, 2015, the Administrative 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.I

I. Financial Settlements.

Plan Sponsor acknowledges and agrees that Claims Administrator may, from time to time, enter into financial settlements (and actuarially determined settlements for Paid Claims) with Providers for, among other reasons, routine Claims adjustments, delayed rate adjustments, cost rate adjustments, Payment Innovations Programs, 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 year. 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.

Section IV.H is deleted from the Agreement.

II. DUTIES AND RESPONSIBILITIES OF HIGHMARK DELAWARE

Sections IV.G is replaced with the following:

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 thirty percent (30%) 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.

The following are added as Sections IV.K, IV.L and IV.M

K. Claim Reprocessing.

Plan Sponsor may request that Claims Administrator undertake reasonable and good faith efforts to reprocess certain Paid Claims as result of (i) a pay-by-exception request; (ii) Claim denial due to the failure of a Member to obtain required authorization for a medical service, treatment or device; or (iii) retroactive benefit or eligibility changes that Plan Sponsor made or in connection with other action by Plan Sponsor, its employees or agents. Plan Sponsor agrees and acknowledges that such requests are subject to Claims Administrator's operational capabilities and the requirements of applicable law. Plan Sponsor acknowledges and agrees that Claims Administrator cannot guarantee the reprocessing of any or all requested Paid Claims due to, among other things, BCBSA policies, Provider contract limitations and applicable state and federal laws or regulations.

L. Cost Reduction and Savings Program.

Claims Administrator agrees to implement various services on behalf of Plan Sponsor aimed at generating savings on Claims. Services may include, but are not limited to, obtaining discounts through secondary networks, fee negotiations with non-participating providers, and arrangements with participating non-network providers. When so implemented, Claims Administrator and its vendor will retain thirty percent (30%) of savings in exchange for this service. If no discount is obtained, there is no cost to Plan Sponsor for this service. Notwithstanding anything herein to the contrary, in circumstances where a non-participating Provider Claim cannot be negotiated, the cost savings program may include Claim pricing in accordance with a nationally-recognized database of one or more vendors of Claims Administrator. In such cases, the allowance established by such database(s) shall supersede the otherwise applicable price for such non-participating Provider Claim that was established by a "Host Blue." (See the BlueCard Program Section of this Agreement.) When so implemented, Claims Administrator and its vendor will retain not more than thirty percent (30%) of savings in exchange for this service. If no discount is obtained, there is no cost to Plan Sponsor for this service. In such cases, the allowance established by such database(s) shall supersede the otherwise applicable price for such non-participating Provider Claim that was established by a "Host Blue" (see Section 12 of this Agreement).

M. Electronic Funds Transfer

Pursuant to the requirement in the Affordable Care Act, Standard for Health Care Electronic Fund Transfer (EFT) and Remittance Advice, if a provider requests that their claims payments be

processed via EFT through an Automated Clearing House (ACH), Claims Administrator agrees to implement the process.

III. MISCELLANEOUS PROVISIONS

The following is added to the Agreement as Section VII.A Definitions, and the sections following are renumbered accordingly:

A. Definitions

1. **Claim** means the amount a Provider, Member or vendor requests from the Plan for payment or reimbursement of a treatment, service or supply.
2. **Paid Claim** refers to the amount charged to Plan Sponsor for Benefits provided to Members during the term of this Agreement. In addition, the amount of a Paid Claim shall be determined as follows:
 - a) Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Claims Administrator actually pays to a Provider without regard to: (i) whether Claims Administrator reimburses such Provider on a percentage of charge basis, a fixed payment basis, a global fee basis, single case rate or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's actual billed charges for a particular service, supply or treatment; or (iii) whether such payments are increased or decreased by the Provider's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Claims Administrator.
 - b) If a Provider or vendor participates in any of Claims Administrator's payment innovation programs in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency or service standards or metrics adopted by Claims Administrator ("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 Plan Sponsor on a per Claim, lump sum, or per Member basis and shall be calculated based on Claims Administrator's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance 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, Claims Administrator shall provide Plan Sponsor with a description of the Payment Innovation Program, the methodology that will be utilized to charge Plan Sponsor, and any reconciliation process performed in connection with such program. Payments to Providers or vendors under these Payment Innovation Programs shall not impact Member cost shares.
 - c) Paid Claims may also include fees paid to Providers or vendors for managing and/or coordinating the care or cost of care for designated Members.
3. **PHI** means "Protected Health Information," as that term is defined in the Privacy Rule.
4. **Plan** means the provisions of the group health plan established by Plan Sponsor, including any amendments thereto, that are administered by Claims Administrator under this Agreement.
5. **Plan Sponsor or "Group,"** refers to the entity identified on the cover page of this Agreement. The Plan Sponsor shall be deemed to be the Plan administrator.

6. **PPACA** means the Patient Protection and Affordable Health Care Act of 2010 and implementing regulations thereunder; including, but not limited to, rules relating to internal Claims and appeals and external review processes under PPACA ("PPACA Claim Rule").

III. EXHIBIT A – QUALIFIED GROUP HEALTH PLAN

Section I, 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 TBD)
2. "A Guide to Your Health Care Benefits" State of Delaware Comprehensive PPO Plan (Print date TBD)
3. "A Guide to Your Health Care Benefits" State of Delaware Blue Care[®] HMO Plan (Print date TBD)
4. "A Guide to Your Health Care Benefits" State of Delaware Consumer-Directed HealthGold Plan with Health Reimbursement Arrangement (HRA) Fund (Print date TBD)
5. "A Guide to Your Health Care Benefits" State of Delaware Diamond State Port Corporation Blue Select[®] POS Plan (Print date TBD)
6. "A Guide to Your Health Care Benefits" State of Delaware Group Special Medicfill Plan (Print date 08/20/14)

Sections B.1, Juvenile Diabetes Case Management Program, and B.2, Collaborative Case Management Activities with Alere are deleted from Exhibit A, and are replaced with the following:

I.B. Health Performance Solutions Intensive Model Program

The Health Performance Solutions Intensive Model Program (hereinafter referred to as "Intensive Model Program") is a special clinical program that utilizes the client's exclusive claim and disease burden information in order to develop a customized program based on the unique risks of members and the company culture. A designated clinical team of nurse health coaches and wellness coaches reaches out to members with targeted conditions to maximize member engagement in telephonic coaching programs, and to proactively identify opportunities for controlling care costs more effectively, while still maintaining an appropriate pattern and level of care for the member. To the extent that the Plan Sponsor has wellness profile information of its members that it provides to Highmark, targeted telephonic outreach is performed proactively to assess member needs and direct individualized wellness interventions.

Highmark Delaware and Plan Sponsor acknowledge and agree that the following performance measures are in effect for the Intensive Model Program for the period from July 1, 2015 through June 30, 2017 only; that this Amendment #3 is contingent upon the Agreement remaining in effect for two (2) successive one year terms for the periods July 1, 2015 through June 30, 2016 and July 1, 2016 through June 30, 2017, as provided in Section II.B. of the Agreement; do not apply to any extension of the Agreement after June 30, 2017; and must be submitted and approved by Highmark Delaware for renewal. The parties also agree that these performance measures constitute confidential and proprietary information and no party shall disclose the content, terms or conditions of such to a third party without the express written permission of the other party.

The performance measures involve two (2) primary categories: Financial and Operational. The amount being placed at risk for the performance measures is a percentage of the Intensive Model Program fee that the Plan Sponsor will pay for the Intensive Model Program in each year of the multi-year contract (Financial – 20%; Operational – 20%). Highmark Delaware will place forty percent (40%) of the Intensive Program fee at risk for these performance measurements.

In the event the performance measures (which are described more specifically hereafter) are not met by Highmark Delaware in any measurement year, the amount at risk, if any, will be refunded to the Plan Sponsor. However, if Plan Sponsor is not current in its payment of claims or Administrative Fees, Highmark Delaware is not required to refund any amount placed at risk. Furthermore, if the Plan Sponsor terminates the underlying Agreement before the end of the term or terminates in the middle of a measurement year, the performance measures are void and Highmark Delaware is not required to refund any amount placed at risk.

Highmark Delaware will determine the results of all performance measures. Where applicable, the annual performance results will be the average of the quarterly results in each measurement category.

Conditions of the Intensive Model Program

The following conditions will apply throughout the measured period of the Intensive Model Program.

- If during any one or more of the two (2) successive one-year terms, total health plan enrollment falls below 2,000 members, performance measures will no longer be valid.
- Plan Sponsor will encourage member engagement by participating in a minimum of two promotional campaigns per year that promote coaching.
- If significant product changes occur during the measurement period on a prospective basis (e.g., transition from full service to High Deductible Health Plan), Highmark Delaware reserves the right to renegotiate or void the performance measures for the current or any future measurement year.
- If the unique membership population increases or decreases by +/- 10% or more or if eligible groups have a segment of business added and/or eliminated over the measurement period, Highmark Delaware reserves the right to re-negotiate or void the performance measures terms.
- Performance measures may be revised or cancelled if a Force Majeure Event occurs (as defined in the Agreement); or there is any major change related to: (i) government actions; (ii) laws or regulations affecting health benefits; (iii) provider networks; or (iv) the industry's practice and/or delivery of medicine and/or medical care, particularly through the use of new technologies or drugs.
- Measures are being offered for the Intensive Model Program based upon historical data for the contract year starting July 1, 2014 and ending June 30, 2015, including two (2) months of claims run-out from July 1, 2015 through August 31, 2015. This baseline will be trended and will be used for the years July 1, 2015 through June 30, 2016 and July 1, 2016 through June 30, 2017.
- To ensure adequate Intensive Model Program engagement, Highmark Delaware must have access to a current and accurate database containing employee contact information. For the performance measures to apply, Highmark Delaware must have valid phone numbers for at least 70% of the targeted members. If more than 35% of targeted members decline to participate or are not able to be reached, performance measures will not apply.
- Employees eligible for "at-risk" components are engaged in the Intensive Model Program through completion of the Highmark Delaware Wellness Profile (WP). To participate in the operational and financial performance measures, minimum requirements are expected to be met with respect to employees and their spouses. The WP completion rate will be based on a twelve month period starting three months prior to the intervention year in order to include the enrollment process if applicable.
- If a wellness profile other than the WP is used or if another clinical vendor is in place, performance measures will not be offered.

- A minimum WP completion rate of 20% is required for the Operational measures to apply.
- The Plan Sponsor's Qualified Group Health Plan as provided in Exhibit A of the Agreement must include the Highmark Delaware Prescription Drug program or, in the alternative, the Plan Sponsor must provide pharmacy utilization data from its prescription drug program in a timely manner. Plan Sponsor must annually provide at least 12 months of pharmacy utilization data from its carrier in the data format and schedule required by Highmark.
- The financial provisions with regard to the Intensive Model Program are in addition to the Financial Information contained in Exhibit B of the Agreement.

The following members are excluded from calculations for the performance measures for the Intensive Model Program:

- Identifiable COBRA members.
- Identifiable Retirees and spouses who are enrolled in Medicare Parts A and B and Medicare is primary.
- That portion of any member's catastrophic claims in excess of \$200,000.
- Members enrolled in a service product only and not enrolled in a Highmark Delaware medical product.

Calculation of the per-member costs will be based on the allowance level of claims. "Allowance levels" refer to the allowable charges provided through contracts between Blue Cross Blue Shield plans and their participating providers.

Managed Conditions (subject to review and change/adjustment)

- Asthma
- Chronic Kidney Disease
- COPD
- Depression (Behavioral Health)
- Diabetes
- Heart Disease
- Heart Failure
- High Risk Pregnancy
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Metabolic Syndrome
- Obesity (Pediatric only)
- Musculoskeletal Pain
- Osteoporosis
- Upper GI

Highmark Delaware Health Management Program

Highmark Delaware's care management program is a primary health coach model with a proactive approach to population health care management integrated for lifestyle, disease, case and utilization management. The program is a multidisciplinary, continuum-based approach to health care information and support that proactively identifies populations with, or at risk for, chronic medical conditions. The program supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbations and complications using evidence-based practice guidelines and cost effective patient empowerment strategies such as self-management. Members are evaluated through the identification and stratification model and prioritized for outreach based upon health and lifestyle risks. Those with condition or disease related risks are directed to the health coaches and those members with lifestyle risks such as stress, weight management, poor nutrition or sedentary lifestyles are directed to the wellness coaching staff. Highmark's health management program does not only rely on condition specific programs for member outreach. Our identification and stratification process looks for impactable elements that the Health Coach can work with the member to improve outcomes such as ER utilization, gaps in care, gaps in testing and adherence. The health and wellness coaching staff complete a comprehensive assessment. The coaches work with the member to address identified risks and to promote lasting behavior change.

The Health Coach:

- engages targeted members in meaningful and sustained behavior change using the most clinically appropriate and cost effective resources
- uses an integrated view of member data
- proactively identifies gaps in care and knowledge and implements personalized interventions, continuously develops, refines and deploys strategies for increasing member involvement in their own health and healthcare decisions including the use of on-line tools
- promotes the completion of Wellness Profiles as a means of uncovering risk and improving health status

The aerial™ clinical programs (aerial) is the primary platform used to support Highmark's integrated model to evaluate a member's condition or case management needs. aerial, a product of MEDecision, combines automation and web-based technology with expert clinical knowledge to provide expanded clinical content and member management tools to the health coach.

Each clinical program includes a comprehensive questionnaire that assesses the severity of each condition as well as the member's readiness to change, activities of daily living, and condition inter-dependencies. Pediatric and Adult specific questionnaires are utilized. Each clinical program problem is ranked by the Health Coach as one of the following: action recommended, attention priority, concern, education or reinforce. The questionnaires guide the Health Coach in assessing common risk factors that affect outcomes. Although questionnaires are specific to each disease (or its condition), there are many domains that are common across all conditions including the following:

- Depression screening
- Special needs
- Psychosocial issues
- Living arrangements
- Collaboration of care
- Health behaviors or controlled risk factors (for example, tobacco use or alcohol use)
- Treatment adherence and self-care practices
- Medication reconciliation and adherence
- Healthcare Utilization: routine medical evaluation or testing

- Annual flu shot
- Readiness to change
- Weight management (for example, height, weight, automated BMI calculator)
- Known allergy identification and documentation

Each member assessment results in an individualized plan of care with specific problems, short and long-term goals, interventions and outcomes as well as barriers the member may encounter during the course of condition management. These condition-specific assessments, goals, intervention strategies and opportunities allow for targeted education to improve health outcomes regardless of age. Members learn about their individual disease state, medications, impact of lifestyle behaviors, self-management monitoring, and how to best follow their provider's treatment plan.

The questionnaires in aerial are also designed to assess for co-morbid conditions. Detailed questions guide the Health Coach in addressing specific co-morbid conditions depending on which condition the member has (for instance for a member with diabetes the questionnaire assesses for blood pressure or vision appointments). If a co-morbid condition is determined to be present the Health Coach will follow the appropriate guidelines for that condition (referral to a specialist, treatment plan or goals are put in place to help the member manage the co-morbid condition, etc.)

Identification and Stratification

Highmark Delaware utilizes Verisk Health's Sightlines Medical Intelligence analytic tools to identify and stratify members appropriate for Condition, Case and Wellness programs. Member demographics, eligibility, member group and client information, medical claims, pharmacy claims, and health risk assessment data provided by Highmark Delaware are used by Verisk Health to run the identification and stratification process. The model also includes customized queries that have been developed by Highmark's clinical team. The goal of the customized queries is to specifically target those members who have modifiable risk. On a monthly basis the output from the application of the Medical Intelligence tools is loaded into aerial to drive member outreach and campaigns. We have the ability to set client-specific thresholds as well as to implement client specific campaigns.

High Risk Member Outreach

Members with chronic conditions identified as high acuity are coached using motivational interviewing techniques with a focus on self-management. Health Coaches individualize the length and frequency of each call based on member need or request. When determining follow-up call schedules, the Health Coach uses clinical judgment and works in collaboration with the member to address any special needs or considerations.

When needed or specifically requested, fulfillment materials are selected and mailed to the member throughout the engagement. Fulfillment and coaching content is based on evidence-based medicine, expert guidelines and protocols, and clinical standards.

Moderate Risk Member Outreach

Members with moderate acuity chronic conditions are targeted for a two-touch IVR (Interactive Voice Response) campaign with calls spaced 120 days apart. The goals of these calls are to provide the member with basic information about their condition, to review the member's perception of their self-management and overall health, to provide health tips and reminders specific to their condition, and to offer the member the opportunity for a warm transfer to speak directly to a Health Coach. When the member accepts the opportunity to speak to a Health Coach the member can be enrolled in a condition management program. This enrollment enables the member to have ongoing access to a Primary Health Coach who will assist the

member to develop short and long-term self-management goals and to develop strategies for overall health improvement. The Health Coach assists the member with any gaps in care that may be impacting their overall health as well as any preventive screening recommendations that may result in earlier detection of potential health concerns.

Low Risk Member Outreach

Members with chronic conditions identified as low acuity are targeted for condition-specific mail campaigns. The materials include topics/questions to discuss with their doctor and a variety of health promotion educational topics such as smoking cessation, nutritional needs and physical activity recommendations. Members receive fulfillment brochures related to their particular disease process that has information on discussions they should have with their doctor and tips for a healthy lifestyle. A cover letter explains the intent of the condition specific information, that additional information is available on the website and a Health Coach is available to speak with them. The mailing is triggered by the monthly member ID and stratification process. Identified low risk members may receive the mailing upon identification. Members may receive these mailings annually

Verisk Health Nurse Dashboard

The Nurse Dashboard integrates key information from health plan claims, risk assessment and biometric screening data and presents it to the Health Coach in an intuitive format in preparation for their discussion with a member. The Health Coach reviews this information during his/her interaction with the member in order to identify near real time needs and opportunities. The most common types of data reviewed include:

- Eligibility and Enrollment Information
- Medical Claims
- Pharmacy claims
- Dental Claims if Highmark Delaware
- Vision Claims if Highmark Delaware
- Utilization Data
- Quality Indicators and Gaps in Care
- Wellness Profile and Biometric Screening Data
- Consumer Persona
- History of enrollment in Highmark Delaware clinical programs
- Risk scores

This tool uses proprietary rules to display risk scores including: Likelihood of hospitalization, likelihood of emergency room utilization and high cost claimant. The model also calculates care gap index based on currently identified clinical risks and gaps in care. A clinical event tab provides information quickly and easily regarding ER visits, admissions, office visits, prescriptions as well as other events. A Health Risk Assessment tab provides general health data such as height, weight, blood pressure, cholesterol level and other markers if collected during a biometric screening event or completion of a wellness profile. A trending analysis by month allows a Health Coach to view fluctuations or spikes throughout the period being reviewed. A pharmacy tab offers prescription information including cost data if covered under the Highmark Delaware drug plan. Data from non-Highmark Delaware pharmacy benefit managers (PBM) will be displayed without cost information if the file is received on a timely basis and the information on the file can be accurately matched to the Highmark Delaware member data.

Look-In Link to UM Clinical platform

A web link is available from aerial that takes the Health Coach directly to the member's inpatient and outpatient authorization history. This provides access to detailed clinical notes as well as dates of service. Automated triggering of tasks based on rules built into the UM platform occurs for both case management and transition of care programs.

HealthWise® Coach

Health Coaches access HealthWise® Coach to provide relevant, validated, and consistent clinical information during any coaching interaction. HealthWise® Coach in addition to clinical content includes tools to complete symptom assessments, and decision support for a multitude of health and wellness related topics. Health Coaches are also able to email reference material including videos, to members.

Condition (Disease) Management

Condition Management programs focus on improving the outcomes of members identified with chronic illnesses by improving their self-management skills and understanding of their illness and treatment options.

The goals of Condition Management include:

- improving the quality of care and outcomes for members with chronic illnesses by addressing and closing gaps in care and improving their self-management skills;
- improving member decision-making skills, including understanding of their treatment options in the context of their personal values, preferences, and priorities;
- promoting dialogue and communication between the provider and member;
- reducing clinical progression of conditions by encouraging preventive screenings and immunizations;
- reducing potentially avoidable healthcare costs

Members may be identified for one of the following Condition Management Programs:

Condition Management Program	Description
Asthma	This program focuses on a plan of care for adults and children diagnosed with asthma that includes assessment questions specific for the three age groups recommended by the Expert Panel from the National Asthma Education and Prevention Program (NAEPP). Emphasis is placed on issues critical to asthma management, such as identification of the member's current level of asthma control by assessing daytime and nighttime asthma symptom frequency, excessive use of relief medications, the number of ER or urgent care visits or hospitalizations, the extent to which asthma symptoms affect daily activity, and the results of pulmonary function tests.

Condition Management Program	Description
Chronic Obstructive Pulmonary Disease (COPD)	This program ensures the proper management of this chronic condition, decreases ED visits and hospitalizations, and helps the member successfully manage the disease and its symptoms. Based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) standards, questions are included that assess the member's specific symptoms, risk factors, systemic effects, and the impact the disease has on the member's everyday activities. Common co-morbid conditions that may impact the member with this condition are assessed as part of the treatment plan.
Depression	This program focuses on treatment plan adherence and assessment of the various types of therapy commonly used to address the symptoms of depression. This program includes a section on Grief and Loss, as well as questions that explore current or past use of ECT therapy in the treatment of depression. The module also includes a Pain and Suicide Risk Assessment section.
Diabetes	This program is appropriate for adults or children diagnosed with either diabetes type 1 or type 2. Questions center on the current treatment plan, frequency of appropriate testing, and disease-related complications. The program reflects the current American Diabetes Association recommendations for target A1C values, annual eye and foot exams, and blood glucose monitoring (including continuous glucose monitoring). A pediatric diabetes questionnaire incorporates the growth and development needs of a pediatric member with diabetes.
Heart Disease	This program is for the adult member diagnosed with coronary heart disease (CHD). Other conditions or diseases considered risk factors for CHD or that contribute to the risk for disease related complications, such as myocardial infarction, atrial fibrillation, diabetes, stroke, or carotid artery disease are also assessed in this module. Vascular disease assessment is expanded to address venous and arterial insufficiency separately. This program ensures the proper management of CHD, provides education regarding the disease process with emphasis on healthy lifestyle changes and self-management, and provides appropriate interventions to prevent avoidable adverse health outcomes and decrease hospitalizations.
Heart Failure	This program is appropriate for the adult member diagnosed with heart failure (HF). Assessments focus on the following: symptom assessment monitoring, the NYHA Heart Failure Classification and stage-related effects on activities of daily living, strict medication and fluid restriction adherence, and careful management of comorbidities. Methods supporting the member's self-management serve to minimize symptoms, avoid hospitalizations and readmissions, and improve the member's quality of life. The program includes updates from the American Heart Association and the American College of Cardiology

Condition Management Program	Description
	and Focused Update: ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults.
Musculoskeletal Pain	This program is appropriate for adults with acute or chronic low back pain, rheumatoid and osteoarthritis pain and other musculoskeletal pain that can be the result of a disease process or an injury. The aim of this module is to optimize members' adherence to follow-up care or therapy, and to help members relieve or manage their musculoskeletal pain to return to their prior level of functioning. This program includes a section focusing exclusively on low back pain, its cause, treatment and assessment of its impact on work and activities of daily living. The program's questions ensure members are assessed for appropriate testing, services and care they need to manage pain.

Condition Management is an opt-in program. Health Coaches are available to receive inbound calls 24 hours a day 7 days a week. Health Coaches are available for outbound calls to members 8:30 am to 9:00 p.m. Monday through Friday and on weekends when requested by the member. Once a member chooses to participate, they are enrolled in a program specific to their needs and are considered engaged. Members may provide consent to allow the Health Coach to discuss their condition with their caregivers.

Wellness

Wellness programs assist the member in setting attainable, realistic goals and keep the member focused on making positive changes that are incorporated into long term lifestyle change. Wellness may focus on meeting goals related to physical activity, nutrition, stress education and weight management

Wellness	Description
Online Wellness	Wellness Profile (Health Risk and Productivity Assessment) WebMD Apps – Daily Victory and Weigh Today WebMD Personal Health Record WebMD Digital Health Assistant Programs (physical activity, nutrition, weight management, stress management, tobacco cessation, emotional health) WebMD Health Trackers WebMD Symptom Checker WebMD Videos (over 3,000 videos on diseases, conditions and wellness topics) WebMD Recipes (over 600 healthy living and lifestyle recipes) WebMD Health Information Content (over 200 health topics) WebMD Health Topics (topics include alcohol, substance abuse, nutrition, emotional health management and more) Reward Programs (incentive platform which allows for setup, tracking and reporting)
How to be Tobacco Free	A telephonic or self-study tobacco cessation program with a wellness coach. Coaches give guidance and support through inbound and outbound calls. Based on the National Cancer Institute's evidence-based Clearing the Air program, How to Be Tobacco Free is for

	<p>members who are thinking about quitting, ready to quit, or want to learn more about quitting tips, tools and resources.</p> <p>State of Delaware's members who elect to participate in How to Be Tobacco Free will receive an enrollment call from a licensed, clinical wellness coach who has been specially trained in tobacco cessation. Using motivational interviewing techniques, our coaches assess each member's readiness to quit tobacco in the first call.</p> <p>The telephonic and self-study programs are set-up as follows:</p> <p>Telephonic</p> <ul style="list-style-type: none"> • 1 enrollment call • 4 coaching calls (1 call/week) • 2 follow-up calls (day 30 & 90) <p>Self-Study</p> <ul style="list-style-type: none"> • 1 enrollment call • Send self-study • 1 follow-up call (day 30)
Drop 10 in 10	<p>An effective weight management program that combines balanced nutrition, sensible activity and meaningful lifestyle changes to help participants lose 10 pounds or 10% of their body weight in 10 weeks. This program employs a multi-modal approach to weight loss. It is available to members in a telephonic, online or self-study option.</p> <p>Drop 10 in 10 is set-up as follows:</p> <p>Telephonic</p> <ul style="list-style-type: none"> • 1 enrollment call • Up to 10 weekly coaching sessions • 2 follow-up calls (week 14 & 20) <p>Self-Study</p> <ul style="list-style-type: none"> • 1 enrollment call • Send self-study • 1 follow-up call <p>Email</p> <ul style="list-style-type: none"> • 1 enrollment call or email (wellnesscoaches@highmark.com) • Weekly emails sent by wellness coach • Inbound support as requested <p>Only program content is sent via email, no clinical conversation occurs through email.</p>
Outbound Wellness Coaching	<p>Available to State of Delaware members based on specific risk and readiness to change criteria for Wellness Profile responses. Telephonic outreach is performed to assess member needs and direct individualized wellness interventions. During a personal wellness consultation, the Wellness Coach helps members understand their Wellness Profile. Coaches will also direct members to online or community resources to help manage lifestyle risks.</p> <p>Members may trigger for outbound wellness coaching if they have a score of 71+ on the wellness profile, coupled with a readiness to change in one of the five risk areas within the next six months. Members may also trigger for outbound wellness coaching if they do not stratify for outreach through our DM/CM program.</p> <p>Once targeted for outreach, the Wellness Coach will attempt to reach the member via telephone 3 times. If the member does not respond, a letter will be mailed to the member asking them to contact a Highmark</p>

24 Hour Health Information Line

Highmark Delaware offers a toll free 24-hour nurse line to answer health, wellness or condition related questions for members and their families. Health Coaches provide objective, evidence-based information to help individuals understand their situation. Health Coaches help members gain insight into their choices and provide them with available on-line resources. Once a Health Coach completes their discussion with a member, the conversation and any follow-up needs are documented in the aerial platform.

Language Assistance

Translation Services are available to those individuals who are not able to speak, read or understand the English language and TTY/TDD are available for hearing/speech impaired.

Explanation of Performance Measures

1. Financial Performance Measures

Return on Investment

The amount at risk under the Financial Performance Measures shall be measured only within the applicable measurement year and will not exceed twenty percent (20%) of the Intensive Model Program fee received by Highmark Delaware under this Agreement for the specified measurement year.

The parties agree that the targeted Return on Investment (ROI)* will be measured for each year of the three year contract based on the Wellness Profile completion rate.

***For the ROI Measures:**

- ✓ Total savings for the Intensive Model Program is calculated by applying national average trends (updated semi-annually) to Plan Sponsor's historical baseline claims and subtracting actual claims.
- ✓ National carrier trends are currently based on a weighted average PPO medical pricing trend as established and available by the following consulting firms: Aon, Buck, Mercer and Towers Watson.
- ✓ *ROI will be calculated as the amount of per member per month savings divided by the amount of per member per month Intensive Model Program fee.

Any refund will be calculated as follows:

- a. **Wellness Profile completion rate less than 20%:** Financial Performance Measures will not apply
- b. **Wellness Profile completion rate of 20% but less than 30%**

<u>ROI</u>	<u>REFUND AMOUNT</u>
2.0 to 1.0 and better	No Refund
1.5 to 1.0 but less than 2.0 to 1.0	Refund 50% of amount at risk
Less than 1.5 to 1.0	Refund 100% of amount at risk

c. **Wellness Profile completion rate of 30% but less than 50%**

<u>ROI</u>	<u>REFUND AMOUNT</u>
2.5 to 1.0 and better	No Refund
2.0 to 1.0 but less than 2.5 to 1.0	Refund 50% of amount at risk
Less than 2.0 to 1.0	Refund 100% of amount at risk

d. **Wellness Profile completion rate of 50% or greater**

<u>ROI</u>	<u>REFUND AMOUNT</u>
3.0 to 1.0 and better	No Refund
2.5 to 1.0 but less than 3.0 to 1.0	Refund 50% of amount at risk
Less than 2.5 to 1.0	Refund 100% of amount at risk

2. Operational Performance Measures

Operational activities include Outreach (Attempt to Contact) and Active Engagement. The amount at risk under the Operational Performance Measures shall be measured only within the applicable measurement year and will not exceed twenty percent (20%) of the Intensive Model Program fee received by Highmark Delaware under this Agreement for the specified measurement year.

Outreach:

Highmark Delaware will outreach (attempt to contact) a minimum of 16.3% of adult members** eligible for the Intensive Model Program.

Attempt to Contact – The member has been identified by the Intensive Model Program for coaching outreach and intervention.

Actively Engaged:

Highmark Delaware will actively engage a minimum of 6.1% of adult members** eligible for the Intensive Model Program.

Actively Engage - The member, health care provider or designee has been contacted by an Intensive Model Program health or wellness coach and has participated in an assessment to develop the intervention plan through one of the telephonic programs. A member is considered engaged when the member has agreed to participate in discussions and goal setting with a Highmark Coach.

**** Adult members are defined as employees and their spouses 18 years of age or older. Medicfill and COBRA participants are excluded**

Depending on the clinical circumstances, a member may be contacted or engaged multiple times during the measurement period.

Failure to meet the operational measures will result in a 50.0% refund of the amount at risk for operational measures for each one missed.

Highmark Delaware reserves the right to change (add or delete) or otherwise revise the measures and methodologies applied, at any time and in its sole discretion, without advance notice, either written or oral, to the Plan Sponsor, for the purpose of enhancing the Intensive Model program in cases where such enhancements will apply

across Highmark's book-of-business. Mutual agreement of the parties is required for any other enhancements.

IV. EXHIBIT B – FINANCIAL INFORMATION

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

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.

The IPA program(s) described in this Contract cover(s) only limited healthcare services received outside of Highmark Delaware's service area. As used in this "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 its 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 these fees as follows:

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 Delaware's general administrative fee. See Exhibit B (Payment for Plan Benefits and Administrative Fees).

Non-Participating Healthcare Providers Outside of the Highmark Delaware Service Area

Member Liability Calculation

(i) In General

When covered healthcare services are provided outside of Highmark's service area by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on the Host Blue's non-participating healthcare provider local payment unless otherwise specified under the terms of this Agreement or as required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

(ii) Exceptions

In some exception cases, Claims Administrator may pay Claims from non-participating healthcare providers outside of Claims Administrator's service area based on a case-specific negotiated rate in situations where, for example, a Member did not have reasonable access to a participating provider, as determined by Claims Administrator in our sole and absolute discretion or by applicable state law. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

Fees and Compensation

Group understands and agrees to reimburse Highmark Delaware for certain fees and compensation which Claims Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable 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 accounts. Such revisions

typically are made annually as a result of Inter-Plan Programs 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.

In addition, Highmark Delaware must pay an administrative fee to the Host Blue, and Group further agrees to reimburse Highmark Delaware for any such administrative fee as set forth below.

Highmark Delaware will charge these fees as follows:

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

Value-Based Programs Overview

In some cases, Group's Members may access covered healthcare services from certain Host Blue participating providers that have entered into specific, Value-Based Programs with a Host Blue. These Value-Based Programs are similar to those that we have entered into with our participating providers within our service area. 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 us, which we will pass on to you in the form 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
- Claim Based (Actual Pricing): The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed via an enhanced fee schedule.
- Estimated/Average Pricing
- 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.

In such cases, we will pass any supplemental amounts on to you as follows will be included as part of the Claims charge on a monthly invoice.

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

- Per Member Per Month billings for incentives/Shared-Savings settlements to accounts are outside of the Claim system. Highmark Delaware will pass these Host Blue charges through to Group as a separately identified amount on the group billings.

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 arrangements at the time when Members incur Claims for covered healthcare services. Consequently, Host Blues may hold some portion of the amounts you pay 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 amounts in the next measurement period.
- Address any deficit in funds through an adjustment to the per-member-per-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. Some Host Blues may retain interest earned as part of their negotiated compensation with their providers, if any, on funds held that are associated with these 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 Highmark Delaware for Care Coordinator Fees which we will pass on to you. Based on the methods that Host Blues use to pass these fees on to Highmark, we then bill you through:

- PMPM billings

or

- 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).

As part of this Agreement, Highmark Delaware and you will not impose Member cost sharing for Care Coordinator Fees.

Return of Overpayments

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Highmark Delaware may request the Host Blue to provide full refunds from participating healthcare providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Highmark Delaware may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of this Agreement.

All other BlueCard Program related fees are included in Highmark Delaware's 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. – 04/30/15). 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. – 04/30/15). The replacement is attached to this Amendment.

V. TABLE OF CONTENTS

Table of Contents, pages 2-3 of the Administrative 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	FOR:	HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
BY:	_____ Signature	BY:	_____ Signature
NAME:	Brenda Lakeman	NAME:	Margaret Eitl
TITLE:	Director of HR Mgt and Benefits Administration	TITLE:	Vice President, Sales and Client Management
DATE:	_____	DATE:	_____

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

**ADMINISTRATIVE SERVICES AGREEMENT
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EXHIBITS

A. The Qualified Group Health Plan

1. "A Guide to Your Health Care Benefits" State of Delaware First State Basic Plan (Print date 06/15/12)
2. "A Guide to Your Health Care Benefits" State of Delaware Comprehensive PPO Plan (Print date 06/15/12)
3. "A Guide to Your Health Care Benefits" State of Delaware Blue Care[®] HMO Plan (Print date 06/15/12)
4. "A Guide to Your Health Care Benefits" State of Delaware Consumer-Directed HealthGold Plan with Health Reimbursement Arrangement (HRA) Fund (Print date 06/15/12)
5. "A Guide to Your Health Care Benefits" State of Delaware Diamond State Port Corporation Blue Select[®] POS Plan (Print date 06/15/12)
6. "A Guide to Your Health Care Benefits" State of Delaware Group Special Medicfill Plan (Print date 07/01/12)
7. Care Management Programs (Progeny Neo-Natal Care Program, Juvenile Diabetes Case Management Program, Collaborative Case Management Activities with Alere)

B. Financial Information

1. Self-Funded Financial Appendix (State – Self Funded Fin. Appx. – 07/01/12)
2. Financial Exhibit for the State of Delaware (State – Self Funded Fin. Exh – 07/01/12)
3. State of Delaware Performance Guarantees (State – Perf. Guar. – 07/01/12)

C. Master Report List HBCBSD and Statewide Benefits Office FY 13 (July 1, 2012 to June 30, 2013) Revised 8-9-12 APS

D. State of Delaware Business Associate Agreement

AMENDMENTS

- A. Amendment #1 to the Administrative Services Agreement between Highmark Blue Cross Blue Shield Delaware and the State Of Delaware, Office Of Management and Budget (OMB) (State ASA Amendment #1 – 05/24/13).
- B. 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) (State ASA Amendment #2 – 04/25/14).

- C. Amendment #3 to the Administrative Services Agreement between Highmark Blue Cross Blue Shield Delaware and the State Of Delaware, Office Of Management and Budget (OMB) (State ASA Amendment #3 – 04/30/15).
-

EXHIBIT B

**FINANCIAL EXHIBIT
For the
STATE OF DELAWARE**

For the Contract Term July 1, 2015 through June 30, 2016

A. Access Fee Limit

Network Access Fees will be waived for claims incurred within the Contract Term if the Plan Sponsor's Employee¹ enrollment exceeds fifty thousand (50,000) during the Contract Term.

If the Employee¹ 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 2.48 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.

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 Employee¹ Per Month)

Except for Special Medifill, the Monthly Retention Charges displayed below include an NIA Advanced Radiology Review Charge of \$0.62 Per Covered Employee¹ Per Month.

• 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 2016, the State of Delaware's Group Health Insurance Program shall participate in the Delaware Health Information Network (DHIN). Effective May 23, 2013, and due 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 Delaware platform.

EXHIBIT B

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.

G. Renewal Delivery Dates December 31, 2015

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).
- b) 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 make available via ebill historical data that spans two (2) calendar months.
- c) Monthly Retention and Other Administrative Fees
Highmark Delaware will invoice the Plan Sponsor monthly for the following:
 - (1) Retention Charges, including applicable NIA Advanced Radiology Review Charges
 - (2) Fees payable to the Delaware Health Information Network (DHIN)
 - (3) External Review Charges, if any (applies to all Plans except Special Medicfill)
 - (4) Programming Charges in Excess of Programming Allowance, if any
 - (5) Other State Taxes and Assessments, if any
 - (6) 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, 2016, 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

EXHIBIT B

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, 2016; 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, July 1, 2014 through June 30, 2015 and July 1, 2015 through June 30, 2016) 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	2%	Monthly	0.25%

EXHIBIT B

	automatically via 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 15 th 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		Annually	0.25%

EXHIBIT B

	Delaware's participation 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 and Highmark 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 from Highmark Delaware at the end of	Every network provider or facility must be re-credentialed at least every three years	Annually	2.00%

EXHIBIT B

	each contract year 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		Open Enrollment	\$2,000

EXHIBIT B

	Delaware will agree at 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,		Open Enrollment	\$2,000

EXHIBIT B

	Summary of Benefits 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 and Highmark 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.

Health Performance Solutions Intensive Model Program

1. Financial Performance Measures

Return on Investment

The amount at risk under the Financial Performance Measures shall be measured only within the applicable measurement year and will not exceed twenty percent (20%) of the Intensive Model Program fee received by Highmark Delaware under this Agreement for the specified measurement year.

The parties agree that the targeted Return on Investment (ROI)* will be measured for each year of the three year contract based on the Wellness Profile completion rate.

***For the ROI Measures:**

- ✓ Total savings for the Intensive Model Program is calculated by applying national average trends (updated semi-annually) to Plan Sponsor's historical baseline claims and subtracting actual claims.
- ✓ National carrier trends are currently based on a weighted average PPO medical pricing trend as established and available by the following consulting firms: Aon, Buck, Mercer and Towers Watson.
- ✓ *ROI will be calculated as the amount of per member per month savings divided by the amount of per member per month Intensive Model Program fee.

Any refund will be calculated as follows:

- a. **Wellness Profile completion rate less than 20%:** Financial Performance Measures will not apply
- b. **Wellness Profile completion rate of 20% but less than 30%**

<u>ROI</u>	<u>REFUND AMOUNT</u>
2.0 to 1.0 and better	No Refund
1.5 to 1.0 but less than 2.0 to 1.0	Refund 50% of amount at risk
Less than 1.5 to 1.0	Refund 100% of amount at risk

- c. **Wellness Profile completion rate of 30% but less than 50%**

<u>ROI</u>	<u>REFUND AMOUNT</u>
2.5 to 1.0 and better	No Refund
2.0 to 1.0 but less than 2.5 to 1.0	Refund 50% of amount at risk
Less than 2.0 to 1.0	Refund 100% of amount at risk

- d. **Wellness Profile completion rate of 50% or greater**

<u>ROI</u>	<u>REFUND AMOUNT</u>
3.0 to 1.0 and better	No Refund
2.5 to 1.0 but less than 3.0 to 1.0	Refund 50% of amount at risk
Less than 2.5 to 1.0	Refund 100% of amount at risk

EXHIBIT B

2. Operational Performance Measures

Operational activities include Outreach (Attempt to Contact) and Active Engagement. The amount at risk under the Operational Performance Measures shall be measured only within the applicable measurement year and will not exceed twenty percent (20%) of the Intensive Model Program fee received by Highmark Delaware under this Agreement for the specified measurement year.

Outreach:

Highmark Delaware will outreach (attempt to contact) a minimum of 16.3% of adult members** eligible for the Intensive Model Program.

Attempt to Contact – The member has been identified by the Intensive Model Program for coaching outreach and intervention.

Actively Engaged:

Highmark Delaware will actively engage a minimum of 6.1% of adult members** eligible for the Intensive Model Program.

Actively Engage - The member, health care provider or designee has been contacted by an Intensive Model Program health or wellness coach and has participated in an assessment to develop the intervention plan through one of the telephonic programs. A member is considered engaged when the member has agreed to participate in discussions and goal setting with a Highmark Coach.

**** Adult members are defined as employees and their spouses 18 years of age or older. Medicfill and COBRA participants are excluded**

Depending on the clinical circumstances, a member may be contacted or engaged multiple times during the measurement period.

Failure to meet the operational measures will result in a 50.0% refund of the amount at risk for operational measures for each one missed.

Highmark Delaware reserves the right to change (add or delete) or otherwise revise the measures and methodologies applied, at any time and in its sole discretion, without advance notice, either written or oral, to the Plan Sponsor, for the purpose of enhancing the Intensive Model program in cases where such enhancements will apply across Highmark's book-of-business. Mutual agreement of the parties is required for any other enhancement.

