SEVENTH AMENDMENT
TO
GROUP INSURANCE POLICY NO. 30500-G
IN EFFECT FOR
THE STATE OF NEW YORK

THIS SEVENTH AMENDMENT (the "Amendment") is entered into by the NEW YORK STATE DEPARTMENT OF CIVIL SERVICE ("DCS" or "Department" or "Employer") on behalf of the STATE OF NEW YORK and UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, (the "Insurance Company") referred to collectively as "the Parties".

WHEREAS, the Group Insurance Policy No. 30500-G (the "Policy"), as amended, provides certain agreed upon services and medical and surgical benefits insurance coverage, but not basic hospital insurance nor mental health/substance abuse insurance for Members of certain Employee Groups covered by the Employer; and

WHEREAS, Effective January 1, 2004, the Parties desire to amend the Policy to add services, benefits and fees for a Medical Benefits Drug Rebate program for Members of certain Employee Groups designated by DCS; and

WHEREAS, effective October 1, 2004, the Parties desire to amend the Policy to add services, benefits and fees for a Basic Medical Provider Discount Program and for Cancer Resource Services for Members of certain Employee Groups designated by DCS; and

WHEREAS, Effective January 1, 2005, the Parties desire to amend the Policy to add services, benefits and fees for a Prosthetic and Orthotic Provider Network for Members of certain Employee Groups designated by DCS; and

WHEREAS, Effective January 1, 2005, the Parties desire to amend the Policy to add a provision for distribution and allocation of communication costs for the Employer; and

WHEREAS, Effective June 1, 2006, the Parties desire to amend the Policy to update Appendix A – Standard Clauses For All New York State Contracts; and

WHEREAS, Effective March 1, 2007, the Parties desire to amend the Policy to add services, benefits fees and performance guarantees for an Integrated Disease Management Program for Members of certain Employee Groups designated by DCS that will replace the Disease Management Programs previously in place; and

WHEREAS, Effective April 1, 2007, the Parties desire to amend the Policy to add services, benefits and fees for a workers compensation recovery program; and

WHEREAS, Effective August 1, 2007, the Parties desire to amend the Policy to add services, benefits and fees for outpatient surgical facility claims services; and

WHEREAS, Effective April 23, 2007, the Parties desire to amend the Policy to expand services and benefits under the Cancer Resource Service program to cover bone marrow transplants, and

WHEREAS, Effective March 1, 2008, the Parties desire to amend the Policy to allow access to the Insurance Companies commercial preferred provider organization (PPO) network for [redacted] for an additional fee; and

WHEREAS, Effective July 1, 2008, the Parties desire to amend the Policy to add services, benefits and fees for a Kidney Resource Services (KRS) program to manage kidney disease and to expand services under the Benefit Management Program with the Prospective Procedure Review that includes pre-notifications of MRA, CT, PET and Nuclear Medicine (including Nuclear Cardiology) procedures for Members of certain Employee Groups designated by DCS; and

WHEREAS, Effective for the period effective January 1, 2005 through December 31, 2008, unless otherwise specified, the Parties agree that the Insurance Policy will renew and the premium rates and performance standards will be amended throughout this period.

NOW, **THEREFORE,** in consideration of the mutual promises set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

I. Article I of the Agreement is amended to add the language as follows:

The term "Drug Rebates" as used in this section means all rebates, discounts or other financial incentives (whether access, base, incentive, market share, volume or other), administrative fees, and any interest thereon which the Insurance Company receives directly or through an intermediary and are obtained in connection with prescription drug products dispensed to Members under the Plan's medical benefit. Drug Rebates do not include any amounts retained by an intermediary as compensation for its services under this Agreement, or any purchasing discounts obtained by an intermediary when purchasing drugs for distribution.

The term "Member" as used in this section, means both the Employees and Dependents covered by the Plan.

II. Article XI. Certificates of the Agreement is amended as follows:

A. Article XI heading "Certificates" is deleted and replaced with "Certificates and Policy Amendments".

B. The following paragraph is added as the new last paragraph to Article XI:

The Employer shall assume responsibility for doing initial filings with the New York State Department of Insurance for any amendments to the Group Policy and Certificates of Insurance that are created for the Employer, following review with the Insurance Company. The Insurance Company will provide copies of any filed documents to the New York State Department of Insurance as necessary, to fulfill its filing requirements.

III. Section E of Article XXII. – Cash Management, is revoked in its entirety and replaced with the following new section E:

The interest rate used to credit the Cash Account for positive cash balances shall be the [redacted] as set by the [redacted] in each month.

IV. Section F of Article XXII. – Cash Management, is revoked in its entirety and replaced with the following new section F:

The interest rate used to charge the Cash Account for negative cash balances shall be [redacted], as set by the [redacted] in each month.

V. Section H of Article XXII. – Cash Management is deleted in its entirety from this Article.

VI. A. Schedule of Premiums, is hereby revoked in its entirety and replaced with new Schedule of Premiums which is attached to this amendment as Exhibit A, and is effective for the period January 1, 2005 through December 31, 2008 unless stated otherwise in Exhibit A.

B. Article XVIII, Performance Standards, is hereby revoked in its entirety and replaced with new Article XXVII, Performance Standards which is attached to this amendment as Exhibit B, and is effective for the period January 1, 2005 through December 31, 2008 unless stated otherwise in Exhibit B.

C. Article XXVII, Additional Services, is hereby revoked in its entirety and replaced with new Article XXVII, Additional Services which is attached to this amendment as Exhibit C, and is effective for the period January 1, 2005 through December 31, 2008 unless stated otherwise in Exhibit C.

VII. The Agreement is amended to incorporate the following new article as follows: Article XXX, Savings and Return of Investment Guarantees, which is attached to this amendment as Exhibit D.

VIII. Appendix A - Standard Clauses for All New York State Contracts is hereby revoked in its entirety and replaced with new Appendix A – Standard Clauses for all New York State Contracts which is attached to this amendment as Exhibit E, and is effective from June 1, 2006.

IX. Except as expressly amended by this Seventh Amendment, all the terms and conditions of the original Agreement and any amendments thereto shall remain in full force and effect.

X. This Amendment shall be deemed effective January 1, 2005 through December 31, 2008 unless otherwise specified.

IN WITNESS WHEREOF, the Parties hereto have hereunder signed this Amendment No. 7 to Policy Number 30500-G on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to the acceptance of this contract amendment, I also certify that original copies of this signature page will be attached to all exact copies of this contract."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

NANCY G. GROENWEGEN
COMMISSIONER

By: _____

Date: _____

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

Date: _____ By _____

Name: _____

Title _____

STATE OF)
) ss:
COUNTY OF)

On the _____ day of _____, _____ , before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

_____

NOTARY PUBLIC

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

The following premium rates shall be in effect for the periods as indicated:

Premium Rate per Employee

	Employee Group with Plan Changes		**Employee Group without Plan Changes**		**GSEU**	
Calendar Year	**Individual Insurance** (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)	**Individual Insurance** (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)	**Individual Insurance** (Monthly/ Biweekly)	**Family Insurance** (Monthly/ Biweekly)
2005	$131.68/$60.61	$307.21/$141.40	$132.50/$60.99	$309.12/$142.28	$34.43/$15.85	$176.85/$81.40
2006	$134.89/$62.09	$313.33/$144.22	$134.88/$62.08	$313.30/$144.20	$35.40/$16.29	$174.41/$80.28
2007	$147.89/$68.07	$344.95/$158.77	$150.01/$69.05	$349.90/$161.05	$40.98/$18.86	$170.64/$78.54
2008	$155.35/$71.31	$370.11/$169.89	___	___	$48.17/$22.11	$192.51/$88.37

The Employer shall furnish to the Insurance Company within 3 months after each premium due date a written statement showing the number of Employees insured for Personal Insurance only and the number insured for Personal and Dependent Insurance, as of such due date.

The premium for Employees accounted for on a bi-weekly basis shall be the daily premium rate multiplied by 14. The daily premium rate shall be calculated by multiplying the monthly premium rate by 12 and dividing the product by the number of days in the calendar year for which the premium is in effect.

The premium rates for each calendar year period have been established with a [redacted] margin. The Employer guarantees an additional margin payment equal to the difference between [redacted] margin and [redacted] margin. In the event that the emerging annual experience results in a deficit, the Employer agrees to make additional premium payments upon notification by the Insurance Company equal to the lesser of [redacted] of the earned premium for year 2005, 2006, and 2007 and [redacted] for year 2008 or the amount of the deficit. The due date on this additional payment, if applicable, is April 15th in the year following the deficit.

The Employer shall make an additional payment when the actual communication expense for any yearly period exceeds the budgeted communication expense of [redacted] for 2005; [redacted] for 2006; [redacted] for 2007; and [redacted] for 2008; and a loss still exists after any additional premium payments have been made for any stated year. The amount of the additional payment shall be equal to the lesser of the amount of the loss after any additional premium payments have been made for any year stated, or the amount of the communication expenses in excess of the budgeted amount. The due date of this additional payment, if applicable, is April 15th in the year following the deficit.

Under the 5-tier structure for Participating Agencies, the month premium rates are as follows:

	Premium Rate per Employee				
Calendar Year	**Plan Prime**		**MediPrime**		
	Individual Insurance	**Family Insurance**	**Individual Insurance**	**Family Insurance (1 Additional)**	**Family Insurance (2 or more)**
2005	**$172.69**	**$360.78**	**$60.43**	**$248.51**	**$136.24**
2006	$176.82	$369.59	$61.69	$254.47	$139.34
2007	$195.61	$407.82	$67.33	$279.54	$151.26
2008	$209.56	$435.95	$73.68	$300.07	$164.19

The Employer guarantees the difference in premiums due to the Insurance Company should the 5-tier rate structure generate less premium than the 2-tier rate structure. Conversely, in the event the 5-tier rate structure generates more premium than the 2-tier structure, the Insurance Company shall return such excess.

Excelsior Plan for the period July 1, 2008 through December 31, 2008.

- [redacted] per Employee per month for individual insurance
- [redacted] per Employee per month for family insurance

Using historical Participating Agency experience, a factor of [redacted] applied to the combined Core and PA Enhancement premium rates was developed for the Excelsior Plan Medical premium. The rates for 2008 were established using this factor approach.

Under the 5-tier structure for Participating Agencies, the monthly premium rates for the Excelsior Plan are as follows:

Calendar Year	Premium Rate per Employee				
	Plan Prime		MediPrime		
	Individual Insurance	Family Insurance	Individual Insurance	Family Insurance (1 Additional)	Family Insurance (2 or more)
2008	$243.07	$505.65	$85.46	$348.05	$190.44

The Employer guarantees the difference in premiums due to the Insurance Company should the 5-tier rate structure generate less premium than the 2-tier rate structure. Conversely, in the event the 5-tier rate structure generates more premium than the 2-tier structure, the Insurance Company shall return such excess.

Uncertainty of actual enrollments and subsequent claim experience for the 2008 policy year requires that the Insurance Company establish parameters for setting the premium using this factor approach. In the event that the overall experience exceeds the [redacted] margin built into the 2008 premium rates, the Insurance Company reserves the right to request a separate retro payment on the Excelsior Plan. A retro payment of up to the current two tier Core plus PA Enhancement premium rates may be applied and is due no later than March 31, 2009. This factor approach will be used to set premiums until this program reaches credibility from both an enrollment and claim history perspective. Credibility is defined as [redacted] or more members consistently enrolled for twelve or more months with a minimum of three months of run-out in order to substantially complete the year.

Included in the premium rates are the following administrative costs of the Additional Services provided under the Group Policy for the period January 1, 2005 through December 31, 2008 unless indicated otherwise. With the exception of Communication Support Services, the following administrative fees include the Insurance Company's [redacted]:

1. **Managed Physical Medicine Program**
   - [redacted] per Member per month for the period January 1, 2005 through December 31, 2005
   - [redacted] per Member per month is effective January 1, 2006

   The cost for this program is applicable to all Empire Plan Members. "Members" means Employees and Dependents covered by the Plan

2. **Empire Plan NurseLine$_{SM}$ Program**

- For the period for the period January 1, 2005 through February 28, 2007: [redacted] per Employee per month
- Effective March 1, 2007:

With the implementation of the integrated Disease Management Program on March 1, 2007, [redacted]

[redacted]

Fees used in the development of premium rates shall be based on the preceding 12 months of utilization ending on March 1st of each year.

The cost for this program is applicable only to Members of certain Employee Groups designated by DCS for which the benefit has been collectively bargained or administratively extended.

3. **Disease Management Program** for the period January 1, 2005 through February 28, 2007.

Cardiovascular Risk Reduction

[redacted]

[redacted]

The cost for this program is applicable only to Members of certain Employee Groups designated by DCS for which the benefit has been collectively bargained or administratively extended.

Managing for Tomorrow Asthma Disease Management

- [redacted] fee per Participant (one-time assessment, per enrolled participant, upon completion of baseline health survey).

Diabetes Disease Management Program

- [redacted] per Participant (one-time assessment, per enrolled participant, upon completion of baseline health survey)

Disease Management Program effective March 1, 2007

- [redacted] per Member per month for the period March 1, 2007 through February 28, 2008.
- [redacted] per Member per month effective March 1, 2008

The cost for this program is applicable to Empire Plan Primary Members (excluding SEHP) for which the benefit has been collectively bargained or administratively extended.

4. **Complementary Alternative Medicine Program**

   - [redacted] per Member per month for network management

   The cost for this program is applicable to all New York Empire Plan Members for which the benefit has been collectively bargained or administratively extended.

5. **Network Integration**

   - [redacted] per Employee residing in the integrated states per month (excluding directory printing).

   The standard access fee for this program is derived from the monthly enrollment (contracts) in the integrated states, and [redacted] market beginning on March 1, 2008, times the monthly fee. Directory printing costs are not included in this premium rate and will be charged to the plan as produced on a cost plus basis with an [redacted] added.

6. **Benefits Management Program including Prospective Procedure Review for elective Magnetic Resonance Imaging (MRI), Voluntary Specialist Consultant Evaluation and Voluntary Medical Case Management** for the period January 1, 2005 through June 30, 2008

The administrative cost for these services shall be based on the actual cost incurred by the Insurance Company.

Prospective Procedure Review effective July 1, 2008

- [redacted] per transaction or [redacted] per Member per month (vendor fees are [redacted] per transaction, not to exceed [redacted] per Member per month) for MRA, CT, PET and Nuclear Medicine (including Nuclear Cardiology) procedures. Comparison and reconciliation of per Member per month vs. per transaction fees are to be performed annually on each July 1st.
- [redacted] per transaction or [redacted] per Member per month (vendor fees are [redacted] per transaction, not to exceed [redacted] per Member per month) for MRI procedures. Comparison and reconciliation of per Member per month vs. per transaction fees are to be performed annually on each July 1st.

7. **Consolidated Toll-Free Service**.
   - [redacted] per Employee per month for operational oversight, technological coordination and monthly reporting on call volume and trends.
   - Charges for script storage, script usage, transfer connect, and toll-free usage are [redacted].

8. **Basic Medical Provider Discount Program**. effective October 1, 2004

   A) [redacted] BMPDP fees are subject to review and approval of the Department.

   B[redacted]

9. **Cancer Resource Services**. effective October 1, 2004
   - [redacted] per employee per month effective with the groups bargained or administratively extended effective date.

10. **Drug Rebates** effective January 1, 2004

    [redacted] of the Drug Rebates the Insurance Company receives in connection with prescription drug products dispensed to Members under the Plan's medical benefit. (The remaining [redacted] of the rebates are to be retained by the Employer.)

11. **Prosthetic and Orthotic Provider Network**.
    - [redacted] per Member per month for Non-Medicare primary members who reside in New York State and for which the benefit has been collectively bargained or administratively extended.

12. **Communication Support Services**.

    Budgeted amounts to be allocated for the calendar years 2005 to 2008 are as communicated by the Employer in the annual rate approval letters to the Insurance Company.

13. **Workers Compensation Recovery Program**. effective April 1, 2007
    - [redacted] of gross recoveries made resulting from this program.

14. **Outpatient Surgical Facility Claims Services**. effective August 1, 2007
    - [redacted] per month for the repricing of claims for outpatient surgical facility fees.

15. **Kidney Resource Services (KRS) Program** (Excludes SEHP Members) effective July 1, 2008
    - [redacted] per Member per month

    The cost for this program is applicable to Empire Plan Primary Members (excludes SEHP) for which the benefit has been collectively bargained or administratively extended.

16. **Taxes Assessments & Surcharges**
    - ***Taxes**:* Premium tax is [redacted] of the amount up to the total of all claims, reserves, claim and administrative costs, other retention, but is subject to change, during the term of the Agreement if the rate as determined by governmental/regulatory agencies changes.

- ***New York State Insurance Department Assessment:*** New York State Insurance Department Assessment shall be charged using the imputed percentage based on the assessment levied by the Department of Insurance; the imputed percentage will be applied to total of all claims, reserves, claim and administrative costs and other retention. The assessment is subject to change, during the term of the Agreement if the rate determined by governmental/regulatory agencies changes. The final assessment will be reconciled and charged based on the final assessment levied by the New York State Insurance Department.
- ***Metropolitan Transportation Business Tax Surcharge (MTA Surcharge):*** Transportation Business Tax Surcharge shall be [redacted] of the premium tax rate applied to the premium for enrollees residing in the Metropolitan Commuter Transportation District (MCTD). The surcharge is subject to change, during the term of the Agreement if the rate as determined by governmental/regulatory agencies changes.
- ***New federal or state tax, assessment or surcharge:*** as implemented during the term of the Agreement at the rate determined by governmental and regulatory agencies.

17. **Other Charges/Credits**

- ***Expense Load:*** The Insurance Company will apply an incremental [redacted] to the Insurance Company's portion of Communication Support Services and all administrative expenses except for those listed in Article XXVII - Additional Services Exhibit C of this amendment.
- ***Risk Charge:*** The Risk Charge for policy years 1999 through 2008 is calculated annually as final earned premium, as displayed in the final financial statement, multiplied by [redacted]

ARTICLE XVIII. PERFORMANCE STANDARDS.

The Insurance Company agrees to a Performance Standards Program in the following areas of Policy administration: (a) claim payment accuracy, (b) customer service accuracy, (c) claim turnaround time, (d) telephone blockage, (e) telephone speed to answer, and (f) telephone abandonment rate. This program includes Group Policy Nos. 30500-G, 30501-G and 30502-G as they are combined on a claim payment basis. These standards apply to the medical benefits and are effective for the period January 1, 2005 through December 31, 2005 and each annual period, otherwise refered to the Guaranteed Period" thereafter while the contract is in force unless stated otherwise.

If the Insurance Company's level of performance falls below the established standards for a Guarantee Period, financial penalties shall be assessed the Insurance Company by the Employer. Measurement of each of the foregoing areas may be established by using statistical estimate techniques or other mutually accepted methods. [redacted]

Additional performance standards may be established for other areas of policy administration as mutually agreed to between the parties. The Employer and the Insurance Company shall agree on the implementation date(s), the level of the standard(s) and the penalty(ies) to apply.

(a) **Claim Payment Accuracy**. Claim payment accuracy shall measure any mispayment of benefits caused by the Insurance Company. The claim payment accuracy rate is measured on a calendar year basis and is equal to the number of claims paid correctly divided by the number of claims reviewed, as shown in the formula below.

Formula for Claim Payment Accuracy:

$$\text{Claim Payment Accuracy Rate} = \frac{\text{Number of Claims Paid Correctly}}{\text{Number of Claims Reviewed}}$$

Standard for Claim Payment Accuracy:

[redacted]

Performance Penalty for Claim Payment Accuracy:
If the Claim Payment Accuracy Rate, as calculated above, is determined to be statistically significant (i.e. the upper confidence limit is less than the standard) the difference between the Claim Payment Accuracy Rate and the standard shall be used to calculate any penalty due.

- For each [redacted], or part thereof, by which the Claim Payment Accuracy Rate falls below [redacted] for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.
- An additional penalty of [redacted] shall be assessed if the Claim Payment Accuracy Rate is below the standard and is lower, by [redacted] or greater, than that for the prior year.
- [redacted]

(b) **Customer Service Accuracy**. Customer Service Accuracy shall measure the accuracy of claims processed by the Insurance Company relative to items that are visible to, and affect, the customer (i.e. the Enrollee or the provider).

Formula for Customer Service Accuracy:

Customer Service Accuracy Rate = Number of Claims With No Customer Service Errors / Number of Claims Reviewed

Standard for Customer Service Accuracy:
[redacted]

Performance Penalty for Customer Service Accuracy:
- If the Customer Service Accuracy Rate, as calculated above, is determined to be statistically significant (i.e. the upper confidence limit is less than the standard) the difference between the Customer Service Accuracy Rate and the standard shall be used to calculate any penalty due.
- For each [redacted], or part thereof, by which the customer service accuracy rate falls below [redacted] for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.

(c) **Claim Turnaround Time.** Claim Turnaround Time shall measure the number of calendar days elapsed from the time the Insurance Company receives a claim to the time a claim action is taken (e.g. a benefit check is issued, a benefit statement is mailed, additional information is requested, etc.). The Claim Turnaround Time standard pertains only to non-participating provider claims.

Formula for Claim Turnaround Time:

Turnaround Time Rate = Number of Claims Within the Standard / Number of Claims Reviewed

Standards for Claim Turnaround Time:
- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] of receipt.

- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] of receipt.

Performance Penalty for Claim Turnaround Time:

- If the Turnaround Time Rate, as calculated above, is determined to be statistically significant (i.e. the upper confidence limit is less than the standard) the difference between the Turnaround Time Rate and the standard shall be used to calculate any penalty due.

- For each [redacted], or part thereof, by which the Turnaround Time Rate falls below the standard in each category for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.

(d) **Telephone Blockage**. Telephone Blockage shall measure overflow calls to the dedicated claims office that sequence through it's automated call distribution system in a calendar year. Overflow calls are calls that are placed to the 800# and receive a busy signal at the point they are connected to the dedicated claims office (not including the Managed Physical Medicine Program but effective July 1, 2002 including calls to the Care Coordination Unit). Telephone Blockage shall be tracked by the Call Management System (CMS) and reported by the Monthly Trunk Group Summary Report.

Formula for Telephone Blockage:

$$\text{Telephone Blockage Rate} = \frac{\text{Number of Overflow Calls}}{\text{Number of Calls Placed to the 800\#}}$$

Standard for Telephone Blockage:

[redacted] blockage.

Performance Penalty for Telephone Blockage:

If the Telephone Blockage Rate, as calculated above, is determined to be above the standard, the difference between the Telephone Blockage Rate results and the standard shall be used to calculate any penalty due.

- For each [redacted], or part thereof, by which the Telephone Blockage Rate exceeds [redacted] for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.

(e) **Telephone Speed to Answer**. Telephone Speed to Answer shall measure the number of calls to the dedicated claims office that sequence through it's automated call distribution system that are answered by a service representative within [redacted] seconds relative to the total calls received by the dedicated claims office (not including the Managed Physical Medicine Program but effective July 1, 2002 including calls to the Care Coordination Unit) in a calendar year. Telephone Speed to Answer shall be tracked by the Call Management System (CMS) and reported by the Monthly Split/ Skill Call Profile Report.

Formula for Telephone Speed to Answer:

$$\text{Telephone Speed to Answer Rate} = \frac{\text{Number of Calls answered within [redacted] seconds}}{\text{Number of Calls Received by the 800\#}}$$

Standard for Telephone Speed to Answer:
[redacted]

Performance Penalty for Telephone Speed to Answer:
If the Telephone Speed to Answer Rate, as calculated above, is determined to be below the standard, the difference between the Telephone Speed to Answer Rate results and the standard shall be used to calculate any penalty due.

- For each [redacted], or part thereof, by which the Telephone Speed to Answer Rate falls below [redacted] for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.

(f) **Telephone Abandonment Rate**. The Telephone Abandonment Rate shall measure calls to the dedicated claims office that sequence through it's automated call distribution system that are abandoned relative to the total calls received by the dedicated claims office (not including the Managed Physical Medicine Program but effective July 1, 2002 including calls to the Care Coordination Unit) in a calendar year. Abandoned calls are hang-up calls that occur before a service representative can answer and service the call. Any calls abandoned within the first [redacted] seconds shall not be considered in calculating the Telephone Abandonment Rate. The Telephone Abandonment Rate shall be tracked by the Call Management System (CMS) and reported by the Monthly System Report.

Formula for Telephone Abandonment Rate:

$$\text{Telephone Abandonment Rate} = \frac{\text{Number of Abandoned Calls}}{\text{Number of Calls Received by the 800\#}}$$

Standard for Telephone Abandonment Rate:
[redacted]

Performance Penalty for Telephone Abandonment Rate:
If the Telephone Abandonment Rate, as calculated above, is determined to be above the standard, the difference between the Telephone Abandonment Rate results and the standard shall be used to calculate any penalty due.

- For each [redacted], or part thereof, by which the Telephone Abandonment Rate exceeds [redacted] for a calendar year, a penalty of [redacted] shall be assessed.

- The maximum penalty for this measurement shall be [redacted] per calendar year.

Targeted Audits
Targeted audits which focus on specific issues or areas of the Plan will be conducted by the Employer as necessary. [redacted]

[redacted]

The Employer shall develop audit rules, to be approved by the Insurance Company, to define the measurement of the Insurance Company's performance against these standards. These audit rules may be amended or changed by the Employer, with the consent of the Insurance Company, for each annual audit period. The rules shall not be construed as preventing the Employer's auditors or the Insurance Company from exercising independent professional judgment in the performance of the audit or in the review of the audit results, respectively.

Change in Reporting Format.

The Insurance Company reserves the right from time to time to replace any report or change the format of any report referenced in these standards. In such event, the changes must be mutually agreed upon by both parties and the report will be modified to the degree necessary to carry out the intent of the parties.

ARTICLE XXVII. ADDITIONAL SERVICES

In addition to the insurance provided by this Policy, the Insurance Company shall provide the following additional services beginning as of an effective date agreed to by the Employer and the Insurance Company, for the employee groups designated by the Employer.

The cost for these additional services are included in the premium rates agreed to by the parties:

1. **Managed Physical Medicine Program** (as implemented on August 1995)

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will provide access to a Managed Physical Medicine Program ("Program").

   A Managed Care Network will be made available to Employees and their Dependents, located in those geographical sites agreed to by the Parties. The Network shall include Providers who render chiropractic treatment, physical and occupational therapies. These Network Providers will be included in a directory of providers with periodic updates and/or telephonic access to the information in the directories.

   The contracted health care providers participating in the Managed Care Network can change at any time. Notice on changes will be given in advance or as soon as reasonably possible.

   The Insurance Company will maintain a grievance process so that Members may obtain assistance with, and express their opinions about, their use of the Managed Care Network.

   The Insurance Company does not employ Network Providers and they are not the Insurance Company's agents or partners. Network Providers participate in Managed Care Networks only as independent contractors. Network Providers and the Members are solely responsible for any health care services rendered to Members that are not covered under the benefits provided by the Insurance Company.

2. **Empire Plan NurseLine$_{SM}$ Program** (as implemented on February 1, 2000).

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will provide Participants with communication materials as mutually agreed upon by the Employer and the Insurance Company, and Empire Plan NurseLine$_{SM}$, a 24-hour, seven (7) days per week service providing general health information, the identification of specific health related concerns, direct the caller to the right setting to meet their health concern as well as education information regarding those concerns, by registered nurses by telephone or via an audio health information library.

3. **Disease Management Program** (as implemented on dates indicated)

   For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company shall offer agreed upon Program services to Members. The Insurance Company will provide access to various Disease Management Programs to the Employee groups designated by the Employer.

The parties agree that the Insurance Company will not disclose to the Employer, the Employer's auditors, or other third parties, the unencrypted identity of Members enrolling in the Program without the Member's written consent.

From claims data received, the Insurance Company will determine those Members who may benefit from the Program. The Insurance Company shall extend invitations to all eligible Members who meet program criteria and may benefit from the Program and shall offer the Members the opportunity to participate in the Program.

The Cardiovascular Risk Reduction program services as implemented on January 1, 2000 shall include, but are not limited to, the following: nutrition consultation; monthly contact and access to a case manager; and consultation with Network Providers.

The Managing for Tomorrow Asthma Disease Management Program services as implemented on January 1, 2002 shall include, but are not limited to, the following: preparing individualized health assessments based on submitted health survey data; distributing asthma management products, for example peak-flow meters and smoking cessation kits; and periodic follow-up and intervention for Program Members.

The Managing for Tomorrow Diabetes Disease Management Program services as implemented on March 1, 2003, shall include, but are not limited to, the following: preparing individualized health assessments based on submitted health survey data; distributing diabetes management products, for example hemoglobin A1c home test kits, low dose aspirin, and diabetes newsletters, publications, videos; periodic follow-up and intervention for Program Members; and intensive disease management by registered nurses, who are trained in diabetes disease management, for high risk Members.

As Implemented on March 1, 2007, the Insurance Company will provide an Integrated Disease Management Program for the conditions of diabetes, asthma, cardiovascular/coronary artery disease, heart failure, and chronic obstructive pulmonary disease independently or through a third party contracted entity or affiliate as proposed by the Insurance Company and approved by DCS. This Integrated Disease Management Program will replace all Disease Management programs previously provided.

The Insurance Company can terminate the disease management services in whole or in part at any time, after providing the Department at least ninety (90) days prior written notice of such termination, for any reason if such termination applies to all of its similarly situated customers. After the initial [redacted] ([redacted] months of disease management services under this Agreement, the Employer may terminate the disease management services with [redacted] days prior written notice.

Additional disease management program may be made available upon agreement by the Parties.

4. **Complementary and Alternative Medicine Program** (as implemented on October 1, 2001)

   The Complementary and Alternative Medicine Program shall make available a network of providers offering discounted charges for complementary and alternative medicine to Employees and their Dependents in those geographical sites agreed to by the parties. The Network shall include massage therapists, acupuncturists, and dietitians/nutritionists.

5. **Network Integration Program** (as implemented on January 1, 1999 for [redacted] and July 1, 2000 for [redacted] and March 1, 2008 for the [redacted] market)

For the cost specified in Exhibit A, Schedule of Premiums, the Insurance Company will make available to the Employer access to agreed upon UnitedHealthcare PPO Networks outside the State of New York. The Insurance Company will conduct an analysis periodically and make recommendations to the Employer regarding which states could realize improved participating provider access for Employees and Dependents residing or traveling outside the State of New York if the UnitedHealthcare PPO Network were made available. If the Employer and the Insurance Company agree to add a PPO network in a state or market, the Insurance Company will take a reasonable time to implement appropriate system changes, effectively communicate any changes to Employees, Dependents and the participating providers and conduct any training necessary for the customer and provider relations staff.

6. **Benefit Management Program** (as implemented on January 1, 2002 and expanded Prospective Procedure Review on July 1, 2008)

   The Insurance Company will provide various Benefit Management Programs administered by the Insurance Company to the Employer Groups designated by the Employer. Benefit Management Programs include: Prospective Procedure Review, Voluntary Medical Case Management, and Voluntary Specialist Consultant Evaluation.

   For services that require Prospective Procedure Review, the Insurance Company will review submitted medical information and compare to nationally accepted medical criteria to determine the appropriateness of the procedure. The Insurance Company will refer services that initially fall outside of the medical criteria to a board certified practicing physician for additional review. The Insurance Company will notify enrollees, in writing, of the outcome of the Prospective Procedure Review within [redacted] business days of receipt of all information needed to complete the review.

   The Insurance Company will identify through claims analysis and consultation with the Hospital Program Insurer, members who may benefit from Medical Case Management. The Insurance Company will offer voluntary participation in the Program to members meeting the criteria. For members who agree to participate in the Program, and in consultation with the treating physician, the Insurance Company will develop and implement a treatment plan which may include home care covered under HCAP, physicial therapy covered under the MPMP, as well as alternate benefits for services/care which are not covered under the Empire Plan benefit design, unless authorized as part of an MCM case.

   The Insurance Company will provide members who contact them regarding a Voluntary Specialist Consultation Evaluation with a list of up to three physicians whose specialty is similar to the treating physician.

   The Prospective Procedure Review program is added effective July 1, 2008 to expand pre-notifications to include those for MRI, MRA, CT, PET and Nuclear Medicine (including Nuclear Cardiology) procedures for eligible members.

7. **Consolidated Toll Free Services** (as implemented on November 1, 2002)

   For the cost shown in the Schedule of Premiums, the Insurance Company will provide a toll-free service for Empire Plan members consolidating toll-free telephone numbers for multiple benefit insurers associated with the Empire Plan. The Insurance Company will act as liaison with each of the Empire Plan insurers for implementation, operational oversight, and

technological coordination for these services and will provide standard monthly call volume and trend reports to the Employer.

8. **Basic Medical Provider Discount Program** (Program effective October 1, 2004)

   The Insurance Company shall make its Physician's Shared Savings Program available to the Employee Groups designated by the Department as eligible for the Empire Plan Basic Medical Provider Discount Program (BMPDP). The BMPDP provides access to discounted charges made available to the Insurance Company from health care providers who contract with a third party to provide such discounted charges when the discounted charges are less than the reasonable and customary value of the claim under the Basic Medical Program. The services under the BMPDP provide access to provider discounts only. These providers do not constitute a network

   If a Member is enrolled in the Empire Plan and receives services from an Empire Plan Network Provider on the date services were rendered or the provider was an Empire Plan Network Provider within two years immediately preceeding the date services were rendered, the BMPDP and any related fees shall not be applicable. In addition, the Department will not pay any fee for misprocessed or ineligible claims.

   Furthermore, in no case will the Department pay, on any claim, any portion of a fee that when added to the BMPDP allowed amount, would cause the Empire Plan to incur a higher cost than would have been incurred under the Basic Medical Program.

   The Insurance Company can terminate all or part of the BMPDP at any time for any reason if such termination applies to all of its similar situated customers with at least [redacted] days written notice to the Department prior to termination of the BMPDP. The Department can terminate the program at any time for any reason by giving the Insurance Company [redacted] days written notice. The Insurance Company will implement the termination on the [redacted] day after receiving such notice.

9. **Cancer Resource Services** (Program effective October 1, 2004 and effective April 23, 2007 the program is expanded to include bone marrow transplants)

   The Insurance Company agrees to provide to the Employee Groups designated by the Employer a network of providers for Oncology Services. The term "Oncology Services" as used in this section includes health care services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology. Oncology Services rendered by these providers, and the discounted rates for these services, are available to Members based on the contractual relationship between the Insurance Company's affiliate, OptumHealth/United Resource Networks, and these providers.

   The Plan will pay for and cover as Plan benefits Oncology Services, which includes supplies and a lifetime travel allowance, in accordance with the collective bargaining agreement in effect for each Employee Group.

10. **Drug Rebates** (Program effective January 1,2004)
    The Insurance Company or an intermediary may negotiate with drug manufacturers regarding the payment of Drug Rebates on applicable prescription drug products dispensed to Members under the Plan's medical benefit starting with July 1, 2003.

The Employer will receive [redacted] of the Drug Rebates the Insurance Company receives in connection with prescription drug products dispensed to Members under the Plan's medical benefit. The Insurance Company will retain the balance of such Drug Rebates as part of its compensation under this Agreement. If an intermediary is involved, it may retain a portion of the gross amounts received from drug manufacturers in connection with the relevant prescription drug products dispensed to Members under the Plan's medical benefit.

The Employer will only receive Drug Rebates to the extent that Drug Rebates are actually received by the Insurance Company. Thus, for example, if a government action or a major change in pharmaceutical industry practices prevents the Insurance Company from receiving Drug Rebates, the amount the Employer receives may be reduced or eliminated.

The Employer agrees that during the term of this Agreement, neither the Employer nor the Plan will negotiate or arrange or contract in any way for Drug Rebates or the purchase of prescription drug products from any manufacturer under the Plan's medical benefit under this Agreement.

11. Prosthetic and Orthotic Provider Network (Program effective January 1, 2005)

The Insurance Company agrees to develop and maintain a network of prosthetic and orthotic providers.

12. Communication Support Services (Program effective January 1, 2005)

The Insurance Company agrees to facilitate the payment of invoices related to the Department's Communication Budget as directed by the Department. DCS will provide the Insurance Company a schedule of the annual Communications Budget including amounts to be collected on a quarterly basis by the Insurance Company from other carriers of the Plan. Amounts collected from other carriers will be treated as an offset to the total communications expense and [redacted] will be applied to the net communications expense. Any invoices received after January 31 of the current year which pertain to the previous years Communications Budget, will be applied to the current years budget. The Insurance Company agrees to provide DCS a report of invoices paid in relation to budgeted amounts each quarter for their review.

13. Workers Compensation Recovery Program (Program effective April 1, 2007)

The Insurance Company will provide recovery services for overpayments related to Workers Compensation (WC) claims through its recovery vendor. Recovery services on claims for Participating Agencies (PA's), Participating Employers (PE's) and spouses and dependents age 16 years or older of New York State (NY) enrollees will be provided and any overpayments will be collected directly from the WC carriers. Recoveries will not involve contact with members or providers and will not apply to claims for active New York State employees. The Employer will not engage any other entity to provide the services described herein without the Insurance Company's prior approval.

Fees will be charged as a [redacted] deducted from the actual recoveries with the net amount of the recovery credited back to the Employer. An advance notice will be provided if there are any changes in the fees for these recovery services.

The Insurance Company has the authority to develop and use, after Department review and approval, standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if it is decided to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. The use of Insurance Company standards and procedures may not result in full or partial recovery for any particular case. A recovery will not be pursued if it is not permitted by any applicable law, or if recovery would be impractical. Litigation may be initiated to recover payments, but there is no obligation to do so.

14. **Outpatient Surgical Facility Claims Services** (Program effective August 1, 2007)

    The Insurance Company will use established reasonable and customary values from a source approved by DCS for outpatient surgical facility claims covered under the Basic Medical Program.

15. **Kidney Resource Services (KRS) Program** (Program effective July 1, 2008)
    The Insurance Company will provide a Kidney Resource Services program to eligible Members. The program will include members with End Stage Renal Disease and Stages 5, 4 and 3 kidney disease who opt to participate.

ARTICLE XXX. SAVINGS AND RETURN ON INVESTMENT GUARANTEES

1. Disease Management Services

A savings/return on investment (ROI) guarantee is in place for the initial three years of the program as described in letters dated August 7, 2006 and September 29, 2006 containing the Insurance Company's program proposal to the Employer. The savings/ROI guarantee covers the period of March 1, 2007 until February 28, 2010.

2. Kidney Resource Services (KRS) Program

A savings guarantee is in place for the initial four years of the Kidney Resource Services program as described in the January 19, 2007 letter containing the Insurance Company's program proposal to the Employer. The savings guarantee covers the period of July 1, 2008 until June 30, 2012.

3. Prospective Procedure Review

A savings guarantee for the first year of the expanded Benefits Management Program for Prospective Procedure Review was negotiated with the external vendor on behalf of the Employer and is the sole responsibility of the external vendor in accordance with the April 9, 2008 letter to the Employer.

APPENDIX A
STANDARD CLAUSES FOR ALL NEW YORK STATE CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. **EXECUTORY CLAUSE**. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. **NON-ASSIGNMENT CLAUSE**. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance law.

3. **COMPTROLLER'S APPROVAL**. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller’s approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6.a).

4. **WORKERS' COMPENSATION BENEFITS**. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. **NON-DISCRIMINATION REQUIREMENTS**. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration, or repair of any public building or public work, or for the manufacture, sale, or distribution of materials, equipment, or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of face, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract, as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex, or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. **WAGE AND HOURS PROVISIONS**. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. **NON-COLLUSIVE BIDDING CERTIFICATION**. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor warrants, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further warrants that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. **INTERNATIONAL BOYCOTT PROHIBITION**. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contractors execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. **SET-OFF RIGHTS**. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. **RECORDS**. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. **IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.** (A) *FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER*. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number; i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(B) *PRIVACY NOTIFICATION*. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purpose and for any other purpose authorized by law; (2) the personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease "the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. **EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN**. In accordance with Section 312 of the Executive law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability, or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status.

Contractor will include the provisions of "a, "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the Work) except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Division of Minority and Women's Business Development pertaining hereto.

13. **CONFLICTING TERMS**. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. **GOVERNING LAW**. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. **LATE PAYMENT**. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article XI-A of the State Finance Law to the extent required by law.

16. **NO ARBITRATION**. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. **SERVICE OF PROCESS**. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. **PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS**. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State. In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State, otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. **MACBRIDE FAIR EMPLOYMENT PRINCIPLES**. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. **OMNIBUS PROCUREMENT ACT OF 1992**. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts. Information on the availability of New York State subcontractors and suppliers is available from:

Department of Economic Development
Division for Small Business
30 South Pearl Street – 7TH Floor
Albany, New York 12245
Tel. 518-292-5220

A directory of certified minority and women-owned business enterprises is available from:

Department of Economic Development
Minority and Women's Business Development Division
30 South Pearl Street – 2nd Floor
Albany, New York 12245
http://www.empire.state ny.us.

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $l million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. **RECIPROCITY AND SANCTIONS PROVISIONS** Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383 respectively) require that they be denied contracts which they would otherwise obtain. Contact the Department of Economic Development for a current list of jurisdictions subject to this provision.

22. **PURCHASES OF APPAREL.** In accordance with State Finance Law Section 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) Such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hour laws and workplace safety laws; and (ii) Vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized for this contract by the bidder.

Revised June 2006