THIRD PARTY ADMINISTRATION CONTRACT
FOR
MEDICAL CLAIMS ADMINISTRATION

CONTRACT #: HCBD22-0161NH

THIS Agreement is entered into by and between the State of Montana, Department of Administration, Health Care and Benefits Division, (State or HCBD), and Health Care Service Corporation, (Contractor), a Mutual Legal Reserve Company. Blue Cross Blue Shield of Montana is a division of Contractor.

1. TERM, RENEWALS

1.1 **Term**. This agreement's initial term is January 1, 2023 (Effective Date) through December 31, 2025 (Initial Term), unless terminated earlier as provided for herein. This agreement is not binding on State unless State's authorized representative signs it.

1.2 **Renewal**. State may renew this agreement in one-year intervals, or any interval that is advantageous to State. This term of this agreement, including any renewals, may not exceed ten years.

2. SERVICES AND/OR SUPPLIES

Contractor shall provide State third party administrator services (Services) for the State of Montana Benefit Plan (State Plan) medical benefits, in Exhibit A, Scope of Services, solicitation #: DOA-HCBD-RFP-2022-0161NH, and the Contractor's response to that solicitation. Contractor shall perform the Services pursuant to the performance guarantees in Exhibit B.

3. STANDARDS OF CARE

Contractor shall: a) perform (or cause to be performed) its duties hereunder in a competent manner; and b) exercise the degree of care, diligence, and skill that a similar third-party administrator would exercise in comparable circumstances.

4. FEES, PAYMENT AND FEE DISCLOSURE

4.1 **Administrative Fees, Payment**. State shall pay Contractor the administration fee(s) in Exhibit C within 30 days of the date the monthly billing report is generated. A monthly billing report is generated the first of each month from State's benefit administration system. The report reconciles administrative fees for the prior 60-day period using the 15th of a month as the cutoff to bill State for newly eligible primary account holders. Administrative fees are credited for retroactive terminations of primary account holders. Contractor shall provide banking information no later than ten business days after the Effective Date to facilitate State electronic funds transfer payments to Contractor.

The primary account holder means an individual enrolled in the State Plan and who is one of the following: active employee, Medicare retiree, retiree, legislator, or COBRA participant, and is listed as the primary account holder. If both spouses are active employees enrolled in the State Plan with the Joint Core coverage option, State will pay the administrative fee for the primary account holder only.

4.2 **Program Service Fees**. State shall pay Contractor the fee(s) for any program(s) offered through Contractor and elected by State, and for which a separate fee is charged. Program service fees

are described in Exhibit C and may include a PEPM amount and/or a pass-through fee from a third-party vendor of Contractor.

4.3 **Compliance Service Fees**. Contractor shall invoice State for any fees related to additional compliance services elected by State and described in Exhibit C, including but not limited to services to help State comply with applicable requirements of the Consolidated Appropriations Act of 2021 and the Patient Protection and Affordable Care Act of 2010, as amended.

4.4 **Fee Changes**. For any renewal term, Contractor shall provide proposed fee increases with written justification no later than 180 days prior to the end of the current term (initial or renewal). Contractor's proposed increase(s) shall not exceed a 3% increase to any one fee. State is not obligated to accept Contractor's proposed fee increases, or to agree to any fee increase.

4.5 **Fee Disclosure**. Contractor agrees that Contractor's compensation related to this agreement and the Services is limited to the administrative fees in Exhibit C. Contractor shall acknowledge in writing that Contractor receives no other direct or indirect compensation related to this agreement, including but not limited to bonuses, finder's fees, prepaid commissions, payments by third parties, or incentive programs. Contractor shall provide the written fee disclosure acknowledgement on or before March 31st, 2024, and each March 31st thereafter.

5. CLAIMS PAYMENT

5.1 **Claims Payment**. On a day set by agreement of the parties (Invoice Date), Contractor shall provide a full check register with invoicing for all medical claims and program fees, as applicable, adjudicated for payment on a schedule determined by the parties. The check register must include at a minimum for each claim payment, provider name, State Plan member name, date of service, and payment amount, and identify any claims paid in excess of the dollar amount set by State. If the Invoice Date falls on a state-recognized holiday, the Invoice Date will be the first business day following that holiday. State shall pay Contractor the invoiced amount within five business days of receipt of Contractor's invoice.

5.2 **Overpayments**. Contractor shall recover overpayments and reimburse State within 30 days of recovery. If Contractor is unable to recover the overpayment and if the overpayment is due to an act or omission by the Contractor rather than the act or omission of a third party, Contractor shall reimburse State the total amount of the unrecovered overpayment. State shall collaborate and cooperate with Contractor as necessary, to pursue and/or prosecute fraudulent payments or payments made due to an egregious provider billing practice.

Contractor will send three separate refund request letters to the recipient of the overpayment, at one or two-month intervals unless circumstances necessitate a longer or shorter time. If the recipient fails or refuses to refund the overpayment within one year from the date of the original claim payment, Contractor will reimburse State for the overpayment as agreed upon by the parties.

The overpayment recovery process in this Section 5.2 does not apply to any individual claim overpayment of $5,000 or more, or a claims processing situation involving multiple claims with the same overpayment reason. State and Contractor shall review each of these overpayment scenarios on a case-by-case basis and determine an appropriate resolution. If the parties cannot agree on a resolution, State shall direct the resolution of the overpayment recovery for that scenario.

6. ACCESS AND RETENTION OF RECORDS

6.1 **Access to Records**. Contractor shall provide State, the Montana legislative auditor or their authorized agents reasonable access to the records necessary to audit compliance with the terms

and conditions of this agreement. The protected health information or other individually identifiable information of State Plan members may only be accessed or disclosed to State or the legislative auditor in accordance with federal laws governing privacy and security of such information, Section 9, and the BAA between the parties.

6.2 **Record Retention**. Contractor shall maintain all records (written or electronic) documenting compliance with the requirements of this agreement and its attachments, and with state and federal law, relating to Contractor's compliance hereunder during the term of this agreement and for eight years following the termination or expiration of this agreement. Contractor must maintain any Protected Health Information of State Plan members, any logs maintained to document an accounting of disclosures of such records, and any other records related to maintenance and storage of the Protected Health Information for a minimum of six years.

7. OWNERSHIP OF DATA

Except for Contractor's Confidential Information, all claim data, information, work in progress, documents, and reports prepared by Contractor under this contract or submitted to Contractor on behalf of State and the State Plan, both in hard-copy form and as may be embodied on any recording and storage media, is deemed State property. Upon completion of the Services or the termination or expiration of this contract, State property shall be turned over to State. State property includes but is not limited to, allowable fee data, claims payment details, claim discounts, other negotiated claim reimbursements, and any other information, related to the State Plan medical claims. This section survives termination or expiration of this agreement.

8. CONFIDENTIALITY

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8.1 **Definition of Confidential Information**. "Confidential Information" means the written or oral information of the disclosing party, related to the operations of that party or a third party that has been identified as confidential or that by the nature of the information or the circumstances surrounding disclosure ought reasonably to be treated as confidential. Confidential Information does not mean the State Data of State Plan members in Section 9. If the Confidential Information is disclosed orally, disclosing party shall reduce the information to writing no later than ten days after disclosure. Failure to put the information in writing eliminates recipient's obligation to keep the information confidential.

8.2 **Request for Confidential Classification**. Contractor shall identify and segregate any document or other information Contractor claims as Confidential Information, mark as "Confidential" and provide a legal analysis supporting the claim of confidentiality. Contractor shall complete State's affidavit of trade secret status, or, alternatively, a form signed by Contractor's legal counsel attesting to the confidential nature of the information.

State shall review Contractor's claim for Confidential Information. If State disagrees with Contractor's determination of the confidential nature of the identified information, State shall notify Contractor. Contractor may change its confidentiality designation or maintain the designation and defend its claim against a public records request.

8.3 **Protection of Confidential Information**. Except as provided otherwise in this agreement and Montana open records laws, the recipient agrees: (i) to use the Confidential Information for the purposes described herein; (ii) not to reproduce the Confidential Information and to hold in confidence and protect the Confidential Information from dissemination to, and use by, any third party; (iii) to not create any derivative work from the Confidential Information; (iv) to restrict access to its employees, agents, and/or consultants, if any, with a need for access; and (v) return or destroy all Confidential Information in its possession upon termination or expiration of this agreement. If recipient determines that return or destruction of the Confidential Information is not feasible, the recipient shall notify the disclosing

party of the conditions that make return or destruction infeasible. The recipient shall extend the protections of this section to that information and limit further uses and disclosures of such to those purposes making return or destruction infeasible, for so long as the recipient stores and maintains the information.

8.4 **Exception**. The provisions of this section do not apply to Confidential Information that (i) is publicly available or in the public domain at the time disclosed; (ii) is or becomes publicly available or enters the public domain through no fault of the recipient; (iii) is rightfully communicated to the recipient by persons not bound by confidentiality obligations with respect thereto; (iv) is already in the recipient's possession free of any confidentiality obligations with respect thereto at the time of disclosure; (v) is independently developed by the recipient; or (vi) is approved for release or disclosure by the disclosing party without restriction.

8.5 **Disclosures**. Recipient may disclose Confidential Information to the limited extent required to comply with the order of a court or other governmental body, or as otherwise necessary to comply with applicable law, provided, that recipient, as early as reasonably possible under the circumstances, gives written notice to disclosing party.

If recipient is State, State shall promptly provide Contractor notice of any request from a third-party seeking release of Confidential Information that Contractor has properly made a request for confidentiality as set forth above and allow Contractor the opportunity to resolve the issue with the requester and/or file an action in court to protect the information.

Contractor acknowledges that State has no obligation to defend Contractor's claim of confidentiality.

8.6 **Survival**. This section survives the termination or expiration of this agreement.

9. DATA PRIVACY, SECURITY AND USE

9.1 **Privacy and Security**. Contractor acknowledges and agrees that all protected health information or PHI of State Plan members (State Data) is subject to the protections of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, the Health Information Technology for Economic and Clinical Health Act, Pub. L. 111-5, as amended, and their implementing regulations ("HIPAA"). Contractor is a business associate of the State Plan and has executed a Business Associate Agreement ("BAA") with the State Plan, attached hereto as Exhibit D.

9.2 **Secure Environment**. Contractor shall provide a secure environment for State Data stored by Contractor or Contractor's designee, and any hardware and software (including servers, network, data components, including any health applications on a mobile device) to be provided or used by Contractor to comply with this agreement.

Contractor's security measures must meet the requirements in Exhibit E, Security Procedures and Standards and at a minimum, remain compliant with the NIST 800-53 (most recent version), Security and Privacy Controls for Information Systems and Organizations (collectively, "Security Best Practices"). Contractor shall require its subcontractors with access to State Data to adhere to the requirements of the section.

9.3 **Contractor's Use of State Data**. Contractor may not use mailing lists generated as part of this agreement for any reason other than to provide the Services. Contractor may not use, sell, rent, transfer, distribute, or otherwise disclose State Data for Contractor's own purposes or for the benefit of anyone other than the State without State's prior written consent.

9.4 **Off-Shore Storage**. Contractor, including Contractor's subcontractors, will not store State Data outside of the continental United States.

9.5 **Security Records and Audit**. Contractor shall maintain complete and accurate records relating to its data protection practices, IT security controls, and security logs of State Data, including any backup, disaster recovery or other policies, practices or procedures relating to State Data.

Upon State's request, Contractor shall make all such records, appropriate personnel and relevant materials available during Contractor's normal business hours for inspection and audit by State or an independent data security expert that is reasonably acceptable to Contractor, provided State: (i) gives reasonable advance notice, (ii) undertakes such audit not more than once per one-year period, except for good cause, and (iii) conducts or causes to be conducted such audit in a manner designed to minimize disruption of Contractor's normal business operations.

State may request a copy of a SOC II, Type II third party audit, or annual HITRUST certification to demonstrate Contractor's compliance with Security Best Practices. Contractor may submit a copy of the summary report and/or make available to State for on-line review, the complete report. Copies of any such audit reports or certifications provided to State will be considered Contractor's Confidential Information.

9.6 **Survival**. This section survives the termination or expiration of this agreement.

10. ASSIGNMENT, TRANSFER, AND SUBCONTRACTING

Contractor may not assign, transfer, or subcontract this agreement or any portion thereof, without State's prior written authorization. Any assignment or transfer of Contractor's rights or delegation of duties under this agreement does not relieve Contractor from compliance with all its obligations under this agreement. Contractor shall be as fully responsible for the acts or omissions of any assignee or subcontractor as it is for its own acts or omissions.

11. DEFENSE AND INDEMNIFICATION

11.1 **Duty to Defend**. Contractor, at its sole cost and expense, shall respond to and defend the state of Montana and the contracting agency or other instrumentality of the state of Montana, and their employees, officers, officials, agents, and volunteers (collectively, Indemnitees) from and against all claims, allegations, lawsuits, or any other action (each a Claim, or collectively, Claims) relating to personal injury, death, damage to property, financial loss, loss of data, or other loss arising or allegedly arising out of or in connection with any of the following:

11.1.1 The performance of Contractor's duties hereunder, unless the act or omission was taken at the express written direction of State; or
11.1.2 A claims administration process of Contractor, Contractor's employee, agent, or subcontractor that was not authorized in writing by State and that was used to adjudicate or process State Plan claims; or
11.1.3 The negligent or willful or alleged negligent or willful act or omission of Contractor or its employee, agent or subcontractor in the review or processing of a claim or any other process related to a State Plan member claim; or
11.1.4 A failure by Contractor or its subcontractor to comply with state or federal law in the performance of Contractor's duties hereunder; or
11.1.5 A breach of Contractor's duties and obligations under this agreement.

11.2 **Duty to Indemnify**. Contractor shall indemnify the Indemnitees against liabilities, losses, damages, judgments, awards of reasonable plaintiff counsel's fees and interest due to plaintiffs,

settlements, penalties, fines, attorney/expert fees, or other expenses and costs (including the reasonable cost of investigation of a Claim, and any advance of an expense or fee) arising from a Claim, unless the Claim arose due to an act or omission by the Contractor taken at the express written direction of the State.

11.3 **Notice of Claim**. State shall give Contractor prompt notice of any allegation of a Claim and at Contractor's expense, State shall cooperate in the defense of the matter. Contractor shall accept the tender, no matter the validity of the Claim, and proceed to respond to and defend against the Claim.

11.4 **State Reimbursement**. If Contractor fails to comply with its duty to defend under this section, State may undertake its own defense. If State undertakes its own defense, Contractor shall reimburse State for all costs of defense including but not limited to reasonable attorney fees, costs to investigate a Claim, discovery costs, expert witness fees, and court costs.

11.5 **Survival**. This section survives the termination or expiration of this agreement.

12. INSURANCE

12.1 **General Requirements**. Contractor shall maintain throughout this agreement, at its cost and expense, insurance against claims for injuries to persons or damages to property, including contractual liability on the commercial general liability, which may arise from or in connection with the performance of the work by Contractor, its officers, officials, employees, agents, volunteers, or subcontractors. This insurance shall cover such claims as may be caused by any negligent act, error, or omission of Contractor, its employees, agents, or subcontractors.

12.2 **Subcontractors**. If Contractor's policy does not cover its subcontractors, Contractor shall require and verify that all subcontractors maintain insurance meeting the requirements in this section.

12.3 **Excess Limits**. The insurance obligations under this agreement shall be all coverage and/or limits carried by or available to Contractor if greater than the insurance coverage requirements and/or limits in this agreement. Any insurance proceeds in excess of or broader than the minimum required coverage and/or limits stated in this agreement, which are applicable to a given loss, shall be available to State.

12.4 **Primary Insurance**. Contractor's commercial general liability insurance is primary insurance with respect to State, its officers, officials, employees, agents, and volunteers and, if applicable, shall apply separately to each project or location. Any insurance or self-insurance maintained by State, its officers, officials, employees, agents, and volunteers is in excess of Contractor's insurance and will not contribute with it.

12.5 **Commercial General Liability**. Contractor shall purchase and maintain occurrence coverage with combined single limits for bodily injury, personal injury, and property damage of two million dollars per occurrence and two million dollars in the aggregate per year to cover such claims as may be caused by any negligent act, error, or omission of Contractor or its officers, officials, employees, agents, volunteers, or subcontractors.

State, its officers, officials, employees, agents, and volunteers are to be listed as additional insureds for liability arising out of activities performed by or on behalf of Contractor, including the insured's general supervision of Contractor; products, and completed operations; and the premises owned, leased, occupied, or used.

Contractor grants to State a waiver of any right to subrogation which any insurer of Contractor may acquire against State by virtue of the payment of any loss under insurance. Contractor shall obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether State has received a waiver of subrogation endorsement from Contractor's insurer.

12.6 **Professional Liability**. Contractor shall purchase and maintain occurrence coverage with combined single limits for each wrongful act at a minimum of two million dollars per occurrence and two million dollars in the aggregate per year to cover such claims as may be caused by any act, omission, negligence of Contractor or its officers, officials, employees, agents, or subcontractors. Note: If "occurrence" coverage is unavailable or cost prohibitive, Contractor may provide "claims made" coverage provided the following conditions are met: (1) the Effective Date of this agreement must not fall outside the effective date of insurance coverage and it will be the retroactive date for insurance coverage in future years; and (2) the claims made policy must have a three-year tail for claims that are made (filed) after the cancellation or expiration date of the policy.

12.7 **Self-Insured Retentions**. Any self-insured retention must be disclosed to State. Any deductible is the responsibility of the Contractor.

12.8 **Certificate of Insurance/Endorsements**. A certificate of insurance from an insurer with a Best's rating of no less than A- indicating compliance with the required coverages must be received by State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135. The certificates must name the State of Montana as certificate holder. Contractor shall notify State promptly of any material change in insurance coverage, such as changes in limits, coverages, or status of policy, etc.; and within 30 days of the cancellation of any insurance coverage. State may request a copy of the policy declarations and endorsement page for Contractor's policies.

12.9 **Fidelity Bond**. Contractor shall purchase and maintain a fidelity bond in the amount of not less than one million dollars per occurrence and two million dollars in the aggregate that provides coverage for employee dishonesty, forgery or alteration, fraud and embezzlement, burglary and theft of cash, securities, or other property inside or outside the premises, computer fraud, funds transfer fraud, money orders, counterfeit currency, and other dishonest acts of any employee, agent, or subcontractor whose duties are to receive, handle or have custody of money, checks, securities, electronic funds, or account for supplies or other property. The policy must allow for reporting of circumstances or incidents that might give rise to a future claim and include an extended reporting period of no less than three years with respect to events that occurred but were not reported during the term of the policy.

12.10 **Cyber/Data Information Security Insurance**. Contractor shall purchase and maintain cyber liability insurance with limits not less than seven million dollars per claim/annual aggregate. Coverage shall be sufficiently broad to cover the duties and obligations of the Contractor and shall include claims involving security breach, system failure, data recovery, business interruption, cyber extortion, social engineering, infringement of intellectual property except for patents (i.e., infringement of copyright, trademark, trade dress), invasion of privacy, information theft, damage to or destruction of electronic information, release of private information, and alteration of electronic information.

The policy shall provide coverage for breach response costs, forensics investigations, legal fees and costs, regulatory fines and penalties, credit monitoring expenses, and data recovery costs with limits sufficient to respond to these obligations, as required by applicable state or federal law.

Note: If occurrence coverage is not available and claims made coverage is authorized by the State, the following conditions apply:

- The retroactive date must be shown and must be before the Effective Date or the beginning of the performance of Services.

- Insurance must be maintained, and evidence of insurance must be provided for at least three years after completion of the Services.
- If coverage is canceled or non-renewed and not replaced with another claims-made policy form with a retroactive date prior to the Effective Date, Contractor shall purchase "extended reporting" coverage for a minimum of three years after completion of Services.

12.11 **Workers Compensation Insurance**. Contractor shall purchase and maintain workers' compensation insurance to the extent required by the state in which Contractor's employees perform Services. Upon request, Contractor shall provide evidence of workers' compensation insurance. If Contractor is not required by law to have workers compensation insurance, Contractor shall provide written confirmation of the same from the appropriate regulatory agency. Neither Contractor nor its employees are State employees.

13. COMPLIANCE WITH LAWS

Contractor shall, in fulfilling its obligations under this agreement, comply with all applicable federal, state, or local laws, rules, regulations, and executive orders including but not limited to, the Montana Human Rights Act, the Equal Pay Act of 1963, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973. Contractor is the employer solely of its employees and not the employees of the State or any third party for the purpose of providing healthcare benefits and paying any applicable penalties, fees and taxes under the Patient Protection and Affordable Care Act [P.L. 111-148, 124 Stat. 119]. Any subletting or subcontracting by Contractor obligates subcontractors to the same requirements.

In accordance with 49-3-207, MCA, and Executive Order No. 04-2016, Contractor agrees that: 1) the hiring of persons to fulfill Contractor's obligations under this Contract will be made based on merit and qualifications, and 2) there will be no discrimination based on race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status, or marital status by the persons complying with this agreement.

14. LICENSURE/REGISTRATION WITH STATE

14.1 **Licensure**. Contractor shall maintain throughout the Initial Term and any renewal term of this agreement, the licensure, registration and/or certification required to operate in Montana as a third-party administrator. Contractor shall provide written evidence of the same annually to State.

14.2 **Business Registration**. Contractor shall register with the Secretary of State and obtain a certificate of authority to demonstrate good standing in Montana. To obtain registration materials, call the Office of the Secretary of State at (406) 444-3665, or visit their website at http://sos.mt.gov.

15. TERMINATION

15.1 **Termination for Cause with Notice to Cure**. Either party may terminate this agreement in whole or in part for the other party's failure to comply with any of the other party's duties or obligations after giving the other party written notice of the stated failure. Written notice shall provide the other party with a reasonable opportunity of at least 30 days to cure the breach. If the other party does not cure the breach within the specified period, the party providing notice may terminate the agreement without further notice. Alternatively, State may, following the 30-day notice of intent to terminate and opportunity to cure, elect to withhold payment of the administrative fees related to Contractor's non-performance of the duty or obligation until Contractor cures the breach. A breach for which notice of intent to terminate and

opportunity for cure may be given by the State may include Contractor's inability to administer a benefit or plan design of the State Plan, Medical Summary Plan Description and for which Contractor did not disclose to State during solicitation DOA-HCBD-RFP-2022-0161NH on the form known as the Plan Design Deviation Form.

15.2 **Termination for Convenience**. State may, by written notice to Contractor, terminate this agreement without cause and without incurring liability to Contractor except as set forth in this Section 15.2. State shall give written notice of termination to Contractor at least 180 days before the effective date of termination. State shall pay Contractor that amount, or prorated portion thereof, owed to Contractor up to the date State's termination takes effect. This is Contractor's sole remedy. State shall not be liable to Contractor for any other payments or damages arising from termination under this section, including but not limited to general, special, or consequential damages such as lost profits or revenues.

15.3 **Reduction of Funding**. State may, with a 30-day prior written notice, terminate this agreement if federal or state government funds that directly or indirectly finance the State Plan are not appropriated or become unavailable or reduced for any reason. State shall be liable to Contractor for the payment, or prorated portion of that payment, owed to Contractor up to the date State's termination takes effect. This is Contractor's sole remedy. State shall not be liable to Contractor for any other payments or damages arising from termination under this section, including but not limited to general, special, or consequential damages such as lost profits or revenues.

15.4 **Immediate Termination**. State may terminate this agreement with a three-business day prior written notice if: a) Contractor engages in any violation of state or federal law applicable to Contractor's compliance hereunder if such violation is intentional or represents a continuing pattern or practice of violations of state or federal law, whether such pattern or practice is intentional or unintentional; or b) if Contractor files for voluntary or involuntary bankruptcy or receivership and State's termination is permitted by federal bankruptcy law.

15.5 **Replacement Services**. If Contractor fails to comply with any of its duties or obligations hereunder, State may, at State's sole election, obtain replacement services and offset any amount paid by State for such replacement services against amounts owed or payable to Contractor under this agreement.

15.6 **Right to Assurance**. If State, in good faith, has reason to believe that Contractor does not intend to, or is unable to comply or has refused to comply or continue complying with any or all of Contractor's duties and obligations under this agreement, State may demand in writing that Contractor give a written assurance of intent to comply. Contractor's failure to provide written assurance within the number of days specified in the demand (not less than five business days) may, at State's option, be the basis for terminating this agreement.

15.7 **Limitation on State Liability**. State's liability under this section shall be that amount, or prorated portion thereof, of unpaid administrative fees for Services performed by Contractor up to the date the termination takes effect. This is Contractor's sole remedy. State shall not be liable to Contractor for any other payments or damages arising from termination, including but not limited to general, special, or consequential damages such as lost profits or lost revenues

15.8 **Other Remedies**. Any remedies provided by this agreement are not exclusive and are in addition to any other remedies provided by law.

16. TRANSITION ASSISTANCE

16.1 **Claim Run-Out Services**. Upon delivery of a notice of the expiration or termination of this agreement, Contractor shall work cooperatively with its successor, State or other third party to facilitate

an orderly transfer of Contractor's duties. At State's request, Contractor shall provide claim run-out services for a 12-month period beginning the day following expiration or termination of the agreement (the "Transition Assistance Period"). Claim run-out services include the processing of a medical claim for a service incurred prior to the expiration or termination of this agreement and received by Contractor before the end of the Transition Assistance Period. Claims run-out services during the Transition Assistance Period also include monthly transmission of standard data extract files to State's data warehouse, monthly claims summary reporting, and a data file of deductibles, copayments, coinsurance, maximum out-of-pocket accumulators, and other benefit accumulators.

16.2 **Contractor Performance**. Contractor shall perform its duties under this agreement during this Transition Assistance Period without interruption or degradation in service delivery.

16.3 **Fees.** The fee for claim run-out services is a one-time amount equal to three times the monthly administration fee in section 4.1 for the last full month of the last term of this agreement times the number of primary account holders for that same month. This fee amount is State's sole obligation to Contractor for claims run-out services during the Transition Assistance Period.

16.4 **State Plan Documentation.** At State's request, Contractor shall provide a copy of any State Plan documentation in Contractor's possession at termination in the format requested by State (hard copy or electronic).

17. FORCE MAJEURE

Neither party will be liable for any failure or delay in performing its duties in this agreement due to Force Majeure Events. "Force Majeure Event" means an event or circumstance beyond a party's reasonable control, such as natural catastrophes and acts of terrorism or war, and the consequences of that event or circumstance. Force Majeure Events do not include labor unrest, price increases, changes in general economic conditions, or a pandemic or other similar national disaster. If a Force Majeure Event continues for 30 days, the other party may terminate this agreement or suspend payment of administrative fees or the performance of Services, as applicable, while the event continues.

18. LIAISON, SERVICE OF NOTICES

18.1 **Liaison**. Liaisons serve as the primary contacts for the parties regarding this agreement. Written notices, reports and other information required to be exchanged between the parties must be directed to the appropriate liaison.

Amy Jenks is State's liaison.
Phone Number (406) 444-2528,
Fax Number (406) 444-0080,
Email: ajenks@mt.gov.

Ginger MacDonald is Contractor's liaison.
Phone Number: (406) 437-6334,
Alternative Phone Number: (406) 459-8342.
Email: ginger_macdonald@bcbsmt.com.

18.2. **Notice**. Any notices or communications required or permitted to be given by this agreement must be (i) given in writing and (ii) personally delivered or mailed, by prepaid, certified mail or overnight courier, or transmitted by facsimile or electronic mail transmission, to the party to whom such notice or communication is directed, to the mailing address or regularly monitored electronic mail address of the party's liaison.

18.3 **Delivery of Notice**. Any such notice or communication shall be deemed to have been given on (i) the day such notice or communication is personally delivered, (ii) five days after such notice or communication is mailed by prepaid certified mail, (iii) one working day after such notice or communication is sent by overnight courier, or (iv) the day such notice or communication is faxed or sent electronically, provided that the sender has received confirmation of delivery. If the sender does not receive a confirmation, it shall provide notice by another means allowed under this section.

18.4 **Change in Liaison**. A party may change its address, fax number, email address or the person to whom a notice or other communication is marked to the attention of, by giving notice of such change to the other party's liaison.

19. CONTRACT MANAGEMENT

Contractor shall meet with State to resolve technical or contract problems or to discuss the progress made by Contractor and State in compliance with their respective obligations, at no additional cost to the State. State may request the meetings as problems arise and meetings will be coordinated by State. State shall provide Contractor prior notice of meeting date, time, and location.

20. CHOICE OF LAW AND VENUE

This agreement shall be governed by and interpreted according to Montana law. Any litigation concerning this agreement shall be brought in First Judicial District Court in and for Lewis and Clark County, State of Montana. Each party shall pay its own costs and attorney fees, except as otherwise stated in this agreement. (18-1-401, MCA)

21. TAX EXEMPTION

The State of Montana is exempt from Federal Excise Taxes (#81-0302402) except as otherwise provided in the federal Patient Protection and Affordable Care Act [P.L. 111-148, 124 Stat. 119].

22. PERSONAL PROPERTY TAX

Contractor shall pay all property taxes, if any, for all property it owns or for which it is otherwise legally obligated to pay.

23. SEVERABILITY

If any provision of this agreement is held invalid, illegal or unenforceable in a judicial proceeding, the remainder of the agreement shall be construed as if it did not contain that particular provision, and the rights and obligations of the parties shall be construed and enforced accordingly to effectuate the intent and purpose of the agreement.

24. SCOPE, ENTIRE AGREEMENT, AND AMENDMENT

24.1 **Scope**. This agreement consists of the agreement, all attachments, exhibits, and amendments thereto, final Solicitation #DOA-HCBD-RFP-2022-0161NH, and Contractor's final response to the solicitation. If there is a dispute or ambiguity arising between or among the documents, the order of precedence of document interpretation is as follows: amendments to the agreement, the agreement, the exhibits and attachments, solicitation # DOA-HCBD-RFP-2022-0161NH, and Contractor's response to solicitation #: DOA-HCBD-RFP-2022-0161NH.

24.2 **Entire Agreement, Amendment**. These documents are the entire agreement of the parties. They supersede all prior agreements, representations, and understandings. Any amendment or modification must be in a written agreement signed by the parties.

25. WAIVER

State's failure to complain of any Contractor act or omission, no matter how long the same may continue, may not be deemed to be a waiver by State of any of its rights hereunder. No State waiver, express or implied, of any breach of this agreement may be deemed a waiver of consent to any subsequent breach of the same or any other provision.

26. EXECUTION

The parties acknowledge that they have read this agreement, understand it, and agree to be bound by its terms.

State of Montana, Department of Administration,
Health Care and Benefits Division
100 N Park Ave, Ste 320
PO Box 200130
Helena, Montana 59620-0130

Contractor

BY: Misty Ann Giles
Director, Department of Administration

DocuSigned by:
Misty Ann Giles 9/15/2022
4EE6E5CA5FE0409...
(Signature)

BY: Collette Hanson
Title: President, Blue Cross and Blue Shield of Montana

DocuSigned by:
Collette Hanson 9/13/2022
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(Signature)

Approved as to Legal Content:

DocuSigned by:
Jerry Hagan 9/13/2022
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Legal Counsel

Approved as to Form:

DocuSigned by:
Nolan Harris 9/13/2022
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Procurement Officer
State Procurement Bureau

EXHIBIT A

Contract No. HCBD22-0161NH

SCOPE OF SERVICES

1. Benefit and Eligibility Plan Design.

   a. Contractor shall administer the State Plan medical benefits in accordance with State's current Wrap Plan Document, Medical Summary Plan Description, and other plan documents approved by State, and with applicable law.

   b. Contractor shall consult with State as necessary, to develop alternative plan designs, multiple plans, or benefit changes.

   c. Contractor shall develop plan documents in conjunction with State, and any necessary forms to administer benefits in the Medical Summary Plan Description.

   d. Upon request, Contractor shall collaborate with State Plan vendors identified by State.

2. Provider/Facility Reimbursement.

   a. Contractor will provide a reimbursement strategy that targets a total aggregate reimbursement level for all in-state and out-of-state facility claims (inpatient and outpatient) not to exceed 195-200% of Medicare in year one.

   b. Contractor will provide a reimbursement strategy that targets a total aggregate reimbursement level for all in-state and out-of-state professional/ancillary provider claims not to exceed 139% of Medicare in year one.

   c. Contractor will target an aggregate reimbursement level for the combined inpatient facility, outpatient facility, and professional/ancillary provider claims of 180% of Medicare by year three of the agreement.

   d. During the initial three-year term, Contractor will employ provider reimbursement strategies that include networks with reference-based pricing methodologies, such as a predetermined fixed unit-cost amount that uses a static base schedule and is adjusted through a negotiated multiplier rate by provider type (e.g., percentage of the CMS Medicare rate). With State's approval, Contractor will employ and/or implement alternative provider payment models to lower provider reimbursements, including but not limited to targeted provider contracting, negotiating single-case agreements for high dollar claims, creating steerage to Blue Distinction Centers through special contracted rates, value-based care programs and focused contracting to reduce reimbursement for outlier facilities.

   e. Total aggregate reimbursement for all inpatient facility, outpatient facility, and professional/ancillary provider claims will be measured annually for a 12-month incurred period with a minimum of 15 paid months for adequate runout each calendar year and made available by Contractor beginning May 1, 2024, and each May 1st thereafter.

   f. Subject to State's approval, Contractor will administer custom alternative payment arrangements with providers.

3. Provider Networks and Provider Credentialing. Contractor shall provide broad access to provider networks for Montana-based and out-of-state facilities and providers subject to the following:

   a. Participation by at least 95% of Montana-based inpatient facilities, including but not limited to acute care hospitals., critical access hospitals, nursing homes, rehabilitation hospitals, inpatient psychiatric facilities, and drug and alcohol addiction treatment facilities.

b. Participation by at least 95% of Montana-based outpatient facilities, including but not limited to ambulatory surgery centers, reference laboratories, dialysis treatment centers, and imaging centers.

c. Participation by at least 90% of Montana-based professional and ancillary healthcare providers., including but not limited to physicians, dentists, mid-level providers, physical and occupational therapists, speech language pathologists, and mental health providers.

d. Participation by at least 85% of ground and air ambulance providers operating within Montana.

e. Access to the Blue Card National PPO network for out-of-state care and treatment with participation by at least 90% of inpatient/outpatient health care facilities, professional/ancillary health care providers, and ground/air ambulance providers.

f. Access to the Blue Distinction Specialty Care program for transplants, Centers of Excellence (Blue Distinction Centers and Blue Distinction Centers+) within Montana and out-of-state for specialty care.

g. No additional access fees for use of any of the above-referenced network options, except for Arizona, Louisiana, Nebraska, North Dakota, Tennessee, West Virginia, and Wyoming. Access fees in these listed states are 1.96% per claim up to a maximum total of $2,000 per case.

h. Contractor shall credential and re-credential every three years to verify through various licensing agencies that providers have the necessary licensure, certification or other credentials and are not listed on any federal government sanctions database.

i. The in-state network percentages above apply to health care providers who are actively licensed and practicing in Montana and eligible to contract with Contractor. Eligibility includes the willingness or ability of a provider or facility to contract with Contractor under reasonable terms and conditions. If the total percentage of any type of provider or facility is less than the minimum percentage listed, the State and Contractor shall review Contractor's network to determine if it is or remains sufficient in numbers and types of providers and facilities to assure that all covered State Plan services are accessible to State Plan members without unreasonable delay, within a reasonable proximity, and with sufficient provider choice, based on the overall availability of those types of providers and facilities.

4. Eligibility Administration. Contractor shall:

a. Administer the State Plan enrollment and eligibility rules in accordance with State's current Wrap Plan Document. Contractor acknowledges State will determine the effective date of coverage and termination date for State Plan members.

b. Accept automated daily enrollment and eligibility feeds from State's benefit administration system. File feeds will include future and retroactive dates for the effective date of coverage and the termination date.

i. Contractor shall identify eligibility file errors, data discrepancies, or missing files and notify State and its benefit administration system within 24 hours of discovery, and work with State and its benefit administration system to resolve in a timely manner.

ii. Contractor will assign a unique identifier to each State Plan member or accept State's unique identifier, and cross reference the identifier against social security numbers.

c. Provide eligibility file feeds to other State Plan vendors on a schedule to be determined by State.

d. Coordinate with State's pharmacy benefit manager to monitor and update Medicare retiree eligibility data for State Plan retirees, as necessary to ensure State Plan compliance with State's Employer Group Waiver Program requirements.

e. Provide new enrollee welcome packets.

f. Provide co-branded virtual ID card through a secure website or mobile app and generate and distribute printed ID cards within 7 days of enrollment for new enrollees. Provide updated ID cards for benefit plan changes or other circumstance that require an updated ID card. ID cards must list dependents by name.

g. Conduct regular eligibility audits to ensure eligibility information in Contractor's system meets eligibility requirements of the State Plan.

5. COBRA Administration. Contractor shall provide COBRA administration services for all State Plan benefits eligible for COBRA, in accordance with federal law. Specifically, Contractor shall:

   a. Assume COBRA administration for existing COBRA participants as of January 1, 2023 and COBRA qualified beneficiaries who have not yet elected COBRA by January 1, 2023 but are within an election period.

   b. Accept weekly COBRA qualifying event files provided by State's benefits administration system.

   c. Provide compliant COBRA notices, including, election notices, disability extension notices, second qualifying event notices to COBRA qualified beneficiaries, and other required notices as may be requested by State.

   d. Coordinate with State to include other State-specific notices in the election packet, including but not limited to the Montana Health Center transition of care notice.

   e. Notify State Plan vendors of COBRA elections by qualified beneficiaries, COBRA coverage periods (including second qualifying event and disability extensions), and COBRA premium payment status, including any missed payments.

   f. Collect COBRA premium payments from COBRA participants and forward funds to State. Provide late premium payment notices to COBRA participants as necessary.

   g. Administer qualifying extensions of coverage (disability, second qualifying event, Medicare, etc.) as required by federal law.

   h. Provide a monthly automatic eligibility feed of COBRA participants to State's data warehouse by the 5th of each month.

   i. Provide monthly reporting to State on all relevant COBRA administration activity (including but not limited to elections, monthly premium collection, etc.) Provide telephone support and secure online website access to COBRA qualified beneficiaries and participants. Contractor's team must be:
      i. Available from 8:00am to 5:00pm MST, Monday through Friday, excluding state and federal holidays,
      ii. Located within the United States, and
      iii. Speak fluent English if English is not the primary language.

   j. Provide an online portal that enables COBRA participants and State staff to view history of all COBRA related events including notifications and elections.

6. Customer Service. Contractor shall:

   a. Provide a dedicated member service support team for State Plan member and provider inquiries on eligibility for benefits, claims, participating providers, Contractor programs, State specific benefit and wellness program information, and other topics to assist State Plan members in utilizing their benefits. Contractor's team must be:
      i. Available from 7:00am to 7:00pm MST, Monday through Friday, excluding state and federal holidays,
      ii. Located within the United States, and
      iii. Speak fluent English if English is not the primary language.

b. Provide a 24/7 interactive voice response system for State Plan members to access self-service functions such as requesting an ID card, obtaining claim status information, verifying eligibility, and asking for basic benefits information.

c. Provide a dedicated toll-free customer service telephone number, secure email, mail and an online chat option via a secure website or mobile application through which State Plan members may submit inquiries.

d. Provide annual State-specific training to all member service support team staff responsible for and/or who will respond to State Plan member inquiries.

e. Record member service support team calls with State Plan members and track all calls and other State Plan member inquiries received via mail, email, facsimile or by other methods on an electronic tracking system. Contractor shall retain recorded calls and tracking system records for at least three years and provide copies of the same to State upon request.

f. Provide language translation services in languages necessary for State Plan member needs.

g. Provide quality assurance programs to ensure the accuracy and consistency of member service support team responses to State Plan member inquiries. Contractor shall report annually to State on quality assurance activities.

h. Provide customer service advocates who can evaluate a State Plan member's needs and provide clinical information, and referrals to clinical programs, utilization review, case management, care management, and other programs as appropriate.

7. Member Communications. Contractor shall:

   a. Develop and distribute State-approved plan communications and materials to State Plan members and providers, including but not limited to brochures, new enrollee welcome packets, co-branded ID cards, open enrollment materials, and claim forms.

   b. Provide electronic and paper-based communication tools to help State communicate with State Plan members (i.e., welcome kits, email notifications, posters, videos, newsletters, live chat, and other methods).

   c. Permit State to customize or white label any provider search tools, State Plan member portal/tools, EOB's, ID cards, and other communication materials accessible by State Plan members.

8. Online Services. Contractor shall provide a secure, web-based system and mobile application available 24/7, for State Plan members to verify eligibility, view and order replacement ID cards, verify benefits and check claim status (pending or processed), obtain claims history with line-item claim detail, and obtain copies of EOB's, provider remittance summaries, forms, and other plan documents. Contractor's website and mobile application shall allow for secure email and/or chat with the member support service team. Additionally, Contractor shall:

   a. Notify State of any scheduled or unscheduled downtime, the nature and expected duration, if known, of the downtime.

   b. Post notice on the website and mobile application of any substantive changes to the website or mobile application functionality; and

   c. Resolve issues within 24 hours, unless agreed otherwise by Contractor and State.

9. Claims Processing. Contractor shall process and accurately pay State Plan claims in accordance with applicable federal and state law, State's Wrap Plan Document, Medical Summary Plan Description, and other plan documents. Specifically, Contractor shall:

a. Use a claims system that complies with all applicable ANSI accredited standards and Health Insurance Portability and Accountability Act (HIPAA) EDI standards for medical claims. Contractor's system must be certified by a third-party testing and certification entity identified by the WEDI/SNIP (Workgroup for Electronic Data Interchange, Strategic National Implementation Process) to ensure interoperability with other systems. Contractor shall timely notify State of major system upgrades or enhancements.

b. Provide a dedicated claim processing team that is fully trained on State Plan benefits.

c. Maintain internal levels of claim processing authority to ensure claims are paid according to Contractor's internal quality standards.

d. Provide ability for providers and State Plan members to file claims electronically and via paper.

e. Track benefit accumulators and amounts accumulated towards deductibles, out-of-pocket maximums, and other benefit maximums to correctly process a claim.

f. Provide claim edit software to review submitted claims for coding accuracy, unbundling/bundling, provider fraud or waste, duplication of services, upcoding, inappropriate place-of-service and level of service, and similar billing errors. Edits must match with NCCI (National Correct Coding Initiative) edits or other standard industry claim edits, except for the following deviation:

    i. NCCI Rule for codes: 70544/70551,70552,70553; 70545/70551, 70552, 70553; 70546/70551, 70552, 70553. Contractor will bypass all bundling edits when MRI of the head is billed with MRI of the brain.

g. Process claims in accordance with Contractor's provider contracts or arrangements, or other State-approved methodology for provider reimbursement.

h. Process and pay claims timely as defined by applicable law, State's Wrap Plan Document, Medical Summary Plan Document. Unless directed otherwise by State in writing, Contractor shall process claims in the order received.

i. Provide a process to identify work-related injuries and other accident-related claims to appropriately apply State Plan exclusions for work-related injuries.

j. Produce and provide co-branded EOBs to State plan members that include all elements of a compliant notice of adverse benefit determination as required by 45 C.F.R. §147.136. EOB's must include a description of the State Plan member and provider appeal rights, with detailed instructions on how to file an appeal.

k. Provide read-only claims system access to State for claims history (pending and processed claims), line-item claims detail, EOB's and provider remittance summaries, eligibility information, and State Plan member ID cards.

l. Provide regular, ongoing training for providers in Contractor's claims system, claims submission process, provider contracting and reimbursement programs, patient care management activities (including medical policies), and other areas related to the State Plan.

m. Provide online access to Contractor's system, including medical policies, for providers.

n. Provide ability for State to access archived claims information within 48 hours of request.

10. Claims Review and Appeal Process. Provide a claims review and appeal resolution process for adverse benefit determinations that is consistent with the claims review process described in 45 CFR §147.136 and State's Wrap Plan Document and Medical Summary Plan Description. Contractor shall:

    a. Use up-to-date medical policy that is: 1) based on a review of currently available, clinical information that includes clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and

health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant research, and 2) evaluated at least annually by appropriate, actively practicing physicians, pharmacists, and other providers with current relevant knowledge.

b. Provide access to Contractor's medical policies by State Plan members and providers via online access.

c. Use appropriate licensed and/or certified physicians and other healthcare professionals to make claim determinations that involve clinical judgment (i.e., medical necessity, experimental and investigational, or cosmetic).

d. Use URAC accredited independent review organizations for reviews that require that an independent reviewer utilize clinical judgement to make a benefit determination or a determination on an appeal (i.e., medical necessity, experimental and investigational, or cosmetic.).

e. Support State with second level reviews, including but not limited to providing a complete file of submitted documentation/claims detail, and arranging for any reviews from an independent review organization.

f. Manage the third external level reviews, when such a review is requested from a State Plan member or authorized representative of such.

g. Assist State where necessary with appeals from other benefit programs such as pharmacy, vision, and dental.

11. Claim Errors. Contractor shall identify, adjust, and reprocess claim processing errors to ensure benefit determinations are consistent with the State's Wrap Plan Document and Medical Summary Plan Description. Contractor shall notify State within five days of discovery of a significant and/or systemic claims processing error, provide State with an impact report and plan for resolution within 30 days of the date of discovery.

12. Overpayment Recovery. Contractor shall take all reasonable steps to recover overpayments made in error to providers and State Plan members, or payments made to the wrong party, and reimburse State within 30 days of the date Contractor recovers the overpayment. If Contractor is unable to recover an overpayment or an erroneous payment, and if the overpayment is due to an act or omission by the Contractor rather than the act or omission of a third party, Contractor will reimburse State the full amount of the overpayment or erroneous payment. Contractor shall not do any of the following to recover funds:

    a. Offsetting a future payment of another Contractor client's medical benefit plan by the amount of overpayment recovery due to the State Plan, even if the provider is the same for both plans.

    b. Reducing the overpayment amount due to the State Plan by any fees that Contractor pays itself or a third party to recover the overpayment; or

    c. Requesting a refund of an overpayment more than 12 months from the last processing date, without prior written authorization of State.

13. Third-Party Recovery. Contractor shall not subrogate against or attempt recovery from settlement funds in any third-party recovery situation, excluding a work-related injury or occupational illness situation. Settlement funds may include but are not limited to auto insurance, commercial or residential premises insurance, medical malpractice insurance (self-funded or other) or other similar third-party sources. Settlement funds do not include workers compensation insurance or other similar coverage for occupational injuries or illnesses (self-funded or insured).

14. Coordination of Benefits. Contractor shall collect Coordination of Benefits (COB) information from State Plan members with other insurance coverage and coordinate benefits pursuant to the terms in the State's

Wrap Plan Document for coordination of benefits. Contractor's COB procedures will include an annual process to identify other primary coverage for a State Plan member, which may include solicitations of State Plan members for that information.

15. Patient Care Management Activities. Contractor shall provide patient care management activities for State Plan members and providers, including State Plan member clinical support, case management (including complex case management), care management, disease management and care coordination. Contractor will provide care management activities to State Plan members who are actively engaged in patient care management activities as of January 1st, 2023 or who may be undergoing a course of treatment that commenced prior to January 1, 2023 and that was preauthorized by State's prior claims administrator, with no additional preauthorization requirements unless the treatment plan changes.

    a. General Criteria. Contractor shall ensure patient care management programs meet the following:

        i. Utilization of up-to-date medical policy that is: 1) based on a review of currently available, clinical information that includes clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant research, and 2) evaluated at least annually by appropriate, actively practicing physicians, pharmacists and other providers with current relevant knowledge.
        ii. URAC or NCQA accreditation in the appropriate area. If Contractor utilizes a contracted vendor to perform one or more patient care management activities, Contractor shall use vendors with appropriate URAC or NCQA accreditation.
        iii. Utilization of appropriate licensed and/or certified physicians and other healthcare professionals.
        iv. Contractor's medical professionals and other clinical management team staff coordinate and collaborate as a team to deliver Contractor's patient care management activities and to support State Plan administration.

    b. Utilization Review. Contractor shall conduct utilization review of submitted pre-certification requests, prior authorizations, and current and retrospective review requests.

    c. Case Management. Contractor shall provide case management for care coordination, patient engagement and advocacy, service access, utilization of and transitions of care to State Plan members. Contractor shall identify appropriate State Plan members and stratify these individuals into risk levels for care coordination and intervention and provide a process for patient engagement with case management professionals. Contractor's case management professionals shall coordinate with and support physicians, hospitals, and other providers to assist State Plan members with care needs.

    d. Disease Management. Contractor shall provide prevention, early detection, and timely intervention activities to address gaps in care, and to work with those State Plan members with identified chronic conditions and behavioral health needs to close identified gaps in care for those individuals.

        i. Contractor shall provide programs to address gaps in care for identified condition(s), including but are not limited to a comprehensive maternity management program.
        ii. Contractor shall develop a communication plan and member outreach materials in conjunction with State. Contractor will distribute any State-approved communication materials to State Plan members.

e. Complex Case Management. Contractor shall provide and support complex case management services for identified State Plan members. Services will be delivered through a multi-disciplinary team, led by a medical director and supported by nurses, social workers and other health professionals as appropriate. Specific service components include but are not limited to:

   i. Process to identify State Plan members with multiple or complex medical and/or psychosocial needs or are at risk of developing complex needs during an acute episode of illness.
   ii. Once identified as appropriate for services, complete an individualized assessment for the State Plan member and family unit to identify specific needs, gaps in care and/or any barriers to treatment adherence.
   iii. Provide support and reinforcement of physician recommended treatment plans and therapy.
   iv. Serve as a liaison for the State Plan member to community resources, including arranging for transportation if identified as a barrier to care.
   v. Educate and assist State Plan members to better their understanding of their benefits, conditions, and treatment plans. If a State Plan member may be eligible for additional coverage (e.g., Medicare), assist where necessary in the enrollment for that coverage.
   vi. Facilitate communication among and between the State Plan member, family members and care givers, healthcare providers, community resources and the State Plan to enhance treatment adherence and quality of life for the State Plan member.
   vii. Track and report episodes of illnesses at the individual and aggregate levels to identify trends, measure medical outcomes, and financial impact to the State Plan.

f. Clinical Support for State Plan Members. Contractor shall:

   i. Provide clinically trained health advisors to explain a diagnosed condition and recommended treatment plan to State Plan members. Provide State Plan member access to digital health modules, 24/7 Nurseline, and other educational tools to help State Plan members understand complex clinical information on health conditions and alternative treatment options.
   ii. Provide an assessment of any gaps in care (pharmacy or preventive care) by clinically trained health advisors for State Plan members. Contractor's health advisors may provide patient education, clinical referrals and appointment scheduling in collaboration with the State Plan member's treating provider to close a gap in care.
   iii. Assist State Plan members with scheduling a second opinion, if requested.
   iv. Collaborate with the State Plan member's treating providers on alternative treatment options and serve as an advocate for the State Plan member when appropriate for a State Plan member's recovery.
   v. Identify appropriate primary care providers, specialty providers, lab or other providers to meet a State Plan member's need.
   vi. Serve as resource for State Plan members to explain biometric screening results, other lab test results, or drug interactions.
   vii. When appropriate for the State Plan member's diagnosis, refer to case management, complex case management, or other appropriate patient care management function.

16. Claim Audits, Payment Integrity. Contractor shall:

a. Conduct internal audits to verify claims are processed according to the State's Wrap Plan Document, Medical Summary Plan Description, or other State-authorized claim procedures. Contractor shall perform internal audits annually, or at such other interval as requested or agreed to by State and provide a written summary of audit findings to State.

b. Conduct pre-and post-payment reviews of claims, including an analysis of inliers and outliers, random sample reviews, and billing audits to ensure claims are paid consistently and appropriately across all type of claims (inpatient, outpatient and professional).

c. Provide Fraud, Waste, and Abuse programs through Contractor's internal special investigations team to identify and report suspected fraud, waste, and egregious provider billing activity. Contractor's programs may include but are not limited to member and provider education, code auditing software, analysis of health care claims data by trained analysts in medicine, insurance and law enforcement, and provider/facility audits with external recovery auditors.

d. Support State performed audits (including audits performed by an independent third-party auditor) and provide access to any Contractor-maintained data related to claims, financial data, patient care management, participating provider contracts, provider credentialing, or other relevant data and documentation requested by State for the purposes of auditing the State Plan. Contractor shall research any discrepancies identified by State or its auditor and report its research results to State within 15 business days of the date Contractor receives the request.

e. Administer State Plan's self-audit program as described in the Wrap Plan Document.

17. Reporting and Data Transfers.

a. Reporting. Contractor shall report to State on plan performance, including financial, enrollment, claims, and other areas determined in conjunction with State. Reporting includes but is not limited to:

i. Enrollment and eligibility reporting as requested by State.
ii. Monthly claims reporting including at a minimum, total plan cost by enrollment, claims aging, claims by participating provider/network status, claims lag, large claims by diagnosis.
iii. Quarterly and annual reporting of provider overpayments, payments made in error and refunds.
iv. Weekly reporting on patient care management including at a minimum, utilization review updates, case management participation, and high risk/dollar admits with excepted cost.
v. Monthly reporting on patient care management including at a minimum, case management engagement and notes, and utilization review reporting.
vi. Quarterly disease management and wellness reporting.
vii. Quarterly COB and subrogation, if any, reporting.
viii. Quarterly reporting on State plan member appeals.
ix. Ad hoc or additional reporting as requested by State.
x. Online access to web-based analysis and reporting and/or ability for State to create its own reporting.
xi. Online real-time access to products, membership information, billing, and other account information to manage employee health coverage in real time.

b. Data Transfers.
i. Contractor shall transmit a claim file by the 5th day of each month to State's data warehouse in accordance with a State-specified data file layout.
ii. At State's request, Contractor shall accept an 837-file feed from State's vendor for the Montana Health Centers.

18. Compliance. Contractor shall:

a. Work collaboratively with State to ensure State Plan compliance with applicable federal and state law.

b. Provide eligibility and enrollment data for State Plan members, including COBRA participants, to allow State to prepare and distribute the Form 1095-C's and related returns for the employer shared responsibility requirements of the PPACA.

c. Provide compliance services for Title I (No Surprises Act), Title II (Transparency in Coverage), and the Mental Health Parity Addiction Equity Act amendments in the Consolidated Appropriations Act of 2021, including but not limited to:
   i. Post payment surprise bill negotiation and, when necessary, arbitration/Independent Dispute Resolution management services.
   ii. ID cards with required cost share information.
   iii. Annual survey of non-quantitative treatment limitations (NQTL) applicable to State Plan mental health benefits. Contractor shall provide State a written report describing how State Plan mental health benefits meet NQTL requirements and include a detailed comparative analysis of the State Plan, both written and in operation.
   iv. Continuity of Care services to identify impacted State Plan members across all applicable networks, send notices to impacted State Plan members, and facilitate appropriate clinical review of requested exceptions.
   v. Disclosure of in-network rates and out-of-network allowed amounts and billed charges in a Machine-Readable File (MRF). Contractor shall create the MRF, post to a secure location on Contractor's website, and provide State with access on Contractor's website. For any networks accessed by the State Plan through Contractor, Contractor shall provide a secure link to the MRF for each network on Contractor's website and provide State with access to those MRF's.
   vi. Provide State Plan members with access to a CAA-compliant online provider search tool that incorporates cost and quality components for providers and facilities.
   vii. Provide an online provider search directory that is updated as required by the CAA.
   viii. Provide compliant Advance EOBs upon request.

d. Ensure State Plan compliance with MMSEA section 111, for group health plan reporting with CMS for payment coordination and other requirements.

e. Provide all required employer/health plan notices and distribute as required by law, or as directed by State, including but not limited to: CHIPRA, WHCRA, SBC's, special enrollment notices, marketplace notices, COBRA, privacy, language assistance, and Medicare Part D notices.

19. Account Management. Contractor shall provide:

a. A contract administrator to serve as the primary point of contact for State and who can serve as a decision maker for Contractor. Contract administrator should be:
   i. Located in Montana, available Monday through Friday, 8am-5pm MST, and able to respond within one business day.
   ii. Able to timely escalate a claims-level issue to appropriate personnel with expertise in claims processing, patient care management or other key area.
   iii. Available for quarterly meetings to discuss State Plan-related topics or on a more frequent basis if requested by State; and
   iv. Able to coordinate and work collaboratively with all Contractor teams, including but not limited to member service support, claims processing, patient care management, eligibility, and executive level team members.
   v. Able to act on behalf of the State Plan to effectively advance the interests of State to Contractor's executive leadership team.

b. Dedicated team members including a designated claims manager and processors, patient care management representative, and leadership from other key areas (e.g., customer service, eligibility/COBRA administration) with specialized knowledge of Contractor's procedures and programs, State, the State Plan and related plan materials and communications, and State Plan vendors.

c. Attendance at quarterly State Employee Group Benefits Advisory Council (SEGBAC) meetings or its alternative, and other meetings as requested by State.

d. Timely notice to State of changes in Contractor's key personnel assigned to State account management team.

e. Timely resolution of issues brought to Contractor's attention by State. Timely resolution means Contractor's initial acknowledgement of a State-identified issue within two business days. Timely final resolution of a State-identified issue means an 85% completion rate within five business days of the initial acknowledgement. For State-identified issues unresolved within five business days, timely final resolution means a 90% completion rate within one month of the initial acknowledgement.

20. Wellness Program and Platform. Contractor shall provide a wellness program and platform that includes:

a. An online member portal and mobile application that integrates with commercially available health and wellness wearable devices (e.g. Fitbit, Garmin) and wellness applications (e.g. MapMyRun, Apple Health). The portal should permit State Plan members to access online assessment tools, health tracking tools for diet exercise, weight loss and others, self-management wellness courses and other health resources at no cost to the State Plan member.

b. An online employer portal that provides communication tools, sample member communication materials and reporting to help State track State Plan member participation and completion of wellness incentive activities and programs.

c. Access to non-customizable online individual and group wellness challenges.

EXHIBIT B

Contract No. HCBD22-0161NH

PERFORMANCE GUARANTEES

Contractor's performance will be measured against the performance guarantees in this exhibit, subject to:

Performance Period. Guarantees are measured annually for a 12-month performance period beginning each January 1st, unless otherwise stated below. For the first year of the initial term, Contractor's performance is measured April 1, 2023 through December 31, 2023. If the agreement terminates during the middle of a performance period, Contractor's performance will be measured for that portion of the performance period prior to the date of the termination.

Performance Measurement. Penalties for failure to meet performance guarantees are determined by an annual audit conducted by Contractor within 90 days of the end of a performance period, unless otherwise stated below. For any undefined performance criteria below, State and Contractor shall mutually determine the criteria and measurement methodology. Contractor shall submit a report of its performance for the prior performance period to State by the end of the first quarter of each calendar year (same due date as a completed audit). State reserves the right to audit Contractor's reporting.

Performance Guarantee Payment. If performance guarantees are not satisfied for a performance period, guarantees shall be paid to State within 120 days of the end of the performance period.

	Standard	Performance Criteria	Performance Guarantee	Percentage of the Administrative Fee at risk
IMPLEMENTATION (Initial Term Only)				
1.	ID Cards	Initial issuance mailed by January 1, 2023, if a complete and accurate eligibility file is submitted to Contractor on or before November 30, 2022. If the eligibility file is submitted to Contractor after November 30, 2022, initial issuance will be mailed within 30 calendar days of Contractor's receipt of the file.	Met Not Met	0% 1%
2.	State Satisfaction	Complete implementation to State's satisfaction. Performance measured by criteria in a mutually determined implementation report card.	Composite score 3.0-5.0 0-2.9	0% 1%

	Standard	Performance Criteria	Performance Guarantee	Percentage of Administrative Fee at Risk
CUSTOMER SERVICE				
1.	Average Speed of Answer	All member calls to Contractor's Member Service Support Team are answered within an average time of 30 seconds or less over the performance period.	31 seconds or more	1%
2.	Call Abandonment Rate	An average call abandonment rate of 2% or less for Contractor's Member Service Support Team over the performance period. Abandoned calls include calls placed in queue but not answered by a customer advocate within 30 seconds.	Greater than 2%	1%
3.	Inquiry Resolution	a) At least 85% of member inquiries (written and telephonic) resolved on the same day of receipt of call by Member Service Support Team.	Less than 85%	1%
		b) At least 90% of member inquiries (written and telephonic) resolved within five business* days of receipt of call by Member Service Support Team.	Less than 90%	1%
		c) At least 98% of member inquiries (written and telephonic) resolved within ten business* days of receipt of call by Member Service Support Team.	Less than 98% but greater than 90%	1%
4.	Call Quality Metrics	At least 95% of resolved member calls meet Contractor's established quality accuracy metric measurements. The sampling for this metric is based on MT, NM and OK Customer Support Team calls.	Less than 95%	1%

5.	Member Satisfaction	At least an 85% member satisfaction rating. Rating measured by Contractor's member satisfaction survey process. Satisfaction survey is based on State Plan members surveyed.	Less than 85%	1%
6.	Provider Satisfaction	At least 85% provider satisfaction rating. Rating measures by Contractor's provider satisfaction survey process. Satisfaction survey is based on Montana based providers only.	Less than 85%	1%

*Note: A business day is a Monday through Friday and does not include any state or federal holiday that falls on a Monday through Friday.

	Standard	Performance Criteria	Performance Guarantee	Percentage of Administrative Fee at Risk
CLAIMS ADMINISTRATION				
1.	Claims Turnaround Time*	At least 96% of process ready claims received by Contractor are processed and fully adjudicated within 14 calendar days of receipt by Contractor without a financial error. A process ready claim is a claim for which all information necessary to process the claim has been received by Contractor and includes but is not limited to correct coding, medical records, COB information, and member eligibility information. A financial error is an error that directly affects the amount paid by the State Plan for any claims or claim line.	Less than 96%	1%
2.	Claims Payment Accuracy*	At least 98% of claims received by Contractor are processed at the correct amount for the claim or any claim line without a payment error. A payment error is a claim adjudicated for an incorrect amount.	98%-100% 0%-97.9%	2%
3	Claims Processing Accuracy	Percent of claims processed accurately in accordance with the State Plan Wrap Plan Document medical benefits.		Report Only
4	Claims Financial Accuracy	Percent of dollars paid accurately in accordance with the State Plan Wrap Plan Document medical benefits.		Report Only

* Any claims adjusted at State's direction are not included in a performance guarantee calculation.

	Standard	Performance Criteria	Performance Guarantee	Percentage of Administrative Fee at Risk
REPORTING/FILE FEED TRANSFERS				
1.	Reporting	Standard Monthly Reporting delivered to State or available online within15 calendar days of the end of each month. Measured monthly.	Met Not met	Report Only
2.	Claim File Transfers	Contractor will transfer a claims data feed to State's data warehouse by the 5th day of each month. Measured monthly and reported annually for each performance period.	Met Not Met	0% 1%
ACCOUNT MANAGEMENT				
1.	Quality Assurance and Compliance	Contact State within five calendar days of the discovery of a significant and/or systemic claims processing error and submit an impact report to State within 30 calendar days of discovery.	Met Not Met	0% 1%
2.	Issue Resolution	Timely resolve any issues brought to Contractor's attention by State. Timely resolution means Contractor's initial acknowledgement of state issues within two business days. Timely resolution of a state issue means an 85% completion rate within five business days of the initial acknowledgement. For state issues unresolved within five business days, a timely final resolution shall mean a 90% completion rate within one month of the initial acknowledgement.	Met Not Met	0% 2%
3.	Account Management	State's satisfaction with Account Management as measured by State, using Contractor's Account Management Client Satisfaction Survey. Measured annually for each performance period.	Composite Score 3.0-5.0 0-2.9	0% 2%

	Standard	Performance Criteria	Performance Guarantee	Percentage of Administrative Fee at Risk
PROVIDER REIMBURSEMENT STRATEGY				

1.	Access & Stability	Comprehensive access to providers and facilities in Montana: a) Primary physicians. At least 98% of State Plan members have the desired access to a primary care physician within 15 miles of their residence. b) Specialty physicians. At least 98% of State Plan members have their desired access to an appropriate specialty physician within 15 miles of their residence. c) Hospitals. At least 98% of State Plan members have their desired access to a hospital within 15 miles of their residence.	Met Not Met Met Not Met Met Not Met	Report Only Report Only Report Only
2.	Multiple of Medicare Performance Guarantees (see chart below).			

MULTIPLE OF MEDICARE GUARANTEES

Contractor's performance will be measured against the Multiple of Medicare guarantees described below, subject to:

Performance Period. Guarantees are measured annually for a 12-month period beginning each January 1st, If the agreement terminates during the middle of a performance period, Contractor's performance will be measured for that portion of the performance period prior to the date of the termination.

Performance Measurement. Penalties for failure to meet performance guarantees are determined by an annual audit conducted by Contractor within 150 days of the end of a performance period. Contractor shall submit a report of its performance for the prior performance period to State on the same data of the completion of the audit. State reserves the right to audit Contractor's reporting.

Performance Guarantee Payment. If performance guarantees are not satisfied for a performance period, guarantees shall be paid to State within 180 days of the end of the performance period.

Plan Year 2023 (January 1, 2023 – December 31, 2023)		
Multiple of Medicare Guarantees	**ALL Categories Combined**	**Fee At Risk (PEPM)**
Target Multiple of Medicare	180%	$0.00
Within 4% of Target	180.01 – 184%	$1.00
Within 8% of Target	184.01 – 188%	$2.00
Within 12% of Target	188.01 – 192%	$3.00
Within 16% of Target	192.01 – 196%	$4.00
Within 20% of Target	196.01 – 200%	$5.00
Outside of 20% of Target	200.01% or greater	$6.00

Plan Year 2024 (January 1, 2024 – December 31, 2024)		
Multiple of Medicare Guarantees	**ALL Categories Combined**	**Fee At Risk (PEPM)**
Target Multiple of Medicare	180%	$0.00
Within 4% of Target	180.01 – 184%	$1.00
Within 8% of Target	184.01 – 188%	$2.00
Within 12% of Target	188.01 – 192%	$3.00
Within 16% of Target	192.01 – 196%	$4.00
Within 20% of Target	196.01 – 200%	$5.00
Outside of 20% of Target	200.01% or greater	$6.00

Plan Year 2025 (January 1, 2025 – December 31, 2025)		
Multiple of Medicare Guarantees	**ALL Categories Combined**	**Fee At Risk (PEPM)**
Target Multiple of Medicare	180%	$0.00
Within 4% of Target	180.01 – 184%	$1.00
Within 8% of Target	184.01 – 188%	$2.00
Within 12% of Target	188.01 – 192%	$3.00
Within 16% of Target	192.01 – 196%	$4.00
Within 20% of Target	196.01 – 200%	$5.00
Outside of 20% of Target	200.01% or greater	$6.00

Multiple of Medicare Calculation Parameters include:

i. Discounts to be tabulated on claims incurred/paid on a 12/15 basis.
ii. Claims with no Medicare pricing available from CMS will be excluded from the tabulation.
iii. All claim amounts to be included in the tabulation. Contractor may not remove large claims or pool over a certain point.
iv. Claims billed at pre-negotiated discount will be assumed to achieve the average discount of all other claims in the same category.
v. "All Categories Combined" includes all inpatient facility, outpatient facility, and all professional/ancillary provider claims.
vi. State-specific provider contracts for primary/preventive care at all-inclusive fee are not included (e.g., One-Health).

EXHIBIT C

Contract No. HCBD22-0161NH

ADMINISTRATIVE FEE SCHEDULE

TYPE OF FEE	2023	2024	2025
Benefits and Claims Administration			
Benefits and Claims Administration (See note 1)	$20.73	$21.04	$21.35
Provider Search, Quality and Cost evaluation tool(s)	Included	Included	Included
COBRA Administration (See note 2)	See note 2	See note 2	**See note** 2
Ad-Hoc Reporting (maximum of 150 hours per year)	Included	Included	Included
HCSC Transition Credit (See note 3)	($1,000,000)	($1,000,000)	($1,000,000)
Fiduciary (See note 4)			
Appeals Decisions: First Level	$1.00	$1.00	$1.00
Appeals Decisions: Second Level	Included in First Level Fee	Included in First Level Fee	Included in First Level Fee
Appeals Decisions: Independent Review Organization (IRO) (Fee is a pass-through fee with no mark-up)	$700 per external review	$700 per external review	$700 per external review
Data Integration			
Benefit Accumulator data feeds from outside vendors (i.e. PBM, MTM), if available (See note 1)	$0.42	$0.42	$0.42
Export Eligibility Feeds (for external vendors), Daily/Monthly	$2,000 annual fee	$2,000 annual fee	$2,000 annual fee
Export Claim Data Extracts (for external data warehouse), Monthly	$2,200 one-time fee	$$400 annual fee	$400 annual fee
Load Data for Medical Management	$5000 annual fee	$5000 annual fee	$5000 annual fee
Other Administration Services			
Injectable Medication Rebate Administration	Included	Included	Included
Medical Rebate Credit- 85% of actuals, PEPM provided and year end true up (See note 5)	($0.99)	TBD based on year 1 actuals	TBD based on year 2 actuals
Compliance Support			
No Surprises Act Compliance, including arbitration/Independent Dispute Resolution (IDR)	See note 6	See note 6	See note 6
Transparency in Mental Health Parity and Addiction Equity Act (MHPAEA) NQTL Analysis	Included	Included	Included
Transparency in Coverage Machine Readable Files	Included	Included	Included
CLINICAL RESOURCES AND CARE MANAGEMENT			
Utilization Review (See note 7)	$0.00	$0.00	$0.00
Case Management, core service (See note 7)	$0.00	$0.00	$0.00
Complex Case Management (See note 7)	$0.00	$0.00	$0.00
Disease Management (See note 7)	$0.00	$0.00	$0.00
Maternity Management Program (See note 7)	$0.00	$0.00	$0.00
Additional programs (See note 8)	$0.00	$0.00	$0.00

WellBeing Management Enable Package	$4.95	$4.95	$4.95
PROVIDER/FACILITY REIMBURSEMENT STRATEGY			
Provider Network Access (Primary)	Included	Included	Included
Provider Network Access (Wrap/Secondary)(See note 9)	Included	Included	Included
Custom Network Development (See note 10)	TBD	TBD	TBD
Provider Negotiation Fee	Included	Included	Included
Provider Pay for Performance Fees	Included	Included	Included
VALUE ADDED BENEFIT OPTIONS (State may elect)			
Condition-Based Point Solution (see note 11)			
Behavioral Health	Included	Included	Included
Cardiac	Included	Included	Included
Diabetes	Included	Included	Included
Musculoskeletal (MSK)	Included	Included	Included
Other conditions	Included	Included	Included
Employee Assistance Program & Behavioral Health Resources (includes 6 telephonic sessions per year)	$1.00 PEPM	$1.00 PEPM	$1.00 PEPM
Wellness Programs and Platform (See note 12)	Included	Included	Included

First Year Immaturity Credit PEPM			
	$1,126,125		

NOTES TO ADMINISTRATIVE FEES

1) Fee is invoiced on a per employee per month (PEPM) basis. An employee includes a State Plan member who is an active employee, retiree, legislator, and COBRA participant and is the primary account holder. If the primary member and spouse are both state of Montana employees and enroll in family coverage (Joint Core coverage), State will only pay the administrative fees for the primary member.
2) COBRA participant fees are $10 per month per COBRA participant; $10 per mailed election packet. $75 per month minimum. Contractor retains the 2% administrative fee. If State elects Open Enrollment services, the following OE options are available and have an additional fee. OE packet fee dependent on number of pages/inserts: 1) Partial Service - HealthEquity will provide a sample Open Enrollment Election Form template for State to provide to State Plan members. HealthEquity will manage carrier and billing updates. Fee would be $8.00 per packet sent. 2) Standard Service –HealthEquity will produce and mail Participant Open Enrollment Notice and Election Form packages (up to 7 sheets of paper, double-sided). HealthEquity will manage carrier and billing updates. Fee would be $15.00 per packet sent, 3) Custom Option –HealthEquity will produce and mail Participant Open Enrollment Notice and Election Form packages (up to 30 sheets of paper, double-sided) Special handling for division-based communications and/or custom inserts. HealthEquity will manage carrier and billing updates. Fee would be $22.00 per packet sent.
3) Transition credit is unrestricted. For each renewal year from year four through ten of this agreement that State elects, Contractor will apply an annual transition credit of $500,000 per renewal year. State is not obligated to renew this agreement.
4) Fee for first level review is a PEPM fee.
5) Contractor will provide a monthly credit of $0.99 per State Plan employee and true-up up to 85%of the actual drug rebate for each specialty drug paid under the medical benefits. Contractor will perform true-up by July 31st following each year of the agreement. State will receive the credit within 30 days of the true-up calculation, subject to timely receipt of data from Contractor's vendor to calculate true-up.
6) Fees for No Surprises Act compliance are $50 per claim that is the subject of informal negotiation with a Provider (fee applies each time a provider determines it will not accept the initial payment amount), and $75 for each claim where Contractor represents State Plan in an IDR (fee applies for each claim for which the provider decides to initiate IDR after the informal negotiation period, and if the State Plan is not the prevailing party, the costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.
7) Care management services may be paid as an all-inclusive Wellbeing Management Enable Package Fee of $4.95 PEPM, or State may separately elect each component for the following fees: Comprehensive UM Prior Authorization ($1.54 PEPM),

Outpatient UM expansion ($1.63 PEPM), Holistic Health Management ($0.59 PEPM, complex case management, case management, and disease management), Women and Family Health ($0.16 PEPM, High Risk Maternity, Well on Target Maternity).

8) Additional Care Management programs are included in the all-inclusive Wellbeing Management Enable Package Fee or State may separately elect each program for the following fees: Specialty Drug Preauthorization ($0.36 PEPM), Core Behavioral Health ($1.05 PEPM), 24/7 Nurse Line ($0.07 PEPM), Fitness program ($0.00), Pharmaceutical Care Management ($0.11), Well on Target Portal ($0.17 PEPM), Member Communications ($0.12 PEPM), Digital Health Partners ($0.05) and Blue Points rewards ($0.10).
9) No access fees for use of Blue Card National PPO network, Blue Distinction Specialty Care program, Centers of Excellence, excluding Arizona, Louisiana, Nebraska, North Dakota, Tennessee, West Virginia, and Wyoming. Access fees in these states are 1.96% per claim up to a maximum total of $2,000 per case.
10) Custom Network Development is an optional service and may be elected by State for a separate fee. Custom Network Development may be used to enhance Contractor's provider contracts to obtain a target reimbursement rate.
11) Condition-based Point Solution programs are included in the all-inclusive Wellbeing Management Enable Package Fee or State may separately elect each program. Behavioral Health may be separately elected for a fee of $1.05 PEPM. Any one or a combination of Contractor's programs may be added for a fee of $0.05 PEPM to address these conditions: Cardiac, Diabetes, Musculoskeletal or another condition,
12) Contractor's wellness program and platform is included in the all-inclusive Wellbeing Management Enable Package Fee or State may separately elect the program.

EXHIBIT D

Contract No. HCBD22-0161NH

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "BAA") is effective January 1, 2023 (the "BAA Effective Date") by and between the State of Montana Benefit Plan ("Covered Entity" or "Plan"), and Blue Cross and Blue Shield of Montana (Business Associate), (collectively, the Parties).

1. RECITALS

A. Covered Entity (or State on Covered Entity's behalf) and Business Associate are parties to a services agreement entered into January 1, 2023 (the "Services Agreement"), as amended by this BAA for the benefit of the Plan.

B. Covered Entity possesses Individually Identifiable Health Information protected under HIPAA, the HIPAA Privacy Regulations, the HIPAA Security Regulations and the HITECH Standards and is permitted to use or disclose such information only in accordance with such laws and regulations.

C. Business Associate may receive such information from Covered Entity, or create, maintain, or receive such information on behalf of Covered Entity, in connection with the Services Agreement; and

D. Covered Entity wishes to ensure that Business Associate will appropriately safeguard the privacy, confidentiality, integrity, and availability of Individually Identifiable Health Information.

2. DEFINITIONS

The terms below shall be modified as necessary, to reflect any changes by applicable law. All terms in this BAA with initial upper-case letters not otherwise defined have the meaning in HIPAA, the HIPAA Privacy Regulations, the HIPAA Security Regulations, and the HITECH Standards, for the same term.

(a) **Breach** means the acquisition, access, use, or disclosure of PHI in a manner not permitted under 45 CFR Part 164, Subpart E (the "HIPAA Privacy Rule") which compromises the security or privacy of the PHI. Breach does not include:

1. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Covered Entity or Business Associate, if the acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Rule; or

2. Any inadvertent disclosure by one person who is authorized to access PHI to another person authorized to access PHI, respectively, and the information received from the disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule; or

3. A disclosure of PHI where the Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) **Data Aggregation** is, with respect to PHI created or received by the Business Associate in its capacity as the Business Associate of the Covered Entity, the combining of the PHI by the Business Associate with the PHI received by the Business Associate in its capacity as Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) **Electronic Health Record** or **EHR** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and their staff. Clinicians may include, but are not limited to, health care providers with direct treatment relationships with individuals (e.g., physicians, nurses, pharmacists, and other allied health professionals). For purposes of this definition, "health-related information on an individual" is Individually Identifiable Health Information and the billing records for any care, treatment of other services provided by a clinician.

(d) **Electronic PHI** or **E-PHI** means PHI that is transmitted by electronic media or maintained in electronic media. Electronic media includes but is not limited to computers (hard drives), tablets, smartphones, and any removable/transportable digital memory medium, such a magnetic tape or disk, optical disk, or digital memory card, and transmission media used to exchange information already in electronic storage media (e.g., the Internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media). Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

(e) **HHS-Approved Technology** means, for data in motion, the encryption guidelines in NIST Special Publications 800-52 Guidelines for the Selection and Use of TLS; 800-77, Guide to IPsec VPNs, or 800-113, Guide to SSL VPNs, or others which are FIPS 140-2 validated. For data at rest, HHS-Approved Technology means the encryption guidelines in National Institutes of Standards and Technology (NIST) Special Publication 800-111. For the destruction of paper, film, or other hard copy media containing PHI, an HHS-Approved Technology means the destruction of the media by shredding or otherwise destroying the media so that PHI cannot be read or reconstructed; for electronic media on which PHI is stored, destruction means the data is cleared, purged or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Destruction. For control frameworks, an HHS-approved Technology means NIST 800-53 (most recent version), CIS, ISO. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary.

(f) **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.

(g) **HIPAA Privacy Regulations** means the regulations promulgated under HIPAA by the US Department of Health and Human Services, including, but not limited to, 45 CFR Part 160 and 45 CFR Part 164, Subpart A and Subpart E.

(h) **HIPAA Security Regulations** means the regulations promulgated under HIPAA by the US Department of Health and Human Services, including, but not limited to, 45 CFR Part 160 and 45 CFR Part 164, Subpart A and Subpart C.

(i) **HITECH Standards** means the privacy, security, and security Breach notification provisions applicable to a Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XIII of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, and regulations promulgated thereunder.

(j) **Individually Identifiable Health Information** means information that is a subset of health information, including demographic information collected from an individual, that is:

1. Created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

    i. Identifies the individual; or
    ii. There is a reasonable basis to believe the information can be used to identify the individual.

(k) **Personal Health Application** means an electronic application used by an individual to access health information about that individual, which can be drawn from multiple sources, provided such information is managed, shared, and controlled by or primarily for the individual, and not by or primarily for a covered entity or another party such as the application developer.

(l) **Protected Health Information** or **PHI** (includes E-PHI) means Individually Identifiable Health Information in any form or medium that (i) is received by Business Associate from the Covered Entity, (ii) Business Associate creates for its own purposes from Individually Identifiable Health Information that Business Associate received from Covered Entity, or (iii) is created, received, transmitted or maintained by Business Associate on behalf of the Covered Entity. PHI excludes employment records held by the sponsor of the Covered Entity in its role as employer.

(m) **Security Incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operation in an information system of Business Associate or a contractor of Business Associate.

(n) **Secretary** means the Secretary of the Department of Health and Human Services.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

A. **Security Safeguards**. Business Associate shall implement appropriate administrative, physical and technical security safeguards as set forth in § 164.306, § 164.308, and § 164.312, that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and prevent use or disclosure of the PHI other than as permitted by this BAA or the Services Agreement. At all times during this BAA, Business Associate shall apply HHS-Approved Technology.

B. **Mitigation**. Business Associate shall mitigate to the extent practicable and as directed by State, any harmful effect known to the Business Associate and relating to a use or disclosure of PHI by the Business Associate that violates the requirements of this BAA, Services Agreement, or applicable law.

C. **Reporting Disclosures**. Business Associate shall report to State any act, error or omission, negligence, misconduct, or Breach that results in a use or disclosure of the PHI not permitted by this BAA or the Services Agreement as soon as practicable but no later than five business days of Business Associate's discovery of such disclosure.

D. **Reporting Security Incidents**. Business Associate shall report to State any Security Incident of which it becomes aware within three business days of discovery, and at the request of State, identify: i) the date of the incident, ii) the scope of the incident, iii) the Business Associate's response to the incident, and iv) the identification of the party responsible for causing the incident, if known.

E. **Breaches. I**f Business Associate becomes aware of or has reason to know there has been a Breach or suspected Breach, Business Associate will do the following, as applicable:

1. Notify State, by facsimile, email, or telephone, of any Breach or suspected Breach of its security related to areas, locations, or computer system that stores PHI, including, without limitation,

any instance of theft, unauthorized access by fraud, deception, or other malfeasance or inadvertent access, as soon as practicable, but no later than three business days of discovery of the incident.

2. Cooperate with State, regulators and law enforcement in investigating the incident, identifying the affected individuals who comprise the PHI, and making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise requested by State.

3. At the State's sole request and with the approval and assistance of State, notify the affected individuals as soon as practicable, but no later than is required to comply with applicable law, or in the absence of any legally required notification period, within ten business days of discovery, or reimburse State for any costs associated with State's notification of the affected individuals. State shall review and approve any notification prior to delivery to the affected individuals. Notice should include:

    a. Brief description of what happened, including date of the incident, if known, and date of discovery of the incident.
    b. Description of the types of PHI involved in the incident (e.g., Social Security Number, full name, date of birth, address, diagnosis).
    c. Steps the affected individuals should take to protect themselves from potential harm resulting from the incident.
    d. Brief description of what is being done to investigate the incident, mitigate the harm, and protect against future incidents.
    e. Contact information for major credit reporting organizations,
    f. Contact procedures for individuals to ask questions or learn additional information, such as a toll-free telephone number, an e-mail address, website, or postal address.

4. Provide and pay for third-party credit and identity-monitoring services to all affected individuals for the period required by law, or in the absence of any legally required period for monitoring services, 24 months following date of notification to affected individuals.

5. Perform or take any other action required of Business Associate or requested by State to comply with applicable law because of the Breach or the suspected Breach.

6. Pay all costs associated with the incident, including but not limited to costs incurred by State in investigating and resolving the incident, including but not limited to reasonable attorney fees, costs, incidental expenses, forensic analysis, and expenses associated with the recovery of any lost data.

7. If the incident is a Breach and involves more than 500 residents of a single state or jurisdiction, Business Associate shall notify the Secretary, pursuant to 45 C.F.R. § 164.408 and prepare and distribute the notice to media outlets as set forth in 45 C.F.R. § 164.406. State shall have the option to review and approve any notification prior to dissemination to media outlets.

8. If the incident is a Breach involving less than 500 individuals, Business Associate shall log the incident and provide a reporting of the log to State for submission to the Secretary. Business Associate shall provide a reporting of the log to State on an annual basis, not later than 45 days after the end of the calendar year.

9. Recreate any lost Plan data in the manner and on the schedule set by State without charge to State.

10. Provide a detailed plan within ten business days of the steps Business Associate will undertake to prevent a future occurrence.

F. **Subcontractors of Business Associates**. Business Associate shall ensure that any of its agents or subcontractors that have access to, or to which Business Associate provides PHI, agree in writing to the same restrictions and conditions concerning the uses and disclosures of PHI contained in this BAA and agree to implement reasonable and appropriate safeguards to protect any PHI that it creates, maintains, or transmits on behalf of Business Associate or, through the Business Associate, or Covered Entity. Business Associate, as required by 45 CFR § 164.504(e)(1)(iii), shall terminate any business associate agreement with a subcontractor that does not comply with the requirements of that business associate agreement. Business Associate agrees that Business Associate is not the agent of State at any time under this BAA.

G. **Internal Records**. Business Associate shall make internal practices, policies and procedures, books, and records relating to the use and disclosure of the Plan's PHI and security of the Plan's E-PHI, available to, or as requested by State or the Secretary, to determine Plan and Business Associate compliance with HIPAA, the HIPAA Privacy Regulation, the HIPAA Security Regulation and the HITECH Standards.

H. **Accounting of Disclosures**. Business Associate shall document disclosures of PHI, collect information related to those disclosures, and provide to State to respond to a request by an Individual for an accounting of disclosures within ten calendar days after discovery of the disclosure. At a minimum, Business Associate shall document for each disclosure, the date of the disclosure, name and if known, address of the recipient of the disclosed PHI, brief description of the disclosed PHI, and a brief statement of the purpose for the disclosure to inform the Individual of the basis for the disclosure. Business Associate shall retain this accounting for at least six years from the date of the disclosure.

J. **Rights of Individuals**. Business Associate shall establish procedures that allow Individuals to exercise their rights under the Privacy Rule, including the right to (i) inspect and obtain copies of records and documents within the possession or control of Business Associate and that contain the Individual's PHI; (ii) request amendments to their PHI; (iii) receive an accounting of disclosures of their PHI; (iv) request restrictions on the use or disclosure of PHI; and (v) receive communications regarding PHI at alternative locations or by alternative means. Business Associate agrees that, if an Individual requests a restriction with respect to the disclosure of PHI, and the restriction relates to disclosure to State to carry out payment or health care operations (but not treatment), and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full, such restriction shall be followed.

K. **Subpoenas, Discovery Requests**. If Business Associate receives a subpoena, discovery request or other lawful process, with or without an order from a court or administrative tribunal, arising out of or in connection with this BAA or the Services Agreement including, but not limited to, any use or disclosure of PHI or any failure in Business Associate's health data security measures, Business Associate shall fully comply with the notice and protective action obligations in 45 C.F.R. § 164.512(e).

L. **EDI Transaction Standards**. To the extent required under HIPAA, Business Associate agrees to use or conduct, in whole or part, standard transactions and utilize code sets or identifiers for or on behalf of the Plan as detailed under HIPAA (including the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162). Business Associate shall also require any subcontractor or agent to also comply with such electronic transaction requirements under HIPAA (including the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162).

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

   A. **Uses and Disclosures**. Business Associate may use or disclose PHI only as permitted or required by this BAA, the Services Agreement, or applicable law.

   B. **Reporting to Authorities**. Business Associate may use PHI to report violations of federal and state laws to appropriate authorities, consistent with 45 CFR § 164.502(j)(1) and (2).

   C. **Business Operations and Management**. Business Associate may use and disclose PHI for Business Associate's business operations and management, or to carry out the legal responsibilities of the Business Associate provided that: (i) the disclosures are required by law; (ii) the disclosures are authorized by this BAA; or (iii) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only for the original purpose of disclosure; and the Business Associate requires the person to whom the information is disclosed to report to Business Associate within two business days any Breach or Security Incident of which it becomes aware.

   D. **Data Aggregation**. Business Associate may only use PHI for Data Aggregation if the Services Agreement authorizes use for Data Aggregation and Data Aggregation is permitted by 42 CFR § 164.504(e)(2)(i)(B).

5. OBLIGATIONS OF COVERED ENTITY

   A. **Change or Revocation of Individual Authorization**. State shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if and to the extent that such changes affect Business Associate's use or disclosure of PHI.

   B. **Restrictions on Use or Disclosure**. State shall notify Business Associate of any restrictions on the use or disclosure of PHI or a request for confidential communication to which Plan has agreed or shall direct Individuals to make any such request directly to Business Associate if and to the extent that such restriction or request may affect Business Associate's use or disclosure of PHI.

   C. **Authorized State Employees**. State shall identify for Business Associate, in writing, the employees of the state of Montana authorized to discuss PHI with Business Associate in connection with the Services Agreement. If Business Associate is contacted by an authorized State employee to discuss an Individual's claim for benefits under the Plan, Business Associate shall treat such inquiry as relating to "treatment, payment or healthcare operations" within the meaning of HIPAA and the HIPAA Privacy Regulations and provide the information permitted under such laws.

   D. **Restriction on Request for Impermissible Disclosures**. State will not ask Business Associate to use or disclose PHI in an impermissible manner under HIPAA, the HIPAA Privacy Regulations, the HITECH Standards, the HIPAA Security Regulations, or other applicable law.

   E. **State Plan Privacy Officer.** Covered Entity shall authorize the Department of Administration to designate Health Care and Benefits Division staff to serve as the Plan's privacy officer and to have general oversight of and responsibility for all tasks, duties, and obligations associated with the Plan's compliance hereunder.

6. TERM AND TERMINATION

   A. **Termination**. This BAA terminates when all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to Covered Entity.

B. **Termination for Breach by Business Associate**. Upon knowledge of a breach, State, in its sole discretion, shall provide an opportunity for Business Associate to cure the breach. State may: (i) end the violation and terminate this BAA and Services Agreement if the Business Associate does not cure the breach; (ii) immediately terminate this BAA and Services Agreement if Business Associate has breached a material term of this BAA and cure is not possible; or (iii) if neither termination nor cure are feasible, report the violation to the Secretary.

C. **Return or Destruction of PHI**. Upon termination of this BAA for any reason, Business Associate shall return or destroy all PHI received from Covered Entity or created or received by Business Associate. Destruction means use of an HHS-Approved Technology. This provision shall apply to all PHI in the possession of subcontractors or agents of Business Associate. Neither Business Associate nor its subcontractors shall retain any copies of the PHI. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this BAA to such PHI and limit further uses and disclosures of the PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. MISCELLANEOUS

A. **References to Regulations**. A reference in this BAA to a section in the HIPAA Privacy Regulations or the HIPAA Security Regulations means the section in the respective regulations, as amended and in effect at the relevant time.

B. **Survival**. The respective rights and obligations of Business Associate under this BAA shall survive the termination of this BAA.

C. **Interpretation of Contract**. Any ambiguity in this BAA, or in determining controlling provisions, shall be resolved in favor of an interpretation that permits the Plan to comply with HIPAA and other applicable law and that provides the greatest privacy and security protections for PHI. In the event of an inconsistency between the provisions of this BAA and mandatory provisions of applicable law, the applicable law shall control. Where provisions of this BAA are different from those under applicable law, but are nonetheless permitted by law, the provisions of this BAA shall control.

D. **Waiver of Individual Rights**. The parties shall not require any individual to waive health information privacy rights as a condition for treatment, payment, enrollment, or eligibility for benefits.

E. **Severability**. A declaration by any court, or any other binding legal source, that any provision of the BAA is unenforceable shall not affect the legality and enforceability of any other provision of the BAA, unless the provisions are mutually dependent.

F. **Third-Party Beneficiary**. There are no third-party beneficiaries to this BAA. Business Associate's obligations, unless expressly noted herein, are only to the Plan and State on the Plan's behalf.

G. **Waiver of Performance**. No change, waiver or discharge of any liability or obligation under this Agreement on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

H. **Entire Agreement, Amendment**. This BAA is the entire agreement of the parties with respect to the subject matter herein and supersedes and replaces all such prior agreements, representations, and understandings between the parties with respect to the subject matter herein. Any amendment or modification must be in a written agreement signed by the parties.

State of Montana Employee Benefit Plan

By: DocuSigned by: Amy Jenks A309DB1800A045A... 9/13/2022

Name: Amy Jenks

Title: Administrator

Organization/Plan Administrator:
Health Care & Benefits Division
Department of Administration

Business Associate

By: DocuSigned by: Collette Hanson 4F3ADDBBDD6D4F9... 9/13/2022

Name: Collette Hanson

Title: President

Organization:
Blue Cross and Blue Shield of Montana

EXHIBIT E

Contract No. HCBD22-0161NH

SECURITY PROCEDURES AND STANDARDS

Contractor's security measures must meet requirements in this exhibit and at a minimum, remain compliant with the NIST 800-53 (most recent version), Security and Privacy Controls for Information Systems and Organizations (collectively, "Security Best Practices").

1. Definitions.

"Security Policies" mean statements of basic principles to secure State Data received, stored, maintained, or transmitted by Contractor (or Contractor's subcontractor) and that are consistent with Security Best Practices and applicable laws and regulations.

"Security Procedures" mean the step-by-step actions of Contractor to comply with Security Best Practices.

"Security Technical Controls" mean any hardware, software, or administrative mechanisms necessary to enforce Security Best Practices and address security risks to Contractor's information technology systems (including health applications on a mobile device), physical locations thereof, or to implement related policies. Security Technical Controls specify technologies, methodologies, implementation procedures, and other processes that implement Security Policy elements.

2. Information Security Policy. Contractor shall maintain:
   a. Security policies, procedures, and technical controls,
   b. Security incident management program,
   c. Security awareness program,
   d. Business continuity and disaster recovery plans, including regular testing, backup procedures and redundancy schemes,
   e. Rigorous change control procedures, and
   f. Procedures to conduct regular independent security risk evaluations to identify critical information assets, assess threats to such assets, determine potential vulnerabilities, and provide for timely remediation.

3. Physical Access. Contractor shall establish and enforce:
   a. Physical security measures for all information assets and information technology to ensure such assets and technology are stored and protected in appropriate data centers,
   b. Appropriate facility entry controls limiting physical access to systems that store or process data,
   c. Processes to ensure access to facilities is monitored and restricted to those who "need to know",
   d. Controls to physically secure State Data and to properly destroy such information when it is no longer needed to provide the Services, and
   e. Process for destruction of electronic media on which State Data is stored or recorded that is consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization.

4. Logical Access. Contractor shall establish and enforce:
   a. Appropriate mechanisms for user authentication and authorization in accordance with a "need to know" policy,
   b. Controls to enforce rigorous access restrictions for remote users, subcontractors, and service providers,
   c. Timely and accurate administration of user account and authentication management,
   d. Processes to ensure assignment of unique IDs to each person with computer access,

e. Processes to ensure Contractor-supplied defaults for passwords and security parameters are changed and appropriately managed ongoing,
f. Mechanisms to track all access to State Data by unique ID,
g. Mechanisms to encrypt or hash all passwords, and
h. Processes to immediately revoke accesses of known inactive accounts or terminated/transferred users.

5. Security Architecture and Design. Contractor shall maintain:
   a. A security architecture to assure delivery of Security Best Practices,
   b. Documented and enforced technology configuration standards,
   c. Encryption processes for data at rest that are consistent with NIST Special Publication 800-111,
   d. Encryption processes for data in motion that comply, as appropriate, with NIST Special Publications 800-52 Guidelines for the Selection and Use of TLS; 800-77, Guide to IPsec VPNs, or 800-113, Guide to SSL VPNs, or others which are FIPS 140-2 validated,
   e. Processes to ensure regular testing of security systems and processes,
   f. Effective firewall(s) and intrusion detection technologies necessary to protect State Data, and
   g. Database and application layer design processes that ensure web site applications protect the State Data collected, processed, and transmitted by these systems.

6. System and Network Management. Contractor shall maintain:
   a. Mechanisms to keep security patches current,
   b. Processes to monitory, analyze, and respond to security alerts,
   c. Appropriate network security design elements that logically segregate data,
   d. Anti-Virus Software, and
   e. Processes to regularly verify the integrity of installed software.