Metropolitan Insurance Companies

APPROVED
STATE OF NEW YORK
NOV 17 1986
SUPERINTENDENT OF INSURANCE

[redacted]

Metropolitan Life Insurance Company

A Mutual Company Incorporated in New York State

Employer	
STATE OF NEW YORK	
Group Policy No	Date of Issue
30501-G	January 1, 1986

In consideration of the payment by the Employer of the initial premium and of the payment hereafter by the Employer, during the continuance of this Policy, of all premiums when they fall due as hereinafter provided,

Metropolitan Life Insurance Company,

(Herein called the Insurance Company)

promises to pay the insurance and other benefits described in the Exhibits listed in the Schedule Of Exhibits hereof as such Exhibits have applicability to the respective Employees insured hereunder, in accordance with and subject to the provisions of this Policy.

The provisions hereinafter contained, including those in the Exhibits, are part of this Policy as fully as if recited over the signatures hereto affixed.

This Policy is issued for an initial period commencing with the date of issue and ending with the day immediately preceding the next renewal date hereof.

In witness whereof, the Insurance Company executes this Policy on _____

[redacted]

Richard M. Blackwell
Vice-President and Secretary

[redacted]

John J. Creedon
President and Chief Executive Officer

_____
Registrar

Dividend, If Any, Determined Annually

30501-G

CONTENTS

ARTICLE I. DEFINITIONS.

"Employee" means any person defined as such in Exhibit 1 listed in the Schedule of Exhibits, or in the Regulations of the President of the Civil Service Commission, as amended from time to time.

"Dependent" means any person defined as such in Exhibit 1 listed in the Schedule of Exhibits.

"Personal Insurance" means insurance or benefits payable on account of the happening of a specified event to the Employee.

"Dependent Insurance" means insurance or benefits payable on account of the happening of a specified event to a Dependent of the Employee.

"Renewal date" means each anniversary of the date of issue hereof.

"Due date" means the first of each month commencing January 1, 1986.

ARTICLE II. ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE.

A. ELIGIBILITY.--Each Employee shall be eligible for Personal Insurance and for Dependent Insurance under this Policy in accordance with the regulations of the President of the New York State Civil Service Commission, as amended from time to time.

B. EFFECTIVE DATES OF INSURANCE.--An Employee shall make a request for Personal Insurance or Personal and Dependent Insurance in accordance with the regulations of the President of the New York State Civil Service Commission, as amended from time to time.

The Personal Insurance or Personal and Dependent Insurance shall become effective on a date or dates determined in accordance with the regulations of the President of the New York State Civil Service Commission, as amended from time to time.

ARTICLE III. CONTRIBUTIONS.

The amount which an Employee may contribute to the cost of the insurance shall not exceed the premium charged for the amounts of his or her insurance.

ARTICLE IV. CESSATION OF INSURANCE.

All insurance hereunder shall automatically cease upon the discontinuance of this Policy and an Employee's insurance shall cease prior thereto in accordance with the provisions pertaining to cessation of insurance specified in the applicable Exhibit.

ARTICLE V. SCHEDULE OF INSURANCE.

The amounts of insurance applicable to any Employee under this Policy shall be the difference between such amounts in accordance with Exhibit 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 3i, 3j, 3k, and 3l and such amounts in accordance with Exhibit 2, subject, however, to the provisions and limitations of said Exhibits.

ARTICLE VI. CONCURRENT REVIEW OF SELECTED ADMISSIONS.

The Insurance Company will enter into a contract with ar independent party acceptable to the Employer for the purpose of conducting concurrent utilization review of all covered admissions to a hospital or approved facility for the treatment of psychiatric conditions,alcoholism and/or substance abuse.

ARTICLE VII. UTILIZATION REVIEW OF CLAIMS.

The Insurance Company will in accordance with Exhibit 4 conduct utilization review of all Participating Provider submitted claims, all psychiatric claims and certain types of major medical claims received under the terms of this Policy.

ARTICLE VIII. CERTIFICATES.

The Insurance Company will issue to the Employer, for delivery to each Employee insured hereunder, an individual certificate which shall state the insurance to which each Employee is entitled under this Policy and to whom benefits are payable, and which shall summarize the provisions of this Policy principally affecting the Employee. The word "certificate" as used in this Policy includes certificate riders and certificate supplements, if any.

ARTICLE IX. COMMUNICATIONS PROGRAM.

The Insurance Company shall participate in a communications program as described in Exhibit 5.

ARTICLE X. WELLNESS PROGRAM.

The Insurance Company shall provide funds to support all or part of a wellness program as designed by the State and mutually agreeable to the Insurance Company.

ARTICLE XI. RECORDS; ENROLLMENT INFORMATION TO BE FURNISHED.

The Insurance Company shall maintain records from which may be determined at all times the names of all Employees and Dependents insured hereunder and the amount of insurance in force for each of such Employees and Dependents, together with the date when any insurance became effective and the effective date of any increase or decrease in amount of insurance. Such records may, with the consent of the Insurance Company, be maintained by the Employer.

The Employer and the Employees shall furnish to the Insurance Company all information which the Insurance Company may reasonably require with regard to any matters pertaining to the insurance under this Policy. The Employer agrees to allow the Insurance Company to inspect all documents, books, and records of the Employer which may have a bearing on the insurance or premiums under this Policy.

ARTICLE XII. REPORTS; INFORMATION TO BE FURNISHED.

The Insurance Company shall produce reports both in accordance with a recurring schedule and on demand. These reports fall into two categories: financial and health service utilization. Financial Reports will include Annual Financial Experience Statements, Quarterly Estimated Financial Experience Statements and Monthly Cash Management Reports. The Annual Statement of Financial Experience shall be delivered to the Employer by the Insurance Company within 75 days of the end of each policy year. The Monthly

Cash Management Report shall be due within 10 days of the end of each month. The Quarterly Estimated Financial Experience Statement shall be due within 30 days of the end of each quarter. The actual format, content and detail of the financial reports will be established by the Employer after consultation with the Insurance Company.

The Health Service Utilization Reports will include the regularly scheduled reports outlined in Exhibit 6 of the attached Schedule of Exhibits. The Insurance Company shall, upon request by the Employer, submit claims and experience data directly to the Joint Committee on Health Benefits. The actual format and data content of all reports will be established by the Employer after consultation with the Insurance Company.

The Insurance Company shall furnish the Employer a tape file containing detailed claim records. The tape file will be produced semi-annually covering claims paid for the semi-annual period and will be submitted to the Department of Civil Service, Division of Employee Benefits in July and January of each year. The Insurance Company shall, upon request of the Employer, provide additional special reports in the format specified by the Employer. In order to protect the privacy of Employees, identification will be deleted from the tape file records by means of encrypting the identification number.

ARTICLE XIII. CONFIDENTIALITY.

All Insurance Company claims and enrollment records relating to this Policy are confidential and shall be used by the Insurance Company solely for the purpose of carrying out its obligations under this Policy and for measuring the performance of the Insurance Company in accordance with Articles XIV and XV of this Policy. Except as directed by a court of competent jurisdiction or as necessary to comply with applicable New York State or Federal law or regulation, or with the written consent of the Employee, no such records may be otherwise used or released to any person by the Insurance Company, its agency or representatives, either during the term of this contract or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Employer, be grounds for termination of this Policy.

ARTICLE XIV. AUDIT AUTHORITY.

The Employer shall have the authority to conduct financial and performance audits of the Insurance Company's administration of this Policy.

Such audit activity may include, but not necessarily be limited to: (1) review of claim certification and adjudication procedures and systems, (2) review of processed claims to assess the accuracy of claims certification and adjudication, including, but not limited to, tests of: (a) claimant eligibility, (b) non-duplication of benefits, (c) proper coordination of benefits, (d) payment of covered services only, (e) proper application of deductible, (f) proper application of coinsurance, (g) proper consideration of Medicare, (h) proper application of other policy provisions,

(3) review of documentary evidence to determine the fairness of all items on the Financial Statement of Experience, and

(4) review of any and all activities relating to the Insurance Company's administration of this Policy.

The Insurance Company shall make available documentary evidence necessary to perform these reviews. Such documentation may include, but is not limited to, source documents, books of account, subsidiary records and supporting workpapers, claim documentation and pertinent contracts and correspondence.

Documentation necessary for an understanding of accounting, claim payment, enrollment or other systems and activities shall be made available. These systems shall be demonstrated to the Employer's auditing personnel upon request. Documentation of computerized aspects of the accounting, claim payment, enrollment and other systems shall be furnished to auditing personnel and the system fully explained.

The Employer's auditing personnel shall be provided an adequate number of screens (CRTs) so that they may access data from accounting, claim payment, enrollment and other systems.

The Insurance Company shall make available to the Employer's auditors all data in its computerized files that are relevant to this Policy. Such data may, at the Employer's discretion, be submitted to the Employer in machine readable format or the data may be extracted by the Employer or by the Insurance Company under the direction of the Employer's auditors.

The Insurance Company, at the Employer's request, shall provide detailed schedules and analyses supporting amounts shown on the Financial Statement of Experience.

The Insurance Company shall, at the Employer's request, search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 45 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would serve to jeopardize the Insurance Company's competitive position. A third party, mutually agreeable to the Employer and the Insurance Company, shall serve as binding arbitrator on those items the Insurance Company excludes from the scope of the Employer's audit, based on the provisions of this paragraph, to which the Employer does not agree.

ARTICLE XV. PERFORMANCE STANDARDS.

The Insurance Company agrees to a Performance Standards Program in the following areas of policy administration: (a) claim payment accuracy-dollar basis, (b) claim payment accuracy-occurrence basis, (c) claim turnaround time, (d) provider participation level, and (e) paid claim data

base accuracy. The Insurance Company's level of performance above or below the established standards will result in financial incentives and/or penalties being assessed the Insurance Company by the Employer. This program includes Group Policy Nos. 30500-G, 30501-G and 30502-G as they are combined on a claim payment basis.

This Article shows tentative benchmark standards, incentives and/or penalties for the second and third year for the following three areas of policy administration:

(b) claim payment accuracy - occurrence basis

(c) claim turnaround time

(e) paid claim data base accuracy

The actual second, third and subsequent year standards, incentives and/or penalties for these policy administration areas will be negotiated by the Insurance Company and the Employer prior to the policy year for which they are in force, taking into account the results of the Employer's claim reviews. Subsequent year standards, incentives and/or penalties for other policy administration areas will be similarly negotiated.

The Employer reserves the right to establish performance standards for additional areas of policy administration. The new performance standards shall become effective on the anniversary date of the Policy. The Employer and the Insurance Company shall agree on the level of the standard and the penalties and possible incentives to apply.

Claim Payment Accuracy-Dollar Basis -- Claim payment dollar errors will be calculated on a net basis (overpayments less underpayments). The net mispayment may be established by using statistical estimate techniques or other generally accepted methods. [redacted]

The standards, incentives and penalties shall be as shown below:

Review Period	Standard	Incentive	Penalty

Claim Payment Accuracy-Occurrence Basis -- This occurrence basis shall measure the number of times an error is made which can or does cause a monetary error. The conditions under which an occurrence error will be recorded will be defined in the audit rules referred to later in this Article.

Claim Turnaround Time -- This standard pertains only to non-participating provider claims.

Claim turnaround time is measured in calendar days from the time a claim is received until a response (benefit check, explanation of reason for no benefit, request for additional information, etc.) is sent to the Employee.

The claim turnaround standards and penalties shall be as follows:

Review Period	Standard % of Non-Participating Provider Claims Processed within [redacted]	Penalty per Claim Below Standard %
[redacted]	[redacted]	[redacted]

Provider Participation Level -- The Insurance Company shall maintain a base line provider participation level in accordance with Article VI of this Policy.

The Insurance Company shall maintain an up-to-date participating provider file containing provider name, provider identification number, address including county, specialty and effective dates of participation. The Employer may at its discretion review the paid claim data base, the provider file and/or send confirmations directly to the Participating Providers in order to measure the level of participation. The standards and penalties shall be as follows:

Review Period	Standard % of Base Line Participation	Penalty per Occurrence per Month
[redacted]	[redacted]	[redacted]

Penalty represents the amount to be charged each month or part thereof for each instance the participation level is below the standard. This standard will be measured quarterly on an actual rather than a statistical estimate basis.

Paid Claim Data Base Accuracy -- The Insurance Company shall maintain an accurate data base of processed claims, both to facilitate the correct and efficient processing of future claims and to produce the regular and special purpose management reports.

The following data elements for each processed claim shall be subject to data base accuracy standard: (a) Employee identification number, (b) patient relationship code, (c) patient sex, (d) patient date of birth, (e) date(s) service provided, (f) diagnosis code, (g) type of service (office visit, surgery, psychiatric, etc.), (h) procedure code, (i) provider identification, (j) participating - non-participating provider code, (k) geographic area of service, (l) patient medicare eligible, (m) coordination of benefits provisions applied, (n) submitted expenses - dollar value, (o) covered expenses - dollar value, (p) benefits paid - dollar value, (q) patient dependent student over 19, (r) patient disabled dependert over 19, (s) Benefit Package Indicator, (t) Participating Agency code, (u) provider fee reduced for reasonable and customary criteria.

The items listed above are intended to be illustrative of the kind of data elements to be tested. The actual items to be tested will be determined after the Employer's auditors have had an opportunity to become familiar with the data stored on the Insurance Company's computerized claim system (UCS). The data elements will be specified in the audit rules as described in this Article.

Performance standards, incentives and penalties are as follows:

Review Period	Performance Standard % of Correct Data Elements	Incentive Amount per # Data Elements Above Standard	Penalty Amount per # Data Elements Below Standard

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.

The determination of performance against the four claim standards shall be accomplished by a monthly review of a sample of processed claims (Quality Control). The combination of the results of these Quality Control reviews will be the measure of performance each review period.

A third party, mutually agreeable to the Employer and the Insurance Company, shall have the power of binding arbitration if agreement cannot be reached on the provisions of this Article.

ARTICLE XVI. COMPUTATION AND PAYMENT OF PREMIUMS; GRACE PERIOD.

The premiums due on and after the date of issue of this Policy for the insurance provided hereunder shall be determined and shall be payable in accordance with the following paragraphs:

The initial premium is due on the date of issue of this Policy and subsequent premiums shall be due on each due date thereafter.

The initial premium rates for the insurance provided hereunder are shown on the Schedule of Premiums herein. The Insurance Company may change any or all of such premium rates (a) on the first renewal date of this Policy and on any due date thereafter, (b) as mutually agreed upon by the Employer and the Insurance Company, or (c) whenever the terms of this Policy, or the benefits provided by the Employer's Basic Benefits plan are changed, provided that in the case of any increase in the premium rates, pursuant to (a) or (b) of this paragraph, the Insurance Company shall deliver to the Employer written notice of such increase at least 120 days prior to the date such increase is to become effective. Renewal rates will be developed based on projected claim experience and expense level, including a margin for claim fluctuation. Any deficits resulting from prior year losses will be made up from all available surplus in future years. The amount of margin used in determining renewal rates will be mutually agreed upon by the Insurance Company and the Employer. Rate changes pursuant to (c) will not be implemented until such time as the Employer can review documentation to support such rate change.

The new rates shall be paid to the Insurance Company as soon as is administratively feasible. The amount of the rate change shall be computed so as to make the rate change retroactive to the date of the change in terms of the Policy.

The Insurance Company shall furnish, in accordance with employer specifications, documented evidence to justify any change in the premiums under this Policy. The Employer may request, and the Insurance Company shall provide, additional information, clarification, greater detail and/or alternate analysis of the evidence supporting any rate change.

The initial premium due on the date of issue of this Policy and the premium due on any due date after the date of issue of this Policy shall be the aggregate of the premiums for the insurance then in force, determined on the basis of the premium rates then in effect for the respective types of insurance.

Premium adjustments involving return of premium to the Employer shall be reported on the Annual Financial Experience Statements. Such statements will report all transactions, including adjustments to prior years, made in the 12 months being reported upon. Adjustments to prior years shall be reported on the Financial Experience Statement covering the period within which the adjustment was made.

All premiums falling due under this Policy are payable by the Employer on or before their respective due dates, either at the Home Office of the Insurance Company (or at such office as the Insurance Company may designate), or to an authorized representative of the Insurance Company in exchange for a receipt signed by the President or Secretary of the Insurance Company and countersigned by such representative. The payment of any premium shall not maintain the insurance under this Policy in force beyond the day

immediately preceding the next due date, except as provided in the next paragraph.

A grace period of 31 days will be granted for the payment of premium accruing after the first premium, during which grace period this Policy shall continue in force, but the Employer shall be liable to the Insurance Company for the payment of the premium accruing for the period the Policy continues in force.

If the Employer fails to pay any premium within the grace period, this Policy may be discontinued on the last day of such grace period, except that if written notice is given by the Employer to the Insurance Company prior to the expiration of the grace period that this Policy is to be discontinued before the expiration of the grace period, this Policy shall be discontinued as of the date of receipt of such written notice by the Insurance Company or the date specified by the Employer for such discontinuance, whichever date is later, and the Employer shall be liable to the Insurance Company for the payment of the pro-rata premium for the period commencing with the last due date and ending with such date of discontinuance.

In the computation of the aggregate premium due under this Policy on any due date, the Insurance Company may use any equitable method which is mutually agreeable to the Employer and the Insurance Company. The Employer shall not be liable for any premium waived pursuant to Exhibits 1a and 1b.

ARTICLE XVII. SPECIAL PROVISIONS RELATING TO THE RESERVES FOR OPEN AND UNREPORTED CLAIMS AND LIABILITY FOR SUCH CLAIMS.

These provisions apply to the combined premiums under Group Policy Nos. 30500-G, 30501-G and 30502-G. All transfers referred to in this Article between the Insurance Company and the Employer are determined on this basis.

While this Policy remains in force, the reserve for open and unreported claims, including the amount needed for claim administration expenses on such claims, shall be held by the Employer. The Insurance Company will be credited with prepayment to the Employer toward such reserve liability an amount equal to the sums deducted from its earned premium and paid instead to satisfy the Employer's liability under predecessor Policy No. 26250-G for repayment of comparable reserves previously transferred to the Employer under that policy.

Within 75 days of the end of each policy year, while this Policy remains in force, the Insurance Company shall determine the appropriate reserve for open and unreported claims under this Policy, including the amount needed for claim administration expenses on such claims. If the total of such reserves exceeds amounts previously credited or transferred to the Employer under this Article, such excess amount shall be immediately paid to the Employer by the Insurance Company in lieu of being held as a reserve for open and unreported claims. If the total of such reserves is lower than the amounts previously credited or transferred to the Employer under this Article, then the amount of the difference shall be paid by the Employer to the Insurance Company within 31 days of receipt of notification from the Insurance Company of its obligation for such payment.

In the event of termination of this Policy, the Insurance Company will not be liable for the full payment of open and unreported claims against the Policy unless the Employer pays a special premium equal to the balance of amounts previously credited or transferred to the Employer against the Policy's reserve for open and unreported claims less any amounts transferred to the Insurance Company under the terms of the preceding paragraphs. Such special premium may be paid to the Insurance Company in installments over a period of 6 months following termination of this Policy, based on the following percentages of the special premium due, with payment being made on or before the 20th of each month: first month - 33 1/3 percent, second month - 25 percent, third month - 16 2/3 percent, fourth month - 8 1/3 percent, fifth month - 8 1/3 percent, and sixth month - 8 1/3 percent. Such special premium may also be paid in accordance with a lower and/or slower repayment schedule than that specified above, provided that the installments paid by the Employer, together with positive balances held by the Insurance Company in the Employer's cash account for this Policy, could reasonably be expected to meet the cash-flow needs of claims payment and administration expense based on prior plan experience; or it may be paid in accordance with such other repayment schedule as may be mutually agreed to by the Employer and the Insurance Company. In the event the special premium is paid at a lower and/or slower schedule, the Insurance Company will charge interest in accordance with its dividend formula upon the difference between the amounts due under the schedule specified above and the amounts actually paid by the Employer.

Upon termination of this Policy, the Insurance Company shall have the obligation, provided all regular and special premiums due have been paid, to pay all benefits that become due in accordance with the provisions of this Policy after the date of termination. If the special premium referred to in the preceding paragraph is being paid in installments extending beyond the date of termination of this Policy, then the Insurance Company's obligation to pay benefits shall be limited to the amount of special premium actually received by the Insurance Company less any charges made by the Insurance Company in accordance with the last sentence of the preceding paragraph. If the special premium has subsequently been paid in full, the Insurance Company will be obligated for all benefits payable pursuant to the terms of the Policy.

If any such premiums remain unpaid, then upon such termination, the Employer shall assume the obligation to pay those benefits, with respect to Employees whose insurance under this Policy is affected by such termination, that become due in accordance with the provisions of this Policy after the date of such termination which are not the obligation of the Insurance Company as herein set forth. Upon request by the Employer, the Insurance Company will pay benefits which are the obligation of the Employer in accordance with the preceding sentence under and subject to the terms of an administrative services agreement between itself and the Employer or its designated agent.

The parties understand and agree that the terms of this Article will be affected in the event appropriate provision reflecting the obligations herein set forth is not made in the State of New York Executive Budget for each Fiscal Year hereafter. The parties agree to amend this Policy in the event such appropriate provision is not made in any Executive Budget.

ARTICLE XVIII. PARTICIPATION; DIVIDENDS.

This Policy is a participating contract and the Insurance Company shall determine annually the dividend, if any, to which this Policy may be entitled. Based on conservative projections of financial experience, the Insurance Company shall declare a preliminary experience credit 3 months prior to the end of each policy year. Such credit shall be payable to the Employer after the last day of the policy year. The Insurance Company shall declare a supplemental experience credit within 75 days after the end of each policy year, which shall be immediately payable to the Employer. The sum of the preliminary and supplemental experience credits shall equal the total dividend to which this Policy may be entitled. The Insurance Company shall pay to the Employer such portions of the payable experience credits as the Employer requests within 10 days after receipt of written requests for such payment. The Employer may apply any dividend to reduce the Employer's cost of this Policy, except that an amount equal to the excess, if any, of the Employees' aggregate contributions toward the cost of the insurance provided hereunder over the net cost of such insurance shall be distributed or applied by the Employer for the sole benefit of the Employees.

In the event of the discontinuance of this Policy, if the cumulative preliminary experience credits exceed the actual cumulative dividends paid under this Policy, the Employer guarantees to refund the total overpayment to the Insurance Company.

In the event this Policy is discontinued prior to the declaration of any preliminary experience credit, or between such declaration and January 1 of the following year, no such preliminary experience credit or supplemental experience credit will be payable. Instead, the Insurance Company shall calculate a terminal dividend, if any, to be paid to the

Employer in accordance with the then current dividend formula of the Insurance Company.

Should the Policy suffer a loss in a policy year, deficits shall be carried over to future policy years.

The financial experience during the initial first policy year under Group Policy Nos. 30500-G and 30502-G, issued to the Employer by the Insurance Company, shall be combined with the financial experience hereunder for the purpose of determining the net divisible surplus payable hereunder. Notwithstanding this provision, experience credits and/or charges shall be calculated on each Policy individually, by a method mutually agreed upon by the Employer and the Insurance Company, for the purpose of allocating available experience credits to specific Policies and calculating appropriate renewal premiums for each Policy. For each policy year following the first policy year, the Employer may elect 150 days in advance of each renewal period whether to pool the financial experience of this Policy with Group Policy Nos. 30500-G and/or 30502-G for the purpose of determining the net divisible surplus payable hereunder.

ARTICLE XIX. CASH MANAGEMENT.

The Insurance Company shall establish a cash management system whereby the financial accounting under this Policy is determined in the manner set forth below. Cash will be combined with that of Group Policy Nos. 30500-G and 30502-G for investment purposes. Interest credits and charges will be allocated in accordance with a formula developed by the Insurance Company subject to Employer approval among Group Policy Nos. 30500-G, 30501-G and 30502-G.

A. Premium and reserve payments to the Insurance Company will be credited upon receipt.

B. Claim payment will be charged when the check clears the bank.

C. Administrative expenses and risk charges will be estimated on a monthly basis and will be charged on the 15th of each month. Any differences between estimated and actual will be reflected with a following month's charge.

D. Dividend payment and reserve transfers to the Employer will be charged when the check clears the bank.

E. Interest credits on positive cash balances will be calculated daily using an interest rate agreed upon by the Employer and the Insurance Company. The rate, initially the six-month Treasury Bill (T-Bill) rate, will vary in accordance with an index rate. This index rate will be a short-term interest rate. For the first year of this Policy, the index rate will also be the six-month T-Bill rate, determined by the first weekly auction in each month.

F. Interest charges on negative cash balances will be calculated daily using the interest rate in E, above, plus [redacted].

G. The Employer shall have the option of changing the index each policy year. Any such index change will be communicated to the Insurance Company prior to the beginning of the policy year.

H. If, at the end of any policy year, the Insurance Company's corporate cash-flow rate proves higher than the index rate selected by the Employer, the Insurance Company will consider raising the Employer's rate, for purposes of calculating interest credits only, to the corporate cash-flow rate.

ARTICLE XX. RENEWAL PRIVILEGE.

This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Article XVI and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to decline to renew this Policy on any renewal date by giving at least 180 days prior written notice to the Employer.

The Insurance Company may also terminate this Policy 180 days following the presentation to the Employer by the Insurance Company of advance notice of such termination, if the number of insured Employees for each type of insurance provided hereunder is less than 75% of the number of Employees eligible for such insurance.

ARTICLE XXI. ENTIRE POLICY.

This Policy and the application of the Employer, a copy of which is attached hereto, constitute the entire contract between the parties. Any statement made by the Employer or by any Employee shall be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application.

ARTICLE XXII. AGENTS; ALTERATIONS.

No Agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and by the Employer and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by the Insurance Company.

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

MAJOR MEDICAL BENEFITS INSURANCE

The initial premium rate shall be in accordance with the following table:

Class	Premium Rate per Employee Personal Insurance Only	Personal and Dependent Insurance
BI-WEEKLY		
Administration Payroll Employees Institution Payroll Employees	$ .89	$ 1.98
MONTHLY		
Monthly Employees Retirees	$ 1.92	$ 4.30

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 [redacted] of the monthly premium, for the first policy year.

Thereafter, 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.

SCHEDULE OF EXHIBITS

Exhibit Number	
1a	General Information for Active State Employees
1b	General Information for Retired State Employees, Vestees and Dependent Survivors
2	Form No. G. 4889-3, Core Only
3a	Form No. G. 4889-3, CSEA
3b	Form No. G. 4889-3, M/C
3c	Form No. G. 4889-3, Council 82
3d	Form No. G. 4889-3, PBA
3e	Form No. G. 4889-3, PEF
3f	Form No. G. 4889-3, DC-37
3g	Form No. G. 4889-3, 92/93
3h	Form No. G. 4889-3, 96/97
3i	Form No. G. 4889-3, UCS 83/95
3j	Form No. G. 4889-3, UCS 85/87
3k	Form No. G. 4889-3, UUP
3l	Form No. G. 4889-3, Retired State Employees, Vestees, Dependent Survivors
4	Utilization Review Procedures
5	Empire Plan Communications Program
6	Regular Health Service Utilization Reports

COPY OF EMPLOYER'S APPLICATION ATTACHED HERETO

NOTICES TO POLICYHOLDER

PRIVILEGE OF VOTING FOR DIRECTORS. An election of Directors of the Insurance Company is held in New York, N.Y., on the second Tuesday of April in each year. The holder of this Policy, after one year from its date of issue, while it remains in force, will have a right to vote. For particulars as to how to vote, apply to the Secretary, 1 Madison Avenue, New York, NY 10010.

NOMINATIONS FOR DIRECTORS. Section 198 of the New York Insurance Law requires the Board of Directors to nominate candidates described as the "Administration Ticket" and permits groups of policyholders to make other nominations not less than five months prior to the election.

METROPOLITAN LIFE INSURANCE COMPANY

HOME OFFICE

1 Madison Avenue
New York, New York
10010

Countersigned 12/1, 1986

BY [redacted]
Licensed Agent

Metropolitan Life Insurance Company
(Herein called Metropolitan)

Application for Group Insurance

STATE OF NEW YORK
(Applicant)

Any Group Policy issued upon this application will be delivered in Albany, New York. Such Policy will be considered a New York contract. The terms of such Policy will be construed in accordance with the laws of that jurisdiction.

The persons who will be eligible for insurance are persons who are in the employ of (i) the Applicant; or (ii) a public authority or a public benefit corporation of the Applicant. Such persons must be paid for services by the respective employer.

Types of Insurance Applied for:

	Employees Only	Employees and their Dependents
Major Medical Coverage	[ ]	[x]

The premiums are to be paid on a periodic basis that is mutually agreed upon by the Applicant and Metropolitan. An advance payment of $371,503 is attached.

It is agreed that:

(a) The conditions of eligibility, the amounts of the insurance and all of the terms and conditions under which the insurance is to be provided will be set forth in the Group Policy (or Policies) issued.

(b) The Group Policy (or Policies) is to be issued only if all of the conditions listed in items (1) through (4) below are met.

(1) This application has been accepted by Metropolitan at its Home Office or at such office as may be designated by Metropolitan for that purpose.

(2) At least 50 of the persons who are eligible on the date of issue are to be insured on that date.

(3) If the insured persons must contribute to the cost of any type of insurance, at least 75% of all persons who are eligible for each such type of insurance on the date of issue must make request, in writing, for each such type of insurance. Such requests must be made on or prior to the date of issue.

(4) Metropolitan has received an amount equal to the initial monthly premium as estimated by Metropolitan.

Dated at Albany, N.Y. on January 28, 1976

[redacted]
Witness

STATE OF NEW YORK
Applicant

By [redacted]
Signature and Title

Form G.4980-1

30501G

EXHIBIT 4

UTILIZATION REVIEW PROCEDURES

REVIEW OF PARTICIPATING PROVIDER CLAIMS

Automated Individual Claim Review

The Insurance Company's claims system will provide a series of on-line criteria to identify individual claims presenting aberrant patterns worthy of additional review. Specific audit criteria for these claims will be mutually agreed upon by the Insurance Company and the Employer. If an audit is indicated for a claim, the claim will be suspended, and the reason for suspension will be noted electronically. The claim will be reviewed by a senior approver, and if the senior approver determines the claim is worthy of additional analysis, the claim will be referred to a claim consultant. The claim consultant will review the claim and contact the provider.

The claim consultant will discuss the claim with the appropriate party or parties indicating the difficulty identified and questioning the provider regarding the reason why the pattern was established. If the situation cannot be resolved to the satisfaction of the claim consultant, the claim consultant will inform the provider of his or her recommendation that the claim be processed on a special basis. Such a special basis includes the possibilities that the claim will either be declined, or reduced benefits will be paid. In any case, the provider involved is informed that this recommendation will be submitted to the Insurance Company's medical consultant for approval. If the medical consultant concurs with the claim consultant's recommendation, notification of that action will be made to the

provider who is also informed of the availability of Peer Review upon receipt of a request for same within 10 working days. At this time, the claim will be electronically placed on a 10-day call-up. If no appeal request is received within the allotted time, the claim will be processed as recommended.

The Insurance Company shall accept the findings of Peer Review and adjust claims in accordance with their recommendation.

Monthly Multi-Claim Audit

On a monthly basis, a series of reports will be prepared identifying multiple claim situations which appear worthy of further analysis regarding unusual charge, utilization or service patterns. Criteria for selecting claims for this analysis will be developed by the Insurance Company, with the approval of the Employer. The monthly data will be reviewed by the Insurance Company's claim consultants, and a list of providers whose practices appear most worthy of additional analysis will be generated. At this point, supporting individual claims data are provided via reports generated from the Insurance Company's Unified Claim System claim history.

When the claim consultant reviews the claim details in accordance with the Insurance Company's audit criteria and determines that direct review with the provider regarding his or her practice pattern is in order, the claim consultant will contact the provider in question. If the claim consultant cannot resolve his or her concerns through discussion with the provider, he or she will recommend to the Insurance Company's medical consultant that the provider be put on a 90-day probation. In addition, the claim consultant may seek monetary recoveries if appropriate. As in the case of automated Individual Claim Review, a provider may seek Peer Review. If additional problems (individual or multi-claim) are identified while the

provider is on 90-day probation, proceedings leading to termination of participation will be initiated. The provider may also bring this Peer Review if he or she believes that the Insurance Company's action is not warranted. In addition, if the provider is placed on probation three times in a 24-month period, termination proceedings will be initiated.

The foregoing utilization review procedures will be implemented under paragraphs 2 and 4 of the attached participating provider agreement.

REVIEW OF PSYCHIATRIC CLAIMS

The Insurance Company will, except when prohibited by law, prior to paying any claim for psychiatric benefits, receive documentation from the provider of psychiatric services attesting to the diagnosis and describing the treatment plan and will review such documentation to assure appropriateness of any benefit payment. The Insurance Company will establish and maintain a procedure of periodic review of continuing courses of outpatient psychiatric treatment including peer review by a qualified third-party organization to assure appropriateness of any benefit payment.

UTILIZATION REVIEW OF OTHER SELECTED MAJOR MEDICAL CLAIMS

The Insurance Company will also conduct analyses of selected major medical claims as described below. Claim paying teams will be organized by specialty to enhance this process.

Chiropractic - The Insurance Company will utilize an in-house consultant to develop and maintain guidelines for careful scrutiny of chiropractic claims. Providers will be required to complete information reports designed to allow the provider to easily provide answers to specific questions necessary to determine if appropriate care is being rendered. These reports, as well as supporting X-rays, will be reviewed by the Insurance Company's consultants who will advise on the necessity, frequency and duration of treatment.

If there is a disagreement between the Insurance Company and the Provider and/or patient, the Insurance Company will utilize the services of certified insurance consultants who will physically examine the patient and provide the Insurance Company with a formal report describing their findings.

Podiatry - The Insurance Company will utilize podiatric consultants who are participants in the New York State Podiatric Peer Review Committee. Podiatric guidelines will be maintained to assist claim processors in the daily handling of claims. The Insurance Company will request X-rays, pathology reports and narrative reports which are reviewed by its consultants to ensure the services being rendered are medically necessary.

Home Nursing Care - At the onset of nursing care, the Insurance Company will advise the patient's family, doctor and nursing personnel of the information necessary for it to evaluate the care. The Insurance Company will provide specially designed charge statements for the nurses to complete, will regularly request and review daily nursing notes to determine if the amount and level of nursing care being rendered is medically necessary. If a question of necessity arises, the Insurance Company will utilize the services

of an independent auditing firm staffed by professionals in the field of home health care. That firm will perform on-site reviews and conduct conferences with the patient and family as well as the nurses and attending physician. It will provide the Insurance Company with a formal report of its findings with recommendations which may include reduction of the number of hours of nursing care, level of nursing care (R.N.'s, L.P.N.'s or aides) or possible termination of nursing care when care becomes custodial.

Surgery - The claim for surgical services will first be subjected to the test of reasonable and customary against the statistical data contained in the Insurance Company's system. If surgical expenses exceed these guidelines, the approver will suspend the claim for review by a senior claim approver. When necessary, the narrative report of surgery anticipating review by the Insurance Company's medical consultant will be obtained to ensure that the appropriate coding has been applied. If, upon receipt of those data and complete review of details, the doctor's fee is found to be higher than the Insurance Company's guidelines, a claim consultant will contact the doctor to discuss a possible fee reduction.

Upon request by the Employer, the Insurance Company will expand its list of selected claims and/or implement a utilization review of all or selected major medical claims similar to the above described review conducted for Participating Provider claims as described above.

AGREEMENT

This Agreement entered into as of this _____ day of _____, 198_____, between Metropolitan Life Insurance Company, a corporation organized and existing under the laws of the State of New York ("Metropolitan"), and _____, a _____ ("Practitioner"), licensed, certified or otherwise authorized to practice within the scope of the authorization under the laws of the State of New York.

WITNESSETH:

WHEREAS, Metropolitan Insures or administers the medical expense benefit programs ("Programs") of the groups ("Employers") listed in Attachment A, which is attached hereto and a part hereof; and

WHEREAS, the parties hereto wish to cooperate in reducing the rising costs of medical care provided to covered employees of Employers and their covered dependents ("Covered Individuals").

NOW, THEREFORE, the parties hereto, in consideration of the mutual convenants and agreements herein contained, do hereby agree as follows:

1. Metropolitan will calculate and pay benefits for covered services in accordance with the provisions of the Programs and on the basis of the lesser of the applicable amount in the Schedule of Allowed Charges set forth in Attachment B, which is attached hereto and a part hereof, and the Practitioner's Customary Charge ("Customary Charge"). Customary Charge is defined as the charge for a medical service rendered by the Practitioner to the majority of his/her patients and is determined on the basis of the actual fees on bills of the Practitioner which have been received as part of claims submissions by Metropolitan. Allowed Charges for medical services which are not listed in Attachment B will be deemed to be the same as those for listed services of reasonably similar difficulty and technique. Any statement of charges rendered by the Practitioner to the Covered Individual for any balance due for covered services will be calculated on the basis that the lesser of the amount in Attachment B and the Customary Charge is the full amount of the Practitioner's charge.

2. In the event of any dispute over the amount of a benefit payment, the Practitioner can request that the claims determination which gave rise to the dispute, be reconsidered. In giving reconsideration to a disputed benefit payment, Metropolitan will arrange to have a review of the original claims determination performed by someone who did not make the original claims determination. Metropolitan may seek the advisory opinions of peer review bodies when, in its own discretion, it deems such to be appropriate. Practitioner will not render a statment of charges for, or attempt to collect from the Covered Individual, any amount which is in dispute.

3. Metropolitan will have the right to examine the Practitioner's patient financial accounts for Covered Individuals and to make notes, copies or transcripts therefrom in connection with this Agreement.

4. Practitioner will comply with the requirements of such utilization review programs as Metropolitan may deem necessary or appropriate.

5. Subject to paragraph 2 hereof, when, in accordance with the provisions of a Program, a Covered Individual assigns benefits to the Practitioner for covered services rendered by the Practitioner, the Practitioner will request payment from the Covered Individual only after receipt of Metropolitan's claim determination with respect to said covered services. Practitioner will not discourage Covered Individuals from assigning benefits where such assignment is permitted under the Program.

6. Metropolitan will provide material for Covered Individuals indicating that the Practitioner is a Participating Provider.

7. Metropolitan's name and the Practitioner's status under this Agreement will not be used by the Practitioner in any form of advertisement or publication without the prior written permission of an officer of Metropolitan.

8. The waiver by either party of one or more defaults on the part of the other party in the performance of obligations under this Agreement, will not be construed to operate as a waiver of any subsequent defaults.

9. The provisions of this Agreement, subject to the limitation on assignment set forth in paragraph 11 hereof, will extend to, and be binding upon, the successors and assigns of each party.

10. This Agreement may be canceled by either the Practitioner or an officer of Metropolitan upon 30 days prior written notice to the other party.

11. This Agreement may not be assigned by either party without the prior written consent of the other party.

12. The terms set forth in this Agreement contain the entire Agreement between the parties and can be altered or amended only by written agreement signed by the Practitioner and an officer of Metropolitan.

13. This Agreement will be governed by and construed in accordance with the laws of the State of New York.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed as of the date first above written.

METROPOLITAN LIFE INSURANCE COMPANY

[redacted]

John D. Moynahan, Jr.
Senior Vice-President
Group Life and Health Operations

_____
(Signature)

_____
(Typed Name)

_____
(Tax Identification No.)

_____
(Typed Address)

ATTACHMENT A

Metropolitan may at any time, add Employers' names to or delete the same from this Attachment, by giving written notice thereof to Practitioner and such changes will be effective upon receipt of such notice by Practitioner.

1. New York State and eligible political subdivisions.

EXHIBIT 5

EMPIRE PLAN COMMUNICATIONS PROGRAM

In order for the Employer and its Employees to obtain maximum benefits under the Empire Plan, information about the program in general and its benefits management features in particular must be widely disseminated in a readily understandable manner. The Insurance Company will participate with other Plan carriers in an ongoing communications program designed to achieve the following goals:

- Assure that the Empire Plan is highly visible tc Employees
- Advise Employees of the Plan's benefits and features.
- Demonstrate the value of these benefits.
- Promote Wellness.
- Educate Employees on health care consumer issues.
- Assure that agency staff assigned to administer the Employer's Health Insurance Program at the various Employer offices and facilities have adequate information to administer the program properly.

Elements of this communications program shall include, but are not limited to:

- Publication and distribution of periodic Employee newsletters highlighting special features of the program; providing information on health care consumerism; explaining group insurance concepts, costs, and advantages; and promoting the Empire Plan in general. There may be separate editions for various groups of Employees as determined solely by the Employer.

- Designing and printing attractive, easy to understand claim forms, benefit statements and related forms customized for the Empire Plan.
- Providing staff for seminars, video tapes and other training efforts designed to acquaint Employees and agency insurance administrators with the Plan's benefits and features.
- Printing and distributing to all State and Participating Agencies a comprehensive directory of Participating Providers. Copies of regional directories must also be provided to each Employee. Subsequently, revised comprehensive directories will be distributed to agencies every six months. Revised regional directories will be distributed to Employees annually. If changes to the providers listed are few, at the Employer's discretion, updates may be distributed in place of reissued directories.
- Operation of a toll-free Health Line designed to provide information on how to use the program wisely, provider participation, what questions to ask doctors, and what health care options might be available.
- Printing and distributing with certain claim benefit statements and Empire Plan Employee Satisfaction Form. The content of the form, procedures for its distribution and return, and the number to be distributed will be mutually agreed upon by the Insurance Company and the Employer.

EXHIBIT 6

REGULAR HEALTH SERVICE UTILIZATION REPORTS

I. Monthly Reports

A. Paid claims by quarter of incurral; paper and diskette

1. By BPI and patient type

2. For core plus enhancements, core, and enhancement

B. Medical care credits by quarter of incurral; paper and diskette

1. By BPI and patient type

2. For core plus enhancement

II. Quarterly Reports

A. Paid claims by type of service and semi-annual period of incurral; paper and diskette

1. By BPI, patient type, and participating provider or major medical

2. For core plus enhancement, core, and enhancement

B. Specified Ambulatory Surgery by year of incurral; paper and diskette

1. By BPI, patient type, and procedure code

2. For core plus enhancement

C. Specified Second Opinion by year of incurral; paper and diskette

1. By BPI, patient type, and procedure code

2. For core plus enhancement

D. Coordination of Benefits Report; paper

1. By NY/PA, enhanced patient type

2. For core plus enhancement

E. Psychiatric Review Activity Report; paper

1. By NY/PA, patient type, inpatient/outpatient

2. For core plus enhancement

III. Semi-annual Reports

A. MIS Report of detailed claim records by semi-annual period of payment; tape

1. In order to protect the privacy of Employees and Dependents identification will be deleted except for an encrypted Employee ID number

2. For core plus enhancement, core, and enhancement

B. Surgical claims by year of incurral; paper and diskette

1. By BPI, patient type, procedure code, in or out of hospital, maternity/other, and participating provider or major medical

2. For core plus enhancement

IV. Annual Reports

A. Psychiatric Claims Analysis by year of incurral; paper and diskette

1. By BPI, patient type, inpatient/outpatient, provider type

2. For core plus enhancement

B. Alcoholism and Substance Abuse Analysis by year of incurral; paper and diskette

1. By BPI, patient type

2. For core plus enhancement

C. Range of Claim Levels by Patient and Policy by year of incurral; paper and diskette

1. By BPI, patient type, participating provider or major medical
2. For core plus enhancement, core, and enhancement

D. Range of Psychiatric Utilization by Patient by year of incurral; paper and diskette

1. By BPI, patient type, inpatient/outpatient
2. For core plus enhancement

E. Provider Report of Provider of Claims with changes of at least $5,000 in the aggregate for the year; paper

1. By provider, county, specialty, and participating/non-participating
2. For core plus enhancement

AGREEMENT

This agreement between the State of New York and Metropolitan Life Insurance Company, sets forth the manner of accounting for a deficit in the financial experience for the policy period commencing January 1, 1986 and ending December 31, 1986.

As of January 1, 1987, a determination shall be made of the aggregate amounts of the following items for the period commencing January 1, 1986 and ending December 31, 1986:

(1) premium earned, exclusive of the stop loss charges,
(2) claims incurred,
(3) expenses, and
(4) risk charges

Such determination shall be in accordance with Metropolitan's normal practices and procedures.

Should the sum of item, (2) plus item (3) plus item (4) exceed 110% of item (1), such excess shall not be charged to the financial experience of Group Policy 30501-G. It is understood and agreed that the procedure described in this letter shall only apply to the policy period commencing January 1, 1986 and ending December 31, 1986.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in duplicate by their respective officers duly authorized to do so, to take effect as of January 1, 1986.

Dated at Albany, NY this 4th day of December, 1986

THE STATE OF NEW YORK

[redacted]

By [redacted]

Chief Insurance Examiner

Dated at New York N.Y. this 1st day of December, 1986

METROPOLITAN LIFE INSURANCE COMPANY

[redacted]

By [redacted]

METROPOLITAN LIFE INSURANCE COMPANY
("Metropolitan")

DEFICIT RECOVERY AMENDMENT

Group Policy No. 30500-G (Policy) issued to the State of New York (State) is amended effective June 28, 1988, as follows, provided this Amendment is signed by the State and returned to Metropolitan:

¶1. The premium rates for 1988 as contained in Attachment "A" hereto shall be reduced to conform to rates contained in Attachment "B" hereto.

¶2. In consideration of Metropolitan's agreement to accept the reduced premium rates, and consistent with the intent of the State Legislature as expressed in Chapter 50 of the Laws of 1988, the State will repay the $135,000,000 projected deficit (Deficit) on the Policy for years 1986 and 1987 in installment payments as provided in Attachment "C" hereto.

¶3. The State's obligation to remit installment payments to Metropolitan to repay the Deficit is not dependent upon the availability of premium surplus or the renewal of the Policy and is expressly intended to survive a termination of the Policy prior to the ending date of the installment payments as set forth in Attachment "C" hereto.

¶4. Except as specifically and expressly provided to the contrary herein, in all other respects, including but not limited to deficit interest charges, the terms and conditions of the Policy remain unchanged.

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
BY: [redacted]
DATE: June 29, 1988

METROPOLITAN LIFE INSURANCE CO.
BY: [redacted]
DATE: June 28, 1988

FORM _____ AMENDMENT NO. _____

ATTACHMENT "A" TO DEFICIT RECOVERY AMENDMENT
TO GROUP POLICY NO. 30500-G

UNAMENDED 1988 PREMIUM RATES

	MONTHLY RATES	BI-WEEKLY RATES
Employee	$ 78.85	$ 36.19
Dependent	116.72	53.58
Family	195.57	89.77

ATTACHMENT "B" TO DEFICIT RECOVERY AMENDMENT
TO GROUP POLICY NO. 30500-G

AMENDED 1988 PREMIUM RATES

	MONTHLY RATES	BI-WEEKLY RATES
Employee	$ 68.52	$ 31.45
Dependent	101.44	46.56
Family	169.96	78.01

ATTACHMENT "C" TO DEFICIT RECOVERY AMENDMENT
TO GROUP POLICY NO. 30500-G

Of the total premium collected in 1988 based on the rates reflected in Attachment "B", $33,750,000 shall be allocated to Deficit recoupment. Should the balance of total premium earned in 1988, less claims incurred and less retention charges, result in a cumulative deficit contract position exceeding $101,250,000, then the amount of such excess cumulative deficit shall be addressed through the rate setting process. Should said balance, on the other hand, result in a cumulative deficit contract position lower than $101,250,000, then the difference between such cumulative deficit and $101,250,000 shall be considered to be a dividend earned in 1988. Any such 1988 dividend, however, earned while the Deficit or any portion thereof remains outstanding, shall at the option of the State, either be applied as a lump sum payment toward the State's liability for subsequent years' Deficit recoupment payments, or be credited to offset an incurred deficit in another Empire Plan carrier's experience.

Any surplus arising from normally calculated premium rates in policy years 1989, 1990 and 1991 (as determined by Metropolitan) would first be applied to new Metropolitan deficits, if any, incurred in 1988, 1989 and 1990 policy years before the determination of the current year's dividend. In addition to the normally calculated premium rates, commencing January 1, 1989, and continuing through December 31, 1991, the State will repay the balance of the Deficit in monthly installment payments of $2,812,500 each, except that the total Deficit payments in any year, including application of lump sum earned dividends, shall not exceed $33,750,000.

In the event that the Policy is terminated prior to December 31, 1991, the schedule of remaining payments will be recalculated to include interest charges consistent with deficit interest charges provided in Metropolitan's then current Dividend Formula.

Metropolitan Life Insurance Company

Group Policy No. 30501-G bearing date of January 1, 1986 and insuring the Employees of STATE OF NEW YORK (Herein called the Employer) is hereby amended as follows:

Effective January 1, 1992,

By deleting from said Group Policy the pages listed in Column A below, and by adding to said Group Policy the pages attached hereto listed in Column B below:

Column A			Column B		
Form No.	Page No.	Dated	Form No.	Page No.	Dated
G.2130-NY-2	8-14	---	G.2130-NY-2	8-14	January 1, 1992

The foregoing amendment is to be attached to and made part of said Group Policy, and is subject to the agreements and covenants therein contained.

Dated at Albany, N.Y. this 31st day of October 19 95

[redacted]
(Witness)

STATE OF NEW YORK

By [redacted]

(Space below for use of Metropolitan Life Insurance Company only)

Dated at Troy, New York this 12th day of September 19 95

[redacted]

Metropolitan Life Insurance Company

Amendment No 1

Form G.24248
Printed in U.S.A.

The Insurance Company shall, at the Employer's request, search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc., described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would serve to jeopardize the Insurance Company's competitive position.

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) claim

coding accuracy, (c) customer service accuracy and (d) claim turnaround time. This program includes Group Policy Nos. 30500-G, 30501-G and 30502-G as they are combined on a claim payment basis. Mental Health and Substance Abuse claims will continue to be included in the audit sample.

If the Insurance Company's level of performance falls below the established standards, financial penalties will 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 generally accepted methods. [redacted]

This Article shows standards for the period beginning January 1, 1992 and ending December 31, 1995. Subsequent year standards for these policy administration areas will be negotiated by the Insurance Company and the Employer prior to the policy year for which they are in force, taking into account the results of the Employer's claim reviews.

The Employer reserves the right to establish performance standards for additional areas of policy administration. The new performance standards shall become effective on the next following anniversary date of the Policy. The Employer and the Insurance Company shall agree on the level of the standard and the penalties to apply.

Claim Payment Accuracy -- Claim payment accuracy will measure any mispayment of benefits caused by MetLife. The payment accuracy rate is the number of claims paid correctly divided by the number of claims reviewed.

The standards and penalties shall be as shown below:

Formula

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

Standard

[redacted]

Performance Penalty

- If the Payment Accuracy Rate (above) is determined to be statistically significant (i.e. the upper confidence limit is less than the standard) the difference between the payment accuracy rate and the standard will be used to calculate any penalty due.

- For each [redacted] or part thereof, by which the payment accuracy rate falls below [redacted] a penalty of [redacted] will be assessed.

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

- An additional penalty of [redacted] will be assessed if the payment accuracy rate is below the standard and is lower than that for the prior year.

Claim Coding Accuracy -- This standard shall measure the accurate usage of CPT-4, ICD-9, HCPC and Revenue codes. The standards and penalties shall be as shown below:

Formula

- Coding Accuracy Rate = Number of Claims With No Coding Errors / Number of Claims Reviewed

Standard

- [redacted]

Performance Penalty

- If the Coding Accuracy Rate (above) is determined to be statistically significant (i.e. the upper confidence limit is less than the standard) the difference between the coding accuracy rate and the standard will be used to calculate any penalty due.

- For each [redacted] or part thereof, by which the coding accuracy rate falls below [redacted] a penalty of [redacted] will be assessed.

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

Customer Service Accuracy -- This standard will measure the accuracy of claims processed relative to items that are visible to, and affect, the customer (i.e., the enrollee or the provider).

Formula

- Customer Service Accuracy Rate = $\frac{\text{Number of Claims With No Cust.Svc.Errors}}{\text{Number of Claims Reviewed}}$

Standard

- [redacted]

Performance Penalty

- If the Customer Service Accuracy Rate (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 will be used to calculate any penalty due.

- For each [redacted] or part thereof, by which the customer service accuracy rate falls below [redacted] a penalty of [redacted] will be assessed.
- The maximum penalty for this measurement will be [redacted] per year.

Claim Turnaround Time -- This standard pertains only to non-participating provider claims.

Claim turnaround time will measure the number of calendar days elapsed from the time MetLife receives a claim to the time a claim action is taken (i.e., a benefit check issued, a benefit statement mailed, additional information requested, etc.).

The claim turnaround standards and penalties shall be as follows:

Formula

- Turnaround Time Rate = Number of Claims Within The Standard / Number of Claims Reviewed

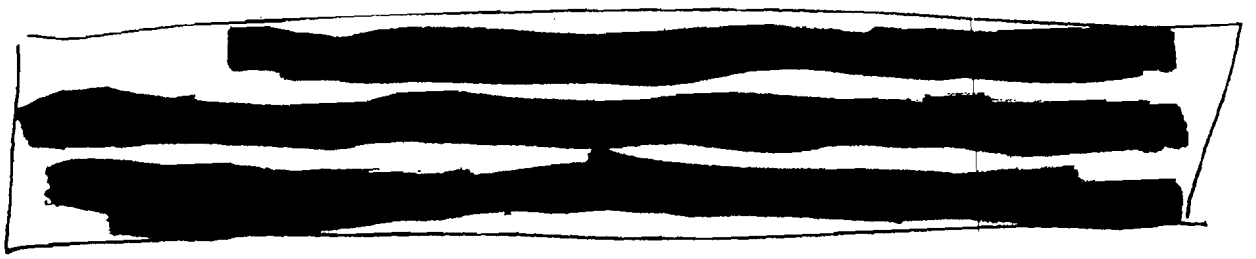
Standards

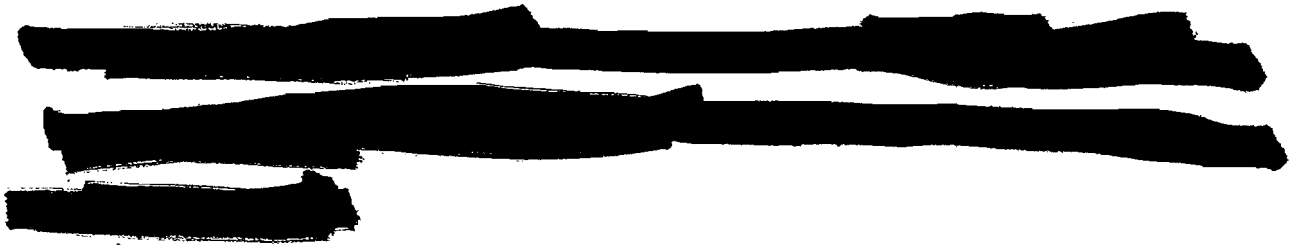
- [redacted] of claims must be processed within [redacted] calendar days of receipt.
- [redacted] of claims must be processed within [redacted] calendar days of receipt.

Performance Penalty

- If the Turnaround Time Rate (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 will 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, a performance penalty of [redacted] will be assessed.
- The maximum penalty for this measurement will be [redacted] per year.

Targeted Audits -- Targeted audits focused on specific issues or areas of the Plan will be conducted by the Employer as necessary. [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.

METROPOLITAN LIFE INSURANCE COMPANY

Group Policy No. 30501-G bearing date of January 1, 1986 and insuring the Employees of STATE OF NEW YORK (Herein called the Employer) is hereby amended as follows:

A. Effective January 1, 1992,

The Form number G.2130-NY-2 appearing on pages 8 through 14 of Amendment No. 1 effective January 1, 1992 to said Group Policy is corrected to read Form G.2130-NY-2-1.

B. Effective January 1, 1996,

By deleting from said Group Policy the pages listed in Column A below, and by adding to said Group Policy the pages attached hereto listed in Column B below:

Column A			Column B		
Form No.	Page No.	Dated	Form No.	Page No.	Dated
G.2130-NY-2-1	8-14	January 1, 1992	G.2130-NY-2-2	8-14	January 1, 1996
G.2130-NY-2	25	---	G.2130-NY-2-2	25	January 1, 1996

The foregoing amendment is to be attached to and made part of said Group Policy, and is subject to the agreements and covenants therein contained.

Dated at Albany N.Y. this 14th day of April 1998

[redacted]
(Witness)

STATE OF NEW YORK
(Employer)

[redacted]

(Space below for use of Metropolitan Life Insurance Company Only)

Dated at Bridgewater, NJ this 31st day of March 19 98

[redacted]

METROPOLITAN LIFE INSURANCE COMPANY

[redacted]

Louis J. Ragusa
Vice-President and Secretary

Form G.24332

Amendment No. 2

The Insurance Company shall, at the Employer's request, search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would serve to jeopardize the Insurance Company's competitive position.

ARTICLE XV. 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 (f) telephone abandonment rate, and (g) pre-determination of benefits turnaround time. This program includes Group Policy Nos. 30500-G, 30501-G and 30502-G as they are combined on a claim payment basis. Mental Health and Substance Abuse claims under Group Policy No. 34450-G shall be included in the audit sample.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 1996 through December 31, 1999.

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 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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

Standards for Claim Turnaround Time:

- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days of receipt.
- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days 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. Telephone Blockage shall be tracked by the Call Management System (CMS) and reported by the Monthly Trunk Group Summary Report.

Formula for Telephone Blockage:

- 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 [redacted] relative to the total calls received by the dedicated claims office (not including the Managed Physical Medicine Program and Home Care Advocacy Program) 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:

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

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 Managec Physical Medicine Program and the Home Care Advocacy Program) 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 [redacted] 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:

- 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.

(g) Pre-Determination of Benefits Turnaround Time. Predetermination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient information shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits Turnaround Time:

•Turnaround Time Rate = $\frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$

Standard for Pre-Determination of Benefits Turnaround Time:

[redacted] of the Pre-Determination of Benefit requests received by the Insurance Company in a calendar year must be processed within [redacted] calendar days of receipt (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty for Pre-Determination of Benefits 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 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.

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 judgement 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 report will be modified to the degree necessary to carry out the intent of the parties.

ARTICLE XXII. AGENTS; ALTERATIONS

No Agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and by the Employer and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by the Insurance Company.

ARTICLE XXIII. FORCE MAJEURE

Neither the Employer nor the Insurance Company shall be liable or deemed to be in default for any delay or failure in performance under this Policy resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slow downs or other labor interruptions due to labor/management disputes involving entities other than the Employer or Insurance Company, or any other causes not reasonably foreseeable or beyond the control of either the Employer or Insurance Company. The Employer and the Insurance Company are required to use best efforts to eliminate or minimize the effect of such events during performance under this Policy and to resume performance under this Policy upon termination or cessation of such events.

THIS AMENDMENT WILL BE ATTACHED TO AND FORM A PART OF THE GROUP POLICY SHOWN BELOW. IT IS ISSUED BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, HAUPPAUGE, NEW YORK TO THE EMPLOYER SHOWN BELOW.

Employer — STATE OF NEW YORK

Policy Number — 30501-G

Effective Date of Amendment — The dates indicated herein

The terms of the policy in effect on the dates shown are amended as follows:

Article XX Renewal Privilege
This section shall be effective as of January 1, 1998

In order to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as codified at 42 USC Sec. 300gg-12, **ARTICLE XX. RENEWAL PRIVILEGE** stating the times and conditions under which the policy can discontinue is amended to read as set forth in **ARTICLE XX. RENEWAL PRIVILEGE** on the attached page 24. Amendment Exhibit A is how amended Article XX will appear on the substituted page that will be inserted in the Group Policy.

Exhibit 7 External Access/Nondisclosure
This section shall be effective as of the date of execution of this Amendment by both Parties.

For the purposes of administration, the Employer periodically requires access to certain proprietary United HealthCare information and other employee medical and individually identifiable information that must be kept confidential. Accordingly, the Group Policy is modified to add, as an Exhibit 7, the External Access/Nondisclosure Agreement. In addition, the Schedule of Exhibits to the Group Policy is revised to include the reference to the new Exhibit 7 and to update the listing of policy certificates by covered group. Amendment Exhibit B is how the new Exhibit 7 and amended Schedule of Exhibits to the Group Policy will appear on the substituted pages that will be inserted in the Group Policy.

Schedule of Premiums
This section shall be effective as of January 1, 2000

For the period January 1, 2000 through December 31, 2001 or when new premiums are designated by the Insurance Company in accordance with the provisions of the Group Policy, the premium each month for the insurance under the said policy for each Employee insured thereunder shall be as stated in the Schedule of Premiums to the Group Policy. Amendment Exhibit C is how amended Schedule of Premiums set forth in the Group Policy will appear on the substituted pages that will be inserted in the Group Policy.

Article XIV Audit Authority
This section shall be effective as of January 1, 2000

Article XIV. Audit Authority is amended to modify restrictive language limiting audit access. Amendment Exhibit D is how Article XIV will appear on the substituted pages that will be inserted in the Group Policy.

Article XV Performance Standards
This section shall be effective as of January 1, 2000

Article XV. Performance Standards is amended to reflect the performance standards agreed to for the period January 1, 2000 through December 31, 2001. Amendment Exhibit E is how Article XV will appear on the substituted pages that will be inserted in the Group Policy.

Article XXIV Additional Services

This section shall be effective as of January 1, 2000

The Group Policy is amended to add a provision for Additional Services provided under said policy. The provision will be added as a new **Article XXIV**. Amendment Exhibit F is how Article XXIV will appear on the substituted pages that will be inserted in the Group Policy.

Article XXV Effect of Assignment

This section shall be effective as of January 1, 2000

The Group Policy is amended to add a provision for the Assignment Agreement of the Group Insurance Policies issued by Metropolitan Life Insurance Company to United HealthCare Insurance Company of New York effective January 1, 2000. Accordingly, **Article XXV Effect of Assignment** is added as a new provision to the Group Policy. Amendment Exhibit G is how Article XXV will appear on the substituted pages that will be inserted in the Group Policy.

Appendix A

This section shall be effective as of January 1, 2000

The Group Policy is amended to add provisions for Standard Clauses for All New York State Contracts; Non-Discrimination In Employment In Northern Ireland - MacBride Fair Employment Principles; and Non-Collusive Bidding Certification. These provisions included in **Appendix A** will follow the Schedule of Exhibits and the Exhibits in the Group Policy. Amendment Exhibit H is how Appendix A will appear on the substituted pages that will be inserted in the Group Policy.

This amendment will not affect any of the terms, provisions or conditions of this policy except as stated above.

This amendment will take effect on the Effective Dates shown above.

Dated at Albany, New York on 5/7/01.

STATE OF NEW YORK

By [redacted]

Official Title Commissioner

APPROVED October 26 2001

[redacted]

FOR THE STATE COMPTROLLER

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

[redacted]

President and CEO

[redacted]

/Policy Registrar

United HealthCare Service Corp.,
Administrator for
United HealthCare Insurance Company of New York

Amendment
Exhibit A

ARTICLE XX. RENEWAL PRIVILEGE.

This policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon payment of the premiums then due as computed in the manner set forth in Article XVI and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to terminate this Policy on any date specified by the Insurance Company, with advance written notice to the Employer, where the Policy is terminated for one of the following reasons consistent with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) as codified at 42 USC Sec. 300gg-12, as amended:

- The Employer has performed an act or practice that is fraud or made an intentional misrepresentation of material fact under the terms of the Policy. The Insurance Company will give notice of the termination to the Employer at least 90 days prior to the date of termination.

- The Employer has failed to comply with the Insurance Company's employer contribution or group participation rules where the number of insured Employees for each type of insurance provided hereunder is less than the 75% of the number of Employees eligible for such Insurance. The Insurance Company will give notice of the termination to the Employer at least 180 days prior to the date of termination.

- The Insurance Company has stopped issuance of the type of group health coverage provided by this Policy in a state for the large group market. The Insurance Company will give notice of the termination to the Employer and Employees at least 90 days prior to the date of the termination. The Employer will be given the option to buy any other health coverage currently offered by the Insurance Company.

- The Insurance Company has stopped issuance of all group health coverage in a state for the large group market. The Insurance Company will give notice of the termination to the applicable state authority, the Employer and Employees at least 180 days prior to the date of termination.

The term large group market will have the meaning given to it under applicable state or federal law.

EXHIBIT 7

EXTERNAL ACCESS/NONDISCLOSURE AGREEMENT

This External Access/Nondisclosure Agreement is entered into by and between the New York State Department of Civil Service ("DCS") and United HealthCare Insurance Company of New York on behalf of itself and its affiliated companies ("United HealthCare") with respect to the Parties' respective disclosure and use of certain information related to the administration of the Empire Plan.

United HealthCare is the insurer of and provides claims administration and other services for the New York State Empire Plan Medical Program ("Plan"). DCS and United HealthCare agree that for purposes related to the administration of the Empire Plan, the DCS may wish to perform examinations, audits or other evaluations of the files, books, and/or records of United HealthCare pertaining to the Empire Plan ("Examinations"), which may include information acquired or maintained by United HealthCare, via access to United HealthCare's Information Systems. This Agreement grants DCS access to such systems, and establishes the terms and conditions of such access. This Agreement supersedes and replaces any existing agreements between the parties relating to DCS's access to United HealthCare's Information Systems and may be in addition to other agreements between the parties regarding Confidential Information.

DCS and United HealthCare recognize they have a legal responsibility to protect medical and other individually identifiable Confidential Information under current and future confidentiality laws. Specific laws that regulate use of medical and other individually identifiable Confidential Information include, but are not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. Law, 104-191, Title II, Subtitle F (including those sections of the law codified at 42 USC Sec. 1171 et seq.), and its implementing regulations.

Section 1 ***Definitions.***

- ***United HealthCare's Information Systems ("United IS")*** includes information systems owned and/or operated by United HealthCare including its parent company, subsidiaries and affiliates.

- ***Proprietary Information*** includes United HealthCare's computer programs and code, business plans, financial records, documents, statistical information, and other information which may be commercially valuable, confidential, proprietary or trade secret in its nature.

- ***Confidential Medical Information*** includes materials that may contain medical or other individually identifiable information.

- ***Confidential Information*** shall collectively refer to Proprietary Information and Confidential Medical Information. However, Confidential Information shall not include information: (i) generally available to the public or generally known in the insurance industry or employee benefit consulting community prior to or during the time of an Examination through authorized disclosure; (ii) obtained from a third party who is under no obligation to United HealthCare not to disclose such information; or (iii) required to be disclosed by subpoena, or other legal process.

Section 2 ***Disclosure of Confidential Information.*** United HealthCare and its agents, subsidiaries and affiliates shall disclose Confidential Information to the DCS in connection with Examinations, provided that such Confidential Information, including all copies thereof, shall be used by the DCS only as permitted by this Agreement.

Section 3 ***Use of Confidential Information.*** The DCS shall: (a) not use, exploit, duplicate, recreate, copy, modify, decompile, disassemble, reverse engineer, translate, create derivative works, or otherwise disclose in any way Confidential Information to another person, nor permit any other person to do so, except for purposes directly related to an Examination; (b) limit use of Confidential Information only to authorized persons who have a need to know for purposes of an Examination; and (c) may release Confidential Information in response to a subpoena or other legal process to disclose Confidential Information, after giving United HealthCare reasonable prior notice of such disclosure. DCS shall protect such Confidential Information with at least the same degree of care DCS use to protect their own confidential and proprietary information.

At the conclusion of an Examination, the DCS either shall relinquish to United HealthCare, or destroy (with such destruction to be certified to United HealthCare), all Confidential Information. If during the course of an Examination it is discovered that this Agreement has been breached by the DCS, then all Confidential Information shall be relinquished to United HealthCare upon demand. However, DCS and authorized persons may retain and use such Confidential Information for use in performing any on-going audit or review function.

Unauthorized use of Confidential Information by the DCS is a material breach of this Agreement resulting in irreparable harm to United HealthCare for which the payment of money damages is inadequate. It is agreed that United HealthCare, upon adequate proof of unauthorized use, and in addition to any other remedies at law or in equity that it may have, may seek injunctive relief in the Supreme Court of New York in Albany County enjoining any continuing or further breaches and may seek entry of judgment for injunctive relief. The DCS agrees to hold United HealthCare harmless with respect to any claims and any damages caused by its breach of this Agreement.

The requirement to treat all Confidential Medical Information as Confidential Information shall survive the termination of this Agreement. The requirement to treat all Proprietary Information as Confidential Information shall remain in full force and effect so long as any Proprietary Information remains commercially valuable, confidential, proprietary and/or trade secret, but in no event less than a period of three (3) years from the date of the Examination.

Section 4 ***Access to United IS.*** Access by DCS shall be granted by United HealthCare consistent with laws (including HIPAA) and the Group Policy when requested for the individuals identified as provided in Section 7 of this Exhibit 7 on the system security request form used by United HealthCare for that purpose. United HealthCare shall identify the system(s) required by DCS. Access will be granted by United HealthCare in a reasonably prompt and timely manner.

Section 5 ***Method of Access.*** DCS shall have access to United IS by a dedicated circuit. United HealthCare shall be responsible for providing the dedicated circuit and termination hardware up to and including a router, or corresponding Wide Area Network (WAN) equipment located at DCS and connected to DCS' network hardware (e.g. ethernet switch). United HealthCare shall be solely responsible for any relationships that may be necessary in maintaining DCS' data connections through the dedicated circuit as provided in Section 6 of this Exhibit 7.

Section 6 ***Hardware, Software and Data Connections Required for Access.*** DCS shall be solely responsible for supplying the internal (to DCS) hardware and software that is required for DCS to obtain access to United IS and for any relationships with third parties that may be necessary in connection with that hardware and software. United HealthCare shall be solely responsible for supplying the data connections and for any relationships with third parties that may be necessary in connection with that data connection. United HealthCare shall provide DCS information regarding the required hardware and software

Section 7 ***System Users.*** DCS shall identify to United HealthCare those persons who require access to United IS for the purpose of conducting Examinations ("System Users"). DCS shall provide to United HealthCare the information required by United HealthCare regarding each System User, including, but not limited to, the United IS each System User will access and the method of each System User's access.

DCS shall promptly notify United HealthCare of any System Users who cease to require access to United IS; such notifications shall be provided promptly whenever a System User no longer requires access. A prospective System User shall be subject to approval by United HealthCare prior to receiving access. United HealthCare may, at its sole discretion, terminate any System User's access to United IS.

DCS shall ensure that each System User complies with the terms of this Agreement and that no System User introduces a computer virus into United IS or takes any other action that adversely affects or damages United IS. DCS is responsible for a System User's non-compliance with the terms of this Agreement.

Section 8 ***Limitations on Access to United IS.*** DCS shall not use its access to United IS for any purpose not consistent with administration of the Empire Plan or any agreement in effect between United HealthCare and New York State for the administration of the Empire Plan.

Section 9 ***No Software License Granted and Ownership.*** The access to United IS granted to DCS under this Agreement is limited to granting DCS access to information contained in United IS, and does not and shall not be construed as granting DCS a license for the use of the software programs contained in the United IS. Any license to the software programs contained in United IS may be subject to a separate license agreement between the parties. Under this Agreement, DCS shall not attempt to reverse engineer or otherwise obtain copies of the software programs contained in United IS or the source code of the software programs contained in United IS.

United HealthCare owns and/or has rights to United IS. This Agreement does not transfer title to or ownership to rights to United IS or to rights in patents, copyrights, trademarks and trade secrets encompassed in United IS to DCS.

Section 10 ***Security Measures.*** DCS shall use reasonable physical and software-based measures, commonly used in the electronic data interchange field, to protect data contained in United IS from unauthorized access. DCS shall implement and comply with and shall not attempt to circumvent or bypass security procedures for the benefit of United IS that are required by United HealthCare.

Section 11 ***Medical Information.*** The information in United IS to which DCS has access pursuant to this Agreement may contain medical and other individually identifiable Confidential Information. DCS shall require any and all System Users to comply with all applicable State and federal laws regarding confidentiality of medical and other individually identifiable Confidential Information. DCS agrees:

1. to only access medical and other individually identifiable Confidential Information in United HealthCare's possession if: a) it is needed for Examinations or to perform other appropriate Empire Plan administrative functions consistent with the insurance policy issued by Metropolitan Life Insurance Company and any other Agreements between New York State and United HealthCare for administration of the Empire Plan pursuant to its fiduciary responsibility or other applicable laws; or, b) there is a signed authorization from the covered person allowing the release of such Confidential Information.
2. to have a reasonable procedure in place to ensure the secure handling of medical and other individually identifiable Confidential Information (i.e., the person receiving the Confidential Information shall not be the same person evaluating a covered person's work performance), and shall not copy such Confidential Information unless express, prior written approval of United HealthCare to do so has been obtained.
3. to limit use of medical and other individually identifiable Confidential Information only to System Users for purposes of the Examination.
4. that medical and other individually identifiable Confidential Information shall not be re-disclosed to any unauthorized entity or person unless allowed by law and shall, if required by subpoena or other legal process to disclose any medical or other individually identifiable Confidential Information, give United HealthCare reasonable prior notice of such disclosure.

Section 12 General.

(1) This Agreement is the entire understanding between the parties as to the subject matter hereof.

(2) The DCS' permissible access to United IS and its permissible use of Confidential Information contained therein shall be deemed to include permissible access and permissible use by DCS' contractors and agents as well, which shall include any employees of contractors of DCS assigned specifically to perform examinations, audits or other evaluations of the administration of the Empire Plan provided that: i) such persons are designated to United HealthCare prior to the examinations, audits or other evaluations of the administration ii) DCS ensures that such persons are aware of and will abide by the terms and conditions of this Agreement and iii) such persons will be bound and the provisions applied as if such persons were parties to this Agreement.

(3) Neither this Agreement nor the DCS's rights or obligation hereunder may be assigned without United HealthCare's prior written approval.

(4) This Agreement shall be effective as of the date of the execution of Amendment No. 3 to Policy Nos. 30500-G, 30501-G, and 30502-G, to which it is attached as Exhibit 9 to Policy No. 30500-G and as Exhibit 7 to Policy Nos. 30501-G and 30502-G, and shall apply to Confidential Information related to the administration of the Empire Plan as of January 1, 1999.

(5) Both parties agree to negotiate in good faith should either party indicate formally in writing to the other party that a change in the agreements reached in this Exhibit 7 is requested. The parties will then have 60 days to negotiate a compromise.

SCHEDULE OF EXHIBITS

Exhibit Number	
1a	General Information for Active State Employees
1b	General Information for Retired State Employees, Vestees and Dependent Survivors.
2	United HealthCare Insurance Company of New York Certificate for Participating Agencies with Core Only
3	United HealthCare Insurance Company of New York Certificate for:
3a	CSEA
3b	M/C and Legislature
3c	Council 82
3d	PBA – NYS Police Troopers
3e	PBA – NYS Police Supervisors
3f	PIA
3e	PEF
3f	DC-37
3g	Participating Employers
3h	Participating Agencies with Core plus Medical and Psychiatric Enhancements
3i	Unified Court System – Judges and Justices; Employees represented by CSEA
3j	Unified Court System – Nonjudicial Employees
3k	UUP
3l	Retired State Employees, Vestees, Dependent Survivors
4	Utilization Review Procedures
5	Empire Plan Communications Program
6	Regular Health Services Utilization Reports
7	External Access/Nondisclosure Agreement

Amendment
Exhibit C

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2000 through December 31, 2000:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement benefits	$20.39/$9.36	$48.50/$22.26

For the period January 1, 2001 through December 31, 2001:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement benefits	$17.34/$7.98	$41.96/$19.31

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.

Included in the premium rates for the periods January 1, 2000 through December 31, 2000 and January 1, 2001 through December 31, 2001 are the following costs of the Additional Services provided under the Group Policy:

1. **Managed Physical Medicine Program** – program effective August 1995
   - [redacted] per Member per month

   "Member" means Employees and Dependents covered by the Plan.

   This cost for this program is applicable to all Empire Plan enrollees.

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

[redacted] (This cost applies only for the period January 1, 2000 through December 31, 2000.)

[redacted]per Employee per month

The cost for this program is applicable only to the following groups for which the benefit has been collectively bargained or administratively extended:

- Management Confidential and Legislative employees, Retirees, Participating Agency employees, Participating Employer group employees, United University Professionals represented employees – program effective February 1, 2000
- Unified Courts System employees, employees represented by the Civil Service Employees Association and employees represented by District Council 37 – program effective July 1, 2000
- Employees represented by the Public Employees Federation and employees represented by Council 82 – program effective October 1, 2000
- Employees represented by the New York State Correctional Officers and Police Benevolent Association - program effective January 1, 2001
- Employees in the Trooper and Supervisor units of the New York State Police represented by the Police Benevolent Association – program effective January 1, 2001.

Negotiations may result in the inclusion of additional employee groups in this benefit.

3. **Disease Management Program (Cardiovascular Risk Reduction)**

[redacted]r Member per month (for administration)

- [redacted](estimate) for printing expense (This cost applies only for the period January 1, 2000 through December 31, 2000.)
- [redacted] per patient for initial patient assessment/Patient not enrolled in the Program
- [redacted]per patient for initial patient assessment and intervention – 1st month
- [redacted] per patient per month for patient assessment and intervention – months 2 - 12
- [redacted] per patient per month for patient assessment and intervention – months 13 – 24

"Member" means Employees and Dependents covered by the Plan.

The costs for this program are applicable only to the following groups for which the benefit has been collectively bargained or administratively extended:

- Management Confidential and Legislative employees, Retirees, Participating Agency employees, Participating Employer group employees, United University Professionals represented employees, Unified Courts System employees, employees represented by the Civil Service Employees Association and employees represented by District Council 37 – program effective July 1, 2000

- Employees represented by the Public Employees Federation – program effective October 1, 2000
- Employees represented by Council 82 – program effective Octobe· 1, 2000
- Employees represented by the New York State Correctional Officers and Police Benevolent Association – program effective January 1, 2001.
- Employees in the Trooper and Supervisor units of the New York State Police represented by the Police Benevolent Association – program effective January 1, 200·
- Employees of the New York State Police Bureau of Criminal Investigation unit represented by the New York State Police Investigators Association – program effective January 1, 2001

4. **Network Integration (program effective 1/1/99 for CT, FL and NJ and 7/1/00 for AZ, NC and SC)**
   - [redacted] per Employee residing in the integrated states per month (excluding directory printing)

The standard access fee for this program is [redacted]

Amendment
Exhibit D

ARTICLE XIV. AUDIT AUTHORITY

The Employer shall have the authority to conduct financial and performance audits of the Insurance Company's administration of this Policy.

Such audit activity may include, but not necessarily be limited to:

(1) review of claim certification and adjudication procedures and systems,

(2) review of processed claims to assess the accuracy of claims certification and adjudication, including, but not limited to, tests of: (a) claimant eligibility, (b) non-duplication of benefits, (c) payment based on schedule of allowances for Participating Providers, (d) reasonable and customary limits on all non-participating provider charges, (e) proper coordination of benefits, (f) payment of covered services only, (g) proper application of deductible, (h) proper application of coinsurance, (i) proper consideration of Medicare, (j) proper application of other policy provisions,

(3) review of documentary evidence to determine the fairness of all items on the Financial Statement of Experience, and

(4) review of any and all activities relating to the Insurance Company's administration of this Policy.

The Insurance Company shall make available documentary evidence necessary to perform these reviews. Such documentation may include, but is not limited to, source documents, books of account, subsidiary records and supporting workpapers, claim documentation and pertinent contracts and correspondence.

Documentation necessary for an understanding of accounting, claim payment, enrollment or other systems and activities shall be made available. These systems shall be demonstrated to the Employer's auditing personnel upon request. Documentation of computerized aspects of the accounting, claim payment, enrollment and other systems shall be furnished to auditing personnel and the system fully explained.

The Employer's auditing personnel shall be provided an adequate number of screens (CRTs) so that they may access data from accounting, claim payment, enrollment and other systems.

The Insurance Company shall make available to the Employer's auditors all data in its computerized files that are relevant to this Policy. Such data may, at the Employer's discretion, be submitted to the Employer in machine readable format or the data may be extracted by the Employer or by the Insurance Company under the direction of the Employer's auditors.

The Insurance Company, at the Employer's request, shall provide detailed schedules and analyses supporting amounts shown on the Financial Statement of Experience.

The Insurance Company shall at the Employer's request search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would jeopardize the Insurance Company's competitive position, except that this provision does not apply to Insurance Company Information necessary ("Necessary Information") to complete an audit. Employer in such situation will have access to such Necessary Information but only pursuant to Exhibit 7/External Access and Nondisclosure Agreement.

Amendment
Exhibit E

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2000 through December 31, 2001.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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 96% 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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

Standards for Claim Turnaround Time:
- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days of receipt.
- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days 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. 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 [redacted] relative to the total calls received by the dedicated claims office (not including the Managed Physical Medicine Program and Home Care Advocacy Program) 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:

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

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 and the Home Care Advocacy Program) 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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time- The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period covered by this Amendment, January 1, 2000 through December 31, 2001 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time :

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.

- The maximum penalty for this measurement will 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]

Cumulative penalties, if any, with applicable interest from the date of audit finalization for which the Insurance Company is liable to the Employer, shall be shown on the annual settlement report and used to increase dividend or reduce loss carried forward. Such penalty amounts for which the Insurance Company is liable shall not be charged either directly or indirectly to the Employer in the current year or subsequent years.

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 judgement 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.

Amendment
Exhibit F

ARTICLE XXIV. 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.

"Participant" means those Employees and/or Dependents utilizing Additional Services described in this Article.

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

1. **Managed Physical Medicine Program** (Program effective August 1995)

   For the cost shown in the Schedule of Premiums, the Insurance Company will provide access to a Managed Physical Medicine Program ("Program") through an organization with which the Insurance Company has contracted to provide such services ("Consultant") to the Employer groups designated by the Employer.

   A Managed Care Network will be made available to Employees and their Dependents, located in those geographical sites agreed to, having Network 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 will be given in advance or as soon as reasonably possible.

   The Insurance Company will maintain a grievance process so that Participants 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 Participants are solely responsible for any health care services rendered to Participants that are not covered under the benefits provided by the Insurance Company.

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

   For the cost specified in the 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, as well as education information regarding those concerns, by registered nurses by telephone or via an audio health information library.

3. **Disease Management Program** (Program effective July 1, 2000)

   The Insurance Company will provide access to various Disease Management Programs ("Program") administered by the Insurance Company or through organizations with which the Insurance Company has contracted to provide such services ("Consultant") to the Employer groups designated by the Employer.

The parties agree that neither the Insurance Company nor the Consultant will disclose to the Employer, the Employer's auditors, or other third parties, the unencrypted identity of Participants enrolling in the Program without the Participants' written consent.

From claims data received, the Insurance Company or Consultant will determine those Participants who may benefit from the Program. Consultant shall notify the Participants' physicians of services available and shall offer the Participants the opportunity to participate in the Program.

For the cost shown in the Schedule of Premiums, the Insurance Company or Consultant shall offer agreed upon Program services to Participants. An example of services provided in the cardiovascular risk reduction program include, but are not limited to, the following: nutrition consultation; monthly contact and access to a case manager; and consultation with Network Providers on prescription antiretroviral drug therapy.

4. **Network Integration** (Program effective January 1, 1999 for CT, FL and NJ and July 1, 2000 for AZ, NC and SC)

For the cost shown in the Schedule of Premiums, the Insurance Company will make available to the Employer access to agreed upon United HealthCare 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 United Healthcare PPO Network were made available. If the Employer and the Insurance Company agree to add a PPO network in a state, 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.

Amendment
Exhibit G

ARTICLE XXV. EFFECT OF ASSIGNMENT

Due to the Assignment Agreement of the Group Insurance Policies issued by Metropolitan Life Insurance Company to United HealthCare Insurance Company of New York effective Jar uary 1, 2000, any references in the Policies and its related documents to Metropolitan Life Insurance Company and/or United HealthCare Insurance Company shall, after January 1, 2000, mean United HealthCare Ins rance Company of New York.

In the event of any conflicts or inconsistencies among the document elements of the Group Policies, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

(a) First, Appendix A, including the appended Non-Collusive Bidding Certification and the MacBride Act Statement;

(b) Second, the Amendments to the Policies; and

(c) Third, the Policies.

Amendment
Exhibit H

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 $15,000 (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 $15,000, 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.

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.** In accordance with 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, age, disability 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 race, 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 REQUIREMENT**. 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, AESOB, 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
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
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 $1 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, Division for Small Business, 30 South Pearl Street; Albany New York 12245, for a current list of jurisdictions subject to this provision.

BIDDER IS REQUIRED TO SIGN BOTH SECTIONS ON THIS PAGE

NON-DISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND
MACBRIDE FAIR EMPLOYMENT PRINCIPLES

In accordance with Chapter 807 of the Laws of 1992 the bidder, by submission of this bid, certifies that it or any individual or legal entity in which the bidder holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the b dder, either (answer "yes" or "no" to one or both of the following, as applicable):

(1) Have business operations in Northern Ireland.

Yes ✓ or No _____

If yes:

(2) Shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations n Northern Ireland, and shall permit independent monitoring of their compliance with such Principles.

[redacted] United Healthcare Insurance Co. of New York
(Name of Business)

NON-COLLUSIVE BIDDING CERTIFICATION

By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his knowledge and belief:

(1) The prices in this bid have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

(2) Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly, to any other bidder or to any competitor; and

(3) No attempt has been made or will be made by the bidder to induce any other person, partnership or [redacted]poration to submit or not to submit a bid for the purpose of restricting competition.

[redacted] United Healthcare Insurance Co. of New York
(Name of Business)

Rev. 11/2000

INSERT PAGES TO GROUP POLICY 30501-G

ARTICLE XX. RENEWAL PRIVILEGE.

This policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon payment of the premiums then due as computed in the manner set forth in Article XVI and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to terminate this Policy on any date specified by the Insurance Company, with advance written notice to the Employer, where the Policy is terminated for one of the following reasons consistent with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) as codified at 42 USC Sec. 300gg-12, as amended:

- The Employer has performed an act or practice that is fraud or made an intentional misrepresentation of material fact under the terms of the Policy. The nsurance Company will give notice of the termination to the Employer at least 90 days prior to the date of termination.

- The Employer has failed to comply with the Insurance Company's employer contribution or group participation rules where the number of insured Employees for each type of insurance provided hereunder is less than the 75% of the number of Employees eligible for such Insurance. The Insurance Company will give notice of the termination to the Employe at least 180 days prior to the date of termination.

- The Insurance Company has stopped issuance of the type of group health coverage provided by this Policy in a state for the large group market. The Insurance Company will give notice of the termination to the Employer and Employees at least 90 days prior to the date of the termination. The Employer will be given the option to buy any other health coverage currently offered by the Insurance Company.

- The Insurance Company has stopped issuance of all group health coverage in a state for the large group market. The Insurance Company will give notice of the termination to the applicable state authority, the Employer and Employees at least 180 days prior to the date of termination.

The term large group market will have the meaning given to it under applicable state or federal law.

ARTICLE XXI. ENTIRE POLICY.

This Policy and the application of the Employer, a copy of which is attached hereto, constitute the entire contract between the parties. Any statement made by the Employer or by any Employee shall be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application.

SCHEDULE OF EXHIBITS

Exhibit Number	
1a	General Information for Active State Employees
1b	General Information for Retired State Employees, Vestees and Dependent Survivors.
2	United HealthCare Insurance Company of New York Certificate for Participating Agencies with Core Only
3	United HealthCare Insurance Company of New York Certificate for:
3a	CSEA
3b	M/C and Legislature
3c	Council 82
3d	PBA – NYS Police Troopers
3e	PBA – NYS Police Supervisors
3f	PIA
3e	PEF
3f	DC-37
3g	Participating Employers
3h	Participating Agencies with Core plus Medical and Psychiatric Enhancements
3i	Unified Court System – Judges and Justices; Employees represented by CSEA
3j	Unified Court System – Nonjudicial Employees
3k	UUP
3l	Retired State Employees, Vestees, Dependent Survivors
4	Utilization Review Procedures
5	Empire Plan Communications Program
6	Regular Health Services Utilization Reports
7	External Access/Nondisclosure Agreement

EXHIBIT 7

EXTERNAL ACCESS/NONDISCLOSURE AGREEMENT

This External Access/Nondisclosure Agreement is entered into by and between the New York State Department of Civil Service ("DCS") and United HealthCare Insurance Company of New York on behalf of itself and its affiliated companies ("United HealthCare") with respect to the Parties' respective disclosure and use of certain information related to the administration of the Empire Plan.

United HealthCare is the insurer of and provides claims administration and other services for the New York State Empire Plan Medical Program ("Plan"). DCS and United HealthCare agree that for purposes related to the administration of the Empire Plan, the DCS may wish to perform examinations, audits or other evaluations of the files, books, and/or records of United HealthCare pertaining to the Empire Plan ("Examinations"), which may include information acquired or maintained by United HealthCare, via access to United HealthCare's Information Systems. This Agreement grants DCS access to such systems, and establishes the terms and conditions of such access. This Agreement supersedes and replaces any existing agreements between the parties relating to DCS's access to United HealthCare's Information Systems and may be in addition to other agreements between the parties regarding Confidential Information.

DCS and United HealthCare recognize they have a legal responsibility to protect medical and other individually identifiable Confidential Information under current and future confidentiality laws. Specific laws that regulate use of medical and other individually identifiable Confidential Information include, but are not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. Law, 104-191, Title II, Subtitle F (including those sections of the law codified at 42 USC Sec. 1171 et seq.), and its implementing regulations.

Section 1 Definitions.

- ***United HealthCare's Information Systems ("United IS")*** includes information systems owned and/or operated by United HealthCare including its parent company, subsidiaries and affiliates.

- ***Proprietary Information*** includes United HealthCare's computer programs and code, business plans, financial records, documents, statistical information, and other information which may be commercially valuable, confidential, proprietary or trade secret in its nature.

- ***Confidential Medical Information*** includes materials that may contain medical or other individually identifiable information.

- ***Confidential Information*** shall collectively refer to Proprietary Information and Confidential Medical Information. However, Confidential Information shall not include information: (i) generally available to the public or generally known in the insurance industry or employee benefit consulting community prior to or during the time of an Examination through authorized disclosure; (ii) obtained from a third party who is under no obligation to United HealthCare not to disclose such information; or (iii) required to be disclosed by subpoena, or other legal process.

Section 2 ***Disclosure of Confidential Information.*** United HealthCare and its agents, subsidiaries and affiliates shall disclose Confidential Information to the DCS in connection with Examinations, provided that such Confidential Information, including all copies thereof, shall be used by the DCS only as permitted by this Agreement.

Section 3 ***Use of Confidential Information.*** The DCS shall: (a) not use, exploit, duplicate, recreate, copy, modify, decompile, disassemble, reverse engineer, translate, create derivative works, or otherwise disclose in any way Confidential Information to another person, nor permit any other person to do so, except for purposes directly related to an Examination; (b) limit use of Confidential Information only to authorized persons who have a need to know for purposes of an Examination; and (c) may release Confidential Information in response to a subpoena or other legal process to disclose Confidential Information, after giving United HealthCare reasonable prior notice of such disclosure. DCS shall protect such Confidential Information with at least the same degree of care DCS use to protect their own confidential and proprietary information.

At the conclusion of an Examination, the DCS either shall relinquish to United HealthCare, or destroy (with such destruction to be certified to United HealthCare), all Confidential Information. If during the course of an Examination it is discovered that this Agreement has been breached by the DCS, then all Confidential Information shall be relinquished to United HealthCare upon demand. However, DCS and authorized persons may retain and use such Confidential Information for use in performing any on-going audit or review function.

Unauthorized use of Confidential Information by the DCS is a material breach of this Agreement resulting in irreparable harm to United HealthCare for which the payment of money damages is inadequate. It is agreed that United HealthCare, upon adequate proof of unauthorized use, and in addition to any other remedies at law or in equity that it may have, may seek injunctive relief in the Supreme Court of New York in Albany County enjoining any continuing or further breaches and may seek entry of judgment for injunctive relief. The DCS agrees to hold United HealthCare harmless with respect to any claims and any damages caused by its breach of this Agreement.

The requirement to treat all Confidential Medical Information as Confidential Information shall survive the termination of this Agreement. The requirement to treat all Proprietary Information as Confidential Information shall remain in full force and effect so long as any Proprietary Information remains commercially valuable, confidential, proprietary and/or trade secret, but in no event less than a period of three (3) years from the date of the Examination.

Section 4 ***Access to United IS.*** Access by DCS shall be granted by United HealthCare consistent with laws (including HIPAA) and the Group Policy when requested for the individuals identified as provided in Section 7 of this Exhibit 7 on the system security request form used by United HealthCare for that purpose. United HealthCare shall identify the system(s) required by DCS. Access will be granted by United HealthCare in a reasonably prompt and timely manner.

Section 5 ***Method of Access.*** DCS shall have access to United IS by a dedicated circuit. United HealthCare shall be responsible for providing the dedicated circuit and termination hardware up to and including a router, or corresponding Wide Area Network (WAN) equipment located at DCS and connected to DCS' network hardware (e.g. ethernet switch). United HealthCare shall be solely responsible for any relationships that may be necessary in maintaining DCS' data connections through the dedicated circuit as provided in Section 6 of this Exhibit 7.

Section 6 ***Hardware, Software and Data Connections Required for Access.*** DCS shall be solely responsible for supplying the internal (to DCS) hardware and software that is required for DCS to obtain access to United IS and for any relationships with third parties that may be necessary in connection with that hardware and software. United HealthCare shall be solely responsible for supplying the data connections and for any relationships with third parties that may be necessary in connection with that data connection. United HealthCare shall provide DCS information regarding the required hardware and software

Section 7 ***System Users.*** DCS shall identify to United HealthCare those persons who require access to United IS for the purpose of conducting Examinations ("System Users"). DCS shall provide to United HealthCare the information required by United HealthCare regarding each System User, including, but not limited to, the United IS each System User will access and the method of each System User's access.

DCS shall promptly notify United HealthCare of any System Users who cease to require access to United IS; such notifications shall be provided promptly whenever a System User no longer requires access. A prospective System User shall be subject to approval by United HealthCare prior to receiving access. United HealthCare may, at its sole discretion, terminate any System User's access to United IS.

DCS shall ensure that each System User complies with the terms of this Agreement and that no System User introduces a computer virus into United IS or takes any other action that adversely affects or damages United IS. DCS is responsible for a System User's non-compliance with the terms of this Agreement.

Section 8 ***Limitations on Access to United IS.*** DCS shall not use its access to United IS for any purpose not consistent with administration of the Empire Plan or any agreement in effect between United HealthCare and New York State for the administration of the Empire Plan.

Section 9 ***No Software License Granted and Ownership.*** The access to United IS granted to DCS under this Agreement is limited to granting DCS access to information contained in United IS, and does not and shall not be construed as granting DCS a license for the use of the software programs contained in the United IS. Any license to the software programs contained in United IS may be subject to a separate license agreement between the parties. Under this Agreement, DCS shall not attempt to reverse engineer or otherwise obtain copies of the software programs contained in United IS or the source code of the software programs contained in United IS.

United HealthCare owns and/or has rights to United IS. This Agreement does not transfer title to or ownership to rights to United IS or to rights in patents, copyrights, trademarks and trade secrets encompassed in United IS to DCS.

Section 10 ***Security Measures.*** DCS shall use reasonable physical and software-based measures, commonly used in the electronic data interchange field, to protect data contained in United IS from unauthorized access. DCS shall implement and comply with and shall not attempt to circumvent or bypass security procedures for the benefit of United IS that are required by United HealthCare.

Section 11 Medical Information. The information in United IS to which DCS has access pursuant to this Agreement may contain medical and other individually identifiable Confidential Information. DCS shall require any and all System Users to comply with all applicable State and federal laws regarding confidentiality of medical and other individually identifiable Confidential Information. DCS agrees:

1. to only access medical and other individually identifiable Confidential Information in United HealthCare's possession if: a) it is needed for Examinations or to perform other appropriate Empire Plan administrative functions consistent with the insurance policy issued by Metropolitan Life Insurance Company and any other Agreements between New York State and United HealthCare for administration of the Empire Plan pursuant to its fiduciary responsibility or other applicable laws; or, b) there is a signed authorization from the covered person allowing the release of such Confidential Information.
2. to have a reasonable procedure in place to ensure the secure handling of medical and other individually identifiable Confidential Information (i.e., the person receiving the Confidential Information shall not be the same person evaluating a covered person's work performance), and shall not copy such Confidential Information unless express, prior written approval of United HealthCare to do so has been obtained.
3. to limit use of medical and other individually identifiable Confidential Information only to System Users for purposes of the Examination.
4. that medical and other individually identifiable Confidential Information shall not be re-disclosed to any unauthorized entity or person unless allowed by law and shall, if required by subpoena or other legal process to disclose any medical or other individually identifiable Confidential Information, give United HealthCare reasonable prior notice of such disclosure.

Section 12 General.

(1) This Agreement is the entire understanding between the parties as to the subject matter hereof.

(2) The DCS' permissible access to United IS and its permissible use of Confidential Information contained therein shall be deemed to include permissible access and permissible use by DCS' contractors and agents as well, which shall include any employees of contractors of DCS assigned specifically to perform examinations, audits or other evaluations of the administration of the Empire Plan provided that: i) such persons are designated to United HealthCare prior to the examinations, audits or other evaluations of the administration ii) DCS ensures that such persons are aware of and will abide by the terms and conditions of this Agreement and iii) such persons will be bound and the provisions applied as if such persons were parties to this Agreement.

(3) Neither this Agreement nor the DCS's rights or obligation hereunder may be assigned without United HealthCare's prior written approval.

(4) This Agreement shall be effective as of the date of the execution of Amendment No. 3 to Policy Nos. 30500-G, 30501-G, and 30502-G, to which it is attached as Exhibit 9 to Policy No. 30500-G and as Exhibit 7 to Policy Nos. 30501-G and 30502-G, and shall apply to Confidential Information related to the administration of the Empire Plan as of January 1, 1999.

(5) Both parties agree to negotiate in good faith should either party indicate formally in writing to the other party that a change in the agreements reached in this Exhibit 7 is requested. The parties will then have 60 days to negotiate a compromise.

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2000 through December 31, 2000:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement benefits	$20.39/$9.36	$48.50/$22.26

For the period January 1, 2001 through December 31, 2001:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement benefits	$17.34/$7.98	$41.96/$19.31

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.

Included in the premium rates for the periods January 1, 2000 through December 31, 2000 and January 1, 2001 through December 31, 2001 are the following costs of the Additional Services provided under the Group Policy:

1. **Managed Physical Medicine Program** – program effective August 1995
   - [redacted] per Member per month

   "Member" means Employees and Dependents covered by the Plan.

   This cost for this program is applicable to all Empire Plan enrollees.

2. **Empire Plan NurseLine$_{SM}$ Program**
   - [redacted] (This cost applies only for the period January 1, 2000 through December 31, 2000.)
   - [redacted] per Employee per month

   The cost for this program is applicable only to the following groups for which the benefit has been collectively bargained or administratively extended:

   - Management Confidential and Legislative employees, Retirees, Participating Agency employees, Participating Employer group employees, United University Professionals represented employees – program effective February 1, 2000
   - Unified Courts System employees, employees represented by the Civil Service Employees Association and employees represented by District Council 37 – program effective July 1, 2000
   - Employees represented by the Public Employees Federation and employees represented by Council 82 – program effective October 1, 2000
   - Employees represented by the New York State Correctional Officers and Police Benevolent Association - program effective January 1, 2001
   - Employees in the Trooper and Supervisor units of the New York State Police represented by the Police Benevolent Association – program effective January 1, 2001.

   Negotiations may result in the inclusion of additional employee groups in this benefit.

3. **Disease Management Program (Cardiovascular Risk Reduction)**
   - [redacted] per Member per month (for administration)
   - [redacted] (estimate) for printing expense (This cost applies only for the period January 1, 2000 through December 31, 2000.)
   - [redacted] per patient for initial patient assessment/Patient not enrolled in the Program
   - [redacted] per patient for initial patient assessment and intervention – 1st month
   - [redacted] per patient per month for patient assessment and intervention – months 2 - 12
   - [redacted] per patient per month for patient assessment and intervention – months 13 – 24

   "Member" means Employees and Dependents covered by the Plan.

   The costs for this program are applicable only to the following groups for which the benefit has been collectively bargained or administratively extended:

   - Management Confidential and Legislative employees, Retirees, Participating Agency employees, Participating Employer group employees, United University Professionals represented employees, Unified Courts System employees, employees represented by the Civil Service Employees Association and employees represented by District Council 37 – program effective July 1, 2000

- Employees represented by the Public Employees Federation – program effective October 1, 2000
- Employees represented by Council 82 – program effective October 1, 2000
- Employees represented by the New York State Correctional Officers and Police Benevolent Association – program effective January 1, 2001.
- Employees in the Trooper and Supervisor units of the New York State Police represented by the Police Benevolent Association – program effective January 1, 2001
- Employees of the New York State Police Bureau of Criminal Investigation unit represented by the New York State Police Investigators Association – program effective January 1, 2001

4. **Network Integration (program effective 1/1/99 for CT, FL and NJ and 7/1/00 for AZ, NC and SC)**
   - [redacted] per Employee residing in the integrated states per month (excluding directory printing)

The standard access fee for this program is [redacted]

The Insurance Company shall at the Employer's request search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would jeopardize the Insurance Company's competitive position, except that this provision does not apply to Insurance Company Information necessary ("Necessary Information") to complete an audit. Employer in such situation will have access to such Necessary Information but only pursuant to Exhibit 7/External Access and Nondisclosure Agreement.

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2000 through December 31, 2001.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

Standards for Claim Turnaround Time:

- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days of receipt.
- [redacted] of claims received by the Insurance Company in a calendar year must be processed within [redacted] calendar days 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. 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 5% 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 [redacted] relative to the total calls received by the dedicated claims office (not including the Managed Physical Medicine Program and Home Care Advocacy Program) 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:

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

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 and the Home Care Advocacy Program) 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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time- The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period covered by this Amendment, January 1, 2000 through December 31, 2001 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time :

- [redacted] of Pre-Determination of Benefits received by the Insurance Cornpany in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and :he Managed Physical Medicine Program)

Performance Penalty:

- If the Turnaround Time Rate, as calculated above, is determined to be statis:ically 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 for a calendar year, a performance penalty of [redacted] will be assessed.

- The maximum penalty for this measurement will 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]

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 judgement 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 XXII. AGENTS; ALTERATIONS

No Agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and by the Employer and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by the Insurance Company.

ARTICLE XXIII. FORCE MAJEURE

Neither the Employer nor the Insurance Company shall be liable or deemed to be in default for any delay or failure in performance under this Policy resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slow downs or other labor interruptions due to labor/management disputes involving entities other than the Employer or Insurance Company, or any other causes not reasonably foreseeable or beyond the control of either the Employer or Insurance Company. The Employer and the Insurance Company are required to use best efforts to eliminate or minimize the effect of such events during performance under this Policy and to resume performance under this Policy upon termination or cessation of such events.

ARTICLE XXIV. 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.

"Participant" means those Employees and/or Dependents utilizing Additional Services described in this Article.

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

1. **Managed Physical Medicine Program** (Program effective August 1995)

   For the cost shown in the Schedule of Premiums, the Insurance Company will provide access to a Managed Physical Medicine Program ("Program") through an organization with which the Insurance Company has contracted to provide such services ("Consultant") to the Employer groups designated by the Employer.

   A Managed Care Network will be made available to Employees and their Dependents, located in those geographical sites agreed to, having Network 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 will be given in advance or as soon as reasonably possible

   The Insurance Company will maintain a grievance process so that Participants 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 Participants are solely responsible for any health care services rendered to Participants that are not covered under the benefits provided by the Insurance Company.

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

For the cost specified in the 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, as well as education information regarding those concerns, by registered nurses by telephone or via an audio health information library.

3. **Disease Management Program** (Program effective July 1, 2000)

The Insurance Company will provide access to various Disease Management Programs ("Program") administered by the Insurance Company or through organizations with which the Insurance Company has contracted to provide such services ("Consultant") to the Employer groups designated by the Employer.

The parties agree that neither the Insurance Company nor the Consultant will disclose to the Employer, the Employer's auditors, or other third parties, the unencrypted identity of Participants enrolling in the Program without the Participants' written consent.

From claims data received, the Insurance Company or Consultant will determine those Participants who may benefit from the Program. Consultant shall notify the Participants' physicians of services available and shall offer the Participants the opportunity to participate in the Program.

For the cost shown in the Schedule of Premiums, the Insurance Company or Consultant shall offer agreed upon Program services to Participants. An example of services provided in the cardiovascular risk reduction program include, but are not limited to, the following: nutrition consultation; monthly contact and access to a case manager; and consultation with Network Providers on prescription antiretroviral drug therapy.

4. **Network Integration** (Program effective January 1, 1999 for CT, FL and NJ and July 1, 2000 for AZ, NC and SC)

For the cost shown in the Schedule of Premiums, the Insurance Company will make available to the Employer access to agreed upon United HealthCare 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 United Healthcare PPO Network were made available. If the Employer and the Insurance Company agree to add a PPO network in a state, 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.

ARTICLE XXV. EFFECT OF ASSIGNMENT

Due to the Assignment Agreement of the Group Insurance Policies issued by Metropolitan Life Insurance Company to United HealthCare Insurance Company of New York effective January 1, 2000, any references in the Policies and its related documents to Metropolitan Life Insurance Company and/or United HealthCare Insurance Company shall, after January 1, 2000, mean United HealthCare Insurance Company of New York.

In the event of any conflicts or inconsistencies among the document elements of the Group Policies, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

(a) First, Appendix A, including the appended Non-Collusive Bidding Certification and the MacBride Act Statement;

(b) Second, the Amendments to the Policies; and

(c) Third, the Policies.

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 $15,000 (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 $15,000, 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.

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.** In accordance with 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, age, disability 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 race, 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 REQUIREMENT.** 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, AESOB, 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
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
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 $1 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, Division for Small Business, 30 South Pearl Street; Albany New York 12245, for a current list of jurisdictions subject to this provision.

BIDDER IS REQUIRED TO SIGN BOTH SECTIONS ON THIS PAGE

NON-DISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND MACBRIDE FAIR EMPLOYMENT PRINCIPLES

In accordance with Chapter 807 of the Laws of 1992 the bidder, by submission of this bid, certifies that it or any individual or legal entity in which the bidder holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the bidder, either (answer "yes" or "no" to one or both of the following, as applicable):

(1) Have business operations in Northern Ireland.

Yes ✓ or No _____

If yes:

(2) Shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles.

[redacted] United Healthcare Insurance Co. of New York
(Name of Business)

NON-COLLUSIVE BIDDING CERTIFICATION

By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his knowledge and belief:

(1) The prices in this bid have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

(2) Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly, to any other bidder or to any competitor; and

(3) No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

[redacted] United Healthcare Insurance Co. of New York
(Name of Business)

Rev. 11/2000

THIS AMENDMENT WILL BE ATTACHED TO AND FORM A PART OF THE GROUP POLICY SHOWN BELOW. IT IS ISSUED BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, HAUPPAUGE, NEW YORK TO THE EMPLOYER SHOWN BELOW.

Employer — STATE OF NEW YORK

Policy Number — 30501-G
Effective Date of Amendment — The dates indicated herein

The terms of the policy in effect on the dates shown are amended as follows:

Section I
This section shall be effective as of January 1, 2002

Schedule of Exhibits

The Group Policy is amended to modify the Schedule of Exhibits appearing in said policy. Amendment Exhibit A is how the Schedule of Exhibits will appear on the substituted pages that will be inserted in the Group Policy.

Schedule of Premiums

For the period January 1, 2002 through December 31, 2002 or when new premiums are designated by the Insurance Company in accordance with the provisions of the Group Policy, the premium each month for the insurance under the said policy for each Employee insured thereunder shall be as stated in the Schedule of Premiums to the Group Policy. Amendment Exhibit B is how amended Schedule of Premiums set forth in the Group Policy will appear on the substituted pages that will be inserted in the Group Policy.

Article XV Performance Standards

Article XV. Performance Standards is amended to reflect the performance standards agreed to for the period January 1, 2002 through December 31, 2002. Amendment Exhibit C is how Article XV will appear on the substituted pages that will be inserted in the Group Policy.

Article XXIV Additional Services

The Group Policy is amended to modify the provision for Additional Services provided under said policy. Amendment Exhibit D is how Article XXIV will appear on the substituted pages that will be inserted in the Group Policy.

Exhibit 4 Utilization Review Procedures

The Group Policy is amended to modify Exhibit 4 Utilization Review Procedures provided under said policy. Amendment Exhibit E is how Exhibit 4 will appear on the substituted pages that will be inserted in the Group Policy.

Section II
This section shall be effective as of April 14, 2003

Article XXVI Use And Disclosure Of Protected Health Information

Pursuant to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder at 45 C.F.R. Parts 160 and 164 ("HIPAA"), effective April 14, 2003 the Group Policy is amended to add a provision for Use And Disclosure Of Protected Health Information under said policy. Amendment Exhibit F is how Article XXVI will appear on the substituted pages that will be inserted in the Group Policy.

Form No. 8053

Section III
This section shall be effective as of January 1, 2004

Appendix A Standard Clauses for All New York State Contracts

The Group Policy is amended to revise that portion of Appendix A stating Standard Clauses for All New York State Contracts. That provision will replace the similarly titled provision included in the Group Policy. Amendment Exhibit G is how that portion of Appendix A will appear on the substituted pages that will be inserted in the Group Policy.

Appendix B – Contractor Compliance with Executive Order No. 127

The Group Policy is amended to add an Appendix B including the following: Contractor Compliance with Executive Order No. 127 and Form ADM-524.1. Appendix B will follow Appendix A in the Group Policy. Amendment Exhibit H is how Appendix B will appear on the substituted pages that will be inserted in the Group Policy. Where and when applicable, references in this Appendix B to "Offeror" or "Contractor" shall mean the "Insurance Company" and to the "Department" shall mean the "Employer".

This amendment will not affect any of the terms, provisions or conditions of this policy except as stated above.

This amendment will take effect on the Effective Dates shown above.

Dated at Albany, New York on 3-10-04.

STATE OF NEW YORK

By [redacted]

Official Title Commissioner

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

[redacted]

President and [redacted]
CEO

[redacted]

Policy Registrar
United HealthCare Service Corp.,
Administrator for
United HealthCare Insurance Company of New York

Amendment Exhibit B

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2002 through December 31, 2002:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$17.94/$8.26	$43.35/$19.95

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 January 1, 2002 premium rates have been established with a [redacted] margin. The Employer guarantees an additional premium payment, if necessary, equal to the difference between [redacted] margin and [redacted] margin. In the event that the emerging 2002 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 2002 earned premium (exclusive of premium for the Graduate Student Employees Union) or the amount of the deficit.

It is further agreed that should a surplus result from 2001 experience, up to [redacted] of the 2002 plan year premium (approximately [redacted] based on projected enrollment), shall be retained by the Insurance Company for the purpose of funding any deficit in 2002 that might occur. The Insurance Company will advise the Employer of any payment due in conjunction with delivery of the 2002 quarterly statements on April 15, July 15, October 15, 2002 and January 15, 2003. Should there be a deficit at the end of any or all quarters, the Insurance Company shall first apply a portion of the 2001 surplus funds to 2002 premium up to the lesser

of [redacted] of the 2002 earned premium (exclusive of premium for the Graduate Student Employees Union) or the amount of the loss. The final 2002 accounting and declaration of any retained 2001 dividend will occur on March 15, 2003. The transaction date for the application of any portion of the 2001 surplus funds to 2002 premium shall be the notification date.

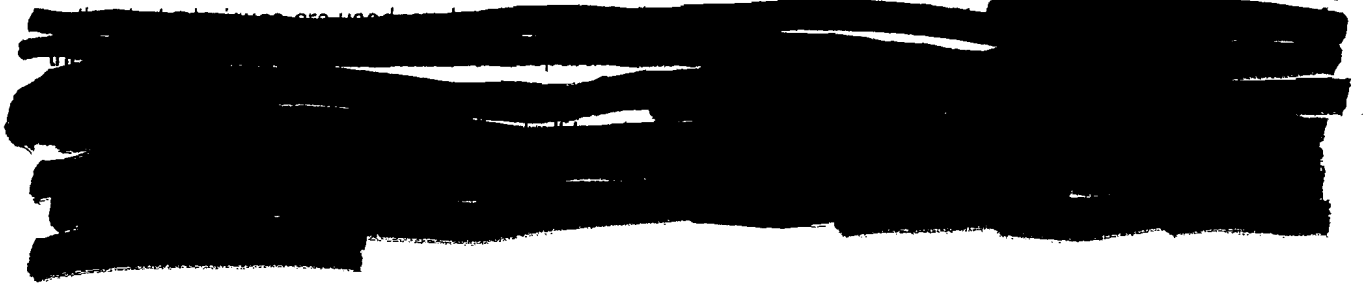
The Employer shall make an additional payment if the actual communication expense for 2002 exceeds the budgeted communication expense of [redacted] and a loss still exists after the application of any 2001 surplus funds to 2002 premium as referenced in the preceding paragraph. The amount of any additional premium payment shall be equal to the lesser of the amount of the loss, after the application of any 2001 surplus funds, or the amount of the communication expenses in excess of the budgeted amount. The due date on this additional payment, if applicable, is April 15, 2003.

Amendment Exhibit C

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]



This Article shows standards for the period beginning January 1, 2002 through December 31, 2002.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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] 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:

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

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 [redacted] 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 exceed [redacted] for a calendar year, a penalty of [redacted] shall be assessed.
- The maximum penalty for this measurement shall be [redacted] per calendar year.

(g) Pre-Determination of Benefits Turnaround Time- The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2002 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.
- The maximum penalty for this measurement will 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]

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 judgement 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.

Amendment Exhibit D

ARTICLE XXIV. ADDITIONAL SERVICES

In addition to the insurance provided by this Policy, the Insurance Company shall provide additional services that are included under ARTICLE XXVII. - ADDITIONAL SERVICES in Group Policy No. 30500-G. Any additional services being provided will begin as of an effective date agreed to by the Employer and the Insurance Company, for the employee groups designated by the Employer.

EXHIBIT 4

UTILIZATION REVIEW PROCEDURES

Review of Provider Claims

The Insurance Company shall identify Provider claims worthy of additional review. The claims are identified through a review of prior history as well as a combination of procedures being billed. The electronic claims processing system bundling edit addresses all bundled procedures prior to claim processing. If additional review is determined, the claim will be pended for review by the nurse consultant. The nurse consultant will review the claim and may contact the Provider. The nurse consultant may request additional information from the Provider of service to confirm procedures(s) rendered and determine benefit payable by the Plan. Claims are adjudicated notifying the participant or Provider of the outcome.

The Fraud and Litigation area shall review individual Provider practices when questionable practices are identified. The Fraud and Litigation department shall alert claim personnel by electronic warnings/messages assigned to the Provider listing of any special handling required.

UTILIZATION REVIEW OF SELECTED MEDICAL CLAIMS

The Insurance Company will also conduct analyses of selected claims as described below.

Physical Medicine – The Insurance Company will develop and maintain guidelines for the review and approval of chiropractic, physical and occupational therapy claims. Providers will be required to complete information reports which document the amount and level of care rendered. These reports, as well as supporting X-rays, will be evaluated by peer clinical professionals using established practical guidelines to determine covered benefits. Written notification of Utilization Review determinations will be provided to the provider of service. If a benefit determination is appealed, a review will be made by a peer clinical professional.

Nursing Care – When benefits for nursing care are requested, the Home Care Advocacy Program (HCAP) will advise the patient's family, doctor and nursing personnel of the information necessary to determine covered benefits. In conducting concurrent review, HCAP may request and review daily nursing notes to determine the amount and level of nursing care that is or will be covered. If a benefit determination is appealed, a review will be made by a peer clinical professional. That clinical professional will perform reviews of all pertinent and available information and medical record documentation. It will provide HCAP with a formal report of its findings with recommendations which will either support HCAP's decision or offer a different conclusion.

Surgery –Claims for surgical services rendered by a non-participating provider will first be subjected to the test of reasonable and customary against the statistical data contained in the Insurance Company's system. If surgical expenses exceed these guidelines, the reasonable & customary allowance shall be paid subject to applicable deductible and coinsurance with written notification to the enrollee and/or provider. When necessary, the narrative report of surgery will be requested and reviewed by the Insurance Company's medical consultant to ensure the appropriate coding, and to obtain information on extenuating circumstances or complications that may have occurred.

Infertility – When benefits for infertility treatment are requested, the patient/provider is required to notify the Insurance Company. The Insurance Company will review the treatment plan outlined and determine covered benefits, subject to the lifetime benefit maximums.

Durable Medical Equipment – When benefits for durable medical equipment are requested, the patient/provider notifies the Home Care Advocacy Program (HCAP) of any durable medical equipment needs prior to purchase/rental. HCAP staff, which includes medical personnel, review such requests to determine covered benefits.

MRI – The Insurance Company will develop and maintain guidelines for review of MRI procedures. When benefits for elective MRI are requested, the patient/provider notifies the Insurance Company prior to undergoing an MRI procedure. The Insurance Company will evaluate the request to determine covered benefits. The evaluation may include peer-to-peer dialogue with the patient's physician. Written notification of the determination will be provided to the patient and provider.

Amendment Exhibit F

ARTICLE XXVI. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PHI. For purposes of this Article, the term "Protected Health Information" ("PHI") is defined as those words are defined under the privacy regulations issued pursuant to the Health Insurance Portability and Accountability ("HIPAA") and codified at 45 CFR Parts 160 and 164. Within the context of this Agreement, PHI may be received by the Insurance Company from Department of Civil Services ("DCS") or other sources in connection with the services provided by the Insurance Company. For the purpose of this Article, the term "Insurance Company" refers to the Insurance Company and/or its subcontractor, if any, for the administration of the Policy. The PHI of Employees and Dependents under the Policy will be referred to in this document as "Enrollee PHI".

Plan Sponsor and Group Health Plan. The Insurance Company acknowledges that DCS, through its president, was authorized by New York law to establish a health insurance plan for state officers and employees, among others. Through such authority DCS established the New York State Health Insurance Program ("NYSHIP"), which is a health plan composed of several group health plans, including insurance coverage known as the "Empire Plan". The Insurance Company provides an insurance policy covering the enrollees in the Empire Plan, which plan qualifies as a group health plan under HIPAA's implementing regulations at 45 CFR § 160.103. The "plan sponsor" of of the NYSHIP plans, including the group health plan, as that term is used in HIPAA, is the "council on employee health insurance" ("Council") defined at NYS CSL § 161-a. The Council's administrative oversight of the group health plan is carried out by DCS. References to DCS in this Article mean DCS's activity on behalf of the plan sponsor and group health plan.

Business Associate. In addition to the services provided on the Empire Plan, the Insurance Company may provide additional services in connection with the New York State Health Insurance Program. To the extent such services are provided and involve the use or disclosure of PHI, the Insurance Company acknowledges that it may be a "business associate". If it is a "business associate", the Insurance Company agrees to amend any contract related to such services and abide all such obligations.

Permitted uses of PHI. The Insurance Company and DCS agree that PHI will be used solely to administer the Empire Plan, including to perform under this Agreement. Information will not be disclosed to any person or entity other than either party's employees, and HIPAA- compliant subcontractors or representatives needing access to such information to administer the Empire Plan or perform this Agreement.

Additional Permissible Uses of PHI. The Insurance Company may use PHI as follows:

1. for proper management and administration and to fulfill any present or future legal responsibilities;
2. to disclose the PHI to third parties for the purpose of proper management and administration or to fulfill any present or future legal responsibilities; provided, however, that the disclosures are required

or permitted by law or the Insurance Company has received from the third party written assurances that the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and the third party will notify the Insurance Company of any instances of which it becomes aware in which the confidentiality of the information has been breached;

3. to aggregate the PHI as permitted under HIPAA;

4. to de-identify any and all PHI provided that the Insurance Company de-identifies the information in accordance with HIPAA. De-identified information does not constitute PHI, and may be used by the Insurance Company (or a related entity) for research, creating comparative databases, statistical analysis, or other studies. De-identified information is the proprietary business information of the Insurance Company;

5. to use, or disclose to a related entity PHI research, as defined under the privacy regulations issued pursuant to HIPAA, including but not limited to projects for therapeutic outcomes research, and for epidemiological studies. The Insurance Company will obtain and maintain, on behalf of the plan, any consents, authorizations or approvals that may be required by applicable federal or state laws and regulations for use or disclosure of PHI for such purposes. The Insurance Company will maintain the confidentiality of such information as it relates to any individual Participant, provider, or the Empire Plan's business. The research, databases, analyses, and studies are the Insurance Company's proprietary business information; and

6. to create or use, or to disclose to a related entity to create or use, limited data sets as permitted under HIPAA. The Insurance Company also may disclose limited data sets to a related entity, DCS or its vendors at DCS direction, provided however, the Insurance Company or any recipient to whom the Insurance Company discloses such limited data sets agree the Insurance Company shall limit use of the limited data sets to research, health care operations or public health purposes and further agree that the Insurance Company shall:

   a. Not use or further disclose the limited data sets other than as permitted by this Agreement or as otherwise required by law;

   b. Use appropriate safeguards to prevent use or disclosure of the limited data sets other than as provided for by this Agreement;

   c. Report to DCS any use or disclosure of the limited data sets not provided for by this Agreement of which the Insurance Company becomes aware;

   d. Ensure that any agents, including a subcontractor, to whom the Insurance Company provides the limited data sets agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and

   e. Not identify the limited data sets or contact the individuals.

Limited data sets are proprietary business information of the Insurance Company.

Insurance Company obligation. Insurance Company agrees that it shall:

1. not use or further disclose the PHI other than as permitted by this Agreement or required by law;
2. use appropriate safeguards to prevent use or disclosure of PHI other than as permitted or required by this Agreement;
3. report to DCS any use or disclosure of any PHI of which we become aware that is not permitted by this Agreement;
4. ensure that any subcontractor or agent to whom the Insurance Company provides any PHI agrees to the same restrictions and conditions that apply to the Insurance Company with regard to the use and/or disclosure of PHI pursuant to this section;
5. respond to individuals' requests for access to PHI in the Insurance Company's possession that constitutes a Designated Record Set in accordance with HIPAA;
6. incorporate any amendments or corrections to the PHI in the Insurance Company's possession that constitutes a Designated Record Set in accordance with HIPAA;
7. provide to individuals an accounting of disclosures, in accordance with HIPAA;
8. make the Insurance Company's internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of HHS for purposes of determining your compliance with HIPAA; and
9. except as provided for herein or as required by law, upon termination of this Agreement, destroy the PHI and retain no copies in any form, if feasible. If the Insurance Company determines that returning or destroying the PHI is infeasible, Insurance Company agrees to extend the protections, limitations and restrictions of this section to such PHI and to limit any further uses and/or disclosures of such PHI retained to the purposes that make the return or destruction of the PHI infeasible, for as long as the Insurance Company maintains such PHI.

DCS Obligations. DCS, on behalf of the Council, has amended the plan documents that govern the group health plan to establish the permitted and required uses and disclosures of PHI by DCS and to incorporate the provisions required by 45 CFR 164.504(f)(2). Further, DCS, on behalf of the Council, has certified to the Empire Plan and to Insurance Company that DCS agrees to comply with the provisions required by 45 CFR 164.504(f)(2) and as set forth in the plan documents as amended. Such certification including as amended, is incorporated into this Article by reference.

Termination under HIPAA. This Agreement may be terminated by either party's discretion if either party determines that the other has violated a material term of this Article or of the Agreement with respect to the Insurance Company's obligations under this Article. Prior to termination, notice must be given to the other party, and for 60 days following the party's receipt of the notice that party shall have an obligation to cure the defect. Termination shall become effective 60 days after the party's receipt of the notice if the party that provided such notice reasonably determines that the term(s) alleged to have been violated have not been cured or substantially cured.

This Article shall be deemed effective April 14, 2003.

Amendment Exhibit G

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 $15,000 (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 $30,000 (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, AESOB, 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, provicing 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 $1 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, Division for Small Business, 30 South Pearl Street; Albany New York 12245, 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.

APPENDIX B

CONTRACTOR COMPLIANCE WITH EXECUTIVE ORDER NO. 127 The Contractor certifies that all information that it has provided or will provide to the Department with respect to Executive Order No. 127 is complete, true, and accurate.

The Contractor shall demonstrate its compliance with Executive Order No. 127 throughout the term of the Agreement by disclosing to the Department information on every person or organization retained, employed, or designated by or on behalf of the Contractor to attempt to influence the procurement process throughout the term of the Agreement. An "*attempt to influence the procurement process*" means any attempt to influence any determination of a member, officer or employee of the Department or any other New York State Executive agency with respect to the solicitation, evaluation or award of a procurement contract, or the preparation of specifications or request for submission of proposals for a procurement contract. The Contractor also shall disclose whether such persons or organizations have a financial interest in the procurement. "*Financial interest in the procurement*" means that a person or organization (i) owns or exercises direct or indirect control over, or owns a financial interest of more than one percent in, a contractor or other entity that stands to gain or benefit financially from a procurement contract; (ii) receives, expects or attempts to receive compensation, fees, remuneration or other financial gain or benefit from a contractor or other individual or entity that stands to benefit financially from a procurement contract; (iii) is being compensated by, or is a member of, an entity or organization which is receiving, expecting, or attempting to receive compensation, fees, remuneration or other financial gain from a contractor or other individual or entity that stands to benefit financially from a procurement contract; (iv) receives, expects or attempts to receive any other financial gain or benefit as a result from the procurement contract; or (v) is a relative of a person with a financial interest in the procurement as set forth in clauses (i) through (iv) of this paragraph. For purposes of this paragraph, "*relative*" means spouse, child, stepchild, stepparent, or any person who is a direct descendant of the grandparents of an individual listed in clauses (i) through (iv) of this paragraph, or of the individual's spouse. The Contractor is required to inform the Department of any and all persons or organizations subsequently retained, employed, or designated by or on behalf of the Contractor before the Department or any other New York State Executive agency is contacted by such persons or organizations. The Contractor is required to submit this information in the manner specified by the Department for that purpose, by use of the form set forth on Page 2 of this Appendix B.

In addition to the bases for termination set forth in the Agreement, the Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with Executive Order No. 127 was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor.

State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

ADMINISTRATIVE SERVICES DIVISION

Procurement Disclosure – Offeror/Contractor Disclosure of Contacts

ADM-524.1 (1/04L)

INSTRUCTIONS:

OFFERORS are required to demonstrate compliance with New York State Executive Order No. 127, "Providing for Additional State Procurement Disclosure" by completing this form at the time the Offeror's Proposal is submitted to the Department, and to provide such additional information throughout the procurement until the date of the final contract award, as necessary to ensure compliance with the Executive Order. Failure to complete and submit this form may result in a determination of non-responsiveness and disqualification of the Offeror's proposal. This information will be maintained in the Procurement Record and will be available for inspection as a public record.

CONTRACTORS are required to use this form to update this information throughout the term of any contract awarded to the Contractor by the Department. This information will be maintained in the record for the contract(s) for which the Contractor provides services and will be available for inspection as a public record.

Date of Submission: _____

Name of Offeror/Contractor: _____

Address: _____

Name and Title of Person Submitting this Form: _____

Please specify whether this is an initial filing in accordance with Section II, paragraph 1 of Executive Order No. 127 or an updated filing in accordance with Section II, paragraph 2 of Executive Order No. 127. (Please check):

☐ Initial filing ☐ Updated filing

The following person or organization was retained, employed, or designated by or on behalf of the Offeror/Contractor to attempt to influence the procurement process:

Name: _____

Address: _____

Telephone Number: _____

Place of Principal Employment: _____

Occupation: _____

Does the above named person or organization have a financial interest in the procurement? (Please check):

☐ no ☐ yes

PLEASE USE ADDITIONAL SHEETS AS NECESSARY AND ATTACH THEM TO THIS PAGE

PERSONAL PRIVACY PROTECTION NOTIFICATION **- The information you provide on this form is requested for the principal purpose ensuring compliance with Executive Order No. 127. Failure to provide the information may interfere with the Department's ability to administer the procurement to which the request for information relates. The information will be maintained by the Procurement Manager for the subject procurement, Department of Civil Service The State Campus, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. For information about the Personal Privacy Protection Law, call (518) 457-9375. For information about this form, call the Procurement Manager.**

INSERT PAGES TO GROUP POLICY 30501-G

SCHEDULE OF EXHIBITS

Exhibit Number	
1a	General Information for Active State Employees
1b	General Information for Retired State Employees, Vestees and Dependent Survivors.
2	United HealthCare Insurance Company of New York Certificate for Participating Agencies with Core Only
3	United HealthCare Insurance Company of New York Certificate for:
3a	CSEA
3b	M/C and Legislature
3c	Council 82
3d	PBA – NYS Police Troopers
3e	PBA – NYS Police Supervisors
3f	PIA
3e	PEF
3f	DC-37
3g	Participating Employers
3h	Participating Agencies with Core plus Medical and Psychiatric Enhancements
3i	Unified Court System – Judges and Justices; Employees represented by CSEA
3j	Unified Court System – Nonjudicial Employees
3k	UUP
3l	Retired State Employees, Vestees, Dependent Survivors
3m	New York State Correctional Officers and Police Benevolent Association
4	Utilization Review Procedures
5	NYSHIP Communication Program
6	Regular Health Services Utilization Reports
7	External Access/Nondisclosure Agreement

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2002 through December 31, 2002:

Employee Group	Premium Rate per Employee Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$17.94/$8.26	$43.35/$19.95

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 January 1, 2002 premium rates have been established with a [redacted] margin. The Employer guarantees an additional premium payment, if necessary, equal to the difference between [redacted] margin and [redacted] margin. In the event that the emerging 2002 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 2002 earned premium (exclusive of premium for the Graduate Student Employees Union) or the amount of the deficit.

It is further agreed that should a surplus result from 2001 experience, up to [redacted] of the 2002 plan year premium (approximately [redacted] based on projected enrollment), shall be retained by the Insurance Company for the purpose of funding any deficit in 2002 that might occur. The Insurance Company will advise the Employer of any payment due in conjunction with delivery of the 2002 quarterly statements on April 15, July 15, October 15 and January 15, 2003. Should there be a deficit at the end of any or all quarters, the Insurance Company shall first apply a portion of the 2001 surplus funds to 2002 premium up to the lesser of

[redacted] of the 2002 earned premium (exclusive of premium for the Graduate Student Employees Union) or the amount of the loss. The final 2002 accounting and declaration of any retained 2001 dividend will occur on March 15, 2003. The transaction date for the application of any portion of the 2001 surplus funds to 2002 premium shall be the notification date.

The Employer shall make an additional payment if the actual communication expense for 2002 exceeds the budgeted communication expense of [redacted] and a loss still exists after the application of any 2001 surplus funds to 2002 premium as referenced in the preceding paragraph. The amount of any additional premium payment shall be equal to the lesser of the amount of the loss, after the application of any 2001 surplus funds, or the amount of the communication expenses in excess of the budgeted amount. The due date on this additional payment, if applicable, is April 15, 2003.

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The Insurance Company shall at the Employer's request search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would jeopardize the Insurance Company's competitive position, except that this provision does not apply to Insurance Company Information necessary ("Necessary Information") to complete an audit. Employer in such situation will have access to such Necessary Information but only pursuant to Exhibit 9/External Access and Nondisclosure Agreement.

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2002 through December 31, 2002.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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 tc 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] 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:

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

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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time - The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2002 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.

- The maximum penalty for this measurement will 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]

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 judgement 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 XXII. AGENTS; ALTERATIONS

No Agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and by the Employer and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by the Insurance Company.

ARTICLE XXIII. FORCE MAJEURE

Neither the Employer nor the Insurance Company shall be liable or deemed to be in default for any delay or failure in performance under this Policy resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slow downs or other labor interruptions due to labor/management disputes involving entities other than the Employer or Insurance Company, or any other causes not reasonably foreseeable or beyond the control of either the Employer or Insurance Company. The Employer and the Insurance Company are required to use best efforts to eliminate or minimize the effect of such events during performance under this Policy and to resume performance under this Policy upon termination or cessation of such events.

ARTICLE XXIV . ADDITIONAL SERVICES

In addition to the insurance provided by this Policy, the Insurance Company shall provide additional services that are included under ARTICLE XXVII. - ADDITIONAL SERVICES in Group Policy No. 30500-G. Any additional services being provided will begin as of an effective date agreed to by the Employer and the Insurance Company, for the employee groups designated by the Employer.

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ARTICLE XXV. EFFECT OF ASSIGNMENT

Due to the Assignment Agreement of the Group Insurance Policies issued by Metropolitan Life Insurance Company to United HealthCare Insurance Company of New York effective January 1, 2000, any references in the Policies and its related documents to Metropolitan Life Insurance Company and/or United HealthCare Insurance Company shall, after January 1, 2000, mean United HealthCare Insurance Company of New York.

In the event of any conflicts or inconsistencies among the document elements of the Group Policies, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

(a) First, Appendix A, including the appended Non-Collusive Bidding Certification and the MacBride Act Statement;

(b) Second, the Amendments to the Policies; and

(c) Third, the Policies.

ARTICLE XXVI. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PHI. For purposes of this Article, the term "Protected Health Information" ("PHI") is defined as those words are defined under the privacy regulations issued pursuant to the Health Insurance Portability and Accountability ("HIPAA") and codified at 45 CFR Parts 160 and 164. Within the context of this Agreement, PHI may be received by the Insurance Company from Department of Civil Services ("DCS") or other sources in connection with the services provided by the Insurance Company. For the purpose of this Article, the term "Insurance Company" refers to the Insurance Company and/or its subcontractor, if any, for the administration of the Policy. The PHI of Employees and Dependents under the Policy will be referred to in this document as "Enrollee PHI".

Plan Sponsor and Group Health Plan. The Insurance Company acknowledges that DCS, through its president, was authorized by New York law to establish a health insurance plan for state officers and employees, among others. Through such authority DCS established the New York State Health Insurance Program ("NYSHIP"), which is a health plan composed of several group health plans, including insurance coverage known as the "Empire Plan". The Insurance Company provides an insurance policy covering the enrollees in the Empire Plan, which plan qualifies as a group health plan under HIPAA's implementing regulations at 45 CFR § 160.103. The "plan sponsor" of the NYSHIP plans, including the group health plan, as that term is used in HIPAA, is the "council on employee health insurance" ("Council") defined at NYS CSL § 161-a. The Council's administrative oversight of the group health plan is carried out by DCS. References to DCS in this Article mean DCS's activity on behalf of the plan sponsor and group health plan.

Business Associate. In addition to the services provided on the Empire Plan, the Insurance Company may provide additional services in connection with the New York State Health Insurance Program. To the extent such services are provided and involve the use or disclosure of PHI, the Insurance Company acknowledges that it may be a "business associate". If it is a "business associate", the Insurance Company agrees to amend any contract related to such services and abide all such obligations.

Permitted uses of PHI. The Insurance Company and DCS agree that PHI will be used solely to administer the Empire Plan, including to perform under this Agreement. Information will not be disclosed to any person or entity other than either party's employees, and HIPAA- compliant subcontractors or representatives needing access to such information to administer the Empire Plan or perform this Agreement.

Additional Permissible Uses of PHI. The Insurance Company may use PHI as follows:

1. for proper management and administration and to fulfill any present or future legal responsibilities;

2. to disclose the PHI to third parties for the purpose of proper management and administration or to fulfill any present or future legal responsibilities; provided, however, that the disclosures are required or permitted by law or the Insurance Company has received from the third party written assurances that the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and the third party will notify the Insurance Company of any instances of which it becomes aware in which the confidentiality of the information has been breached;
3. to aggregate the PHI as permitted under HIPAA;
4. to de-identify any and all PHI provided that the Insurance Company de-identifies the information in accordance with HIPAA. De-identified information does not constitute PHI, and may be used by the Insurance Company (or a related entity) for research, creating comparative databases, statistical analysis, or other studies. De-identified information is the proprietary business information of the Insurance Company;
5. to use, or disclose to a related entity PHI research, as defined under the privacy regulations issued pursuant to HIPAA, including but not limited to projects for therapeutic outcomes research, and for epidemiological studies. The Insurance Company will obtain and maintain on behalf of the plan, any consents, authorizations or approvals that may be required by applicable federal or state laws and regulations for use or disclosure of PHI for such purposes. The Insurance Company will maintain the confidentiality of such information as it relates to any individual Participant, provider, or the Empire Plan's business. The research, databases, analyses, and studies are the Insurance Company's proprietary business information; and
6. to create or use, or to disclose to a related entity to create or use, limited data sets as permitted under HIPAA. The Insurance Company also may disclose limited data sets to a related entity, DCS or its vendors at DCS direction, provided however, the Insurance Company or any recipient to whom the Insurance Company discloses such limited data sets agree the Insurance Company shall limit use of the limited data sets to research, health care operations or public health purposes and further agree that the Insurance Company shall:
   a. Not use or further disclose the limited data sets other than as permitted by this Agreement or as otherwise required by law;
   b. Use appropriate safeguards to prevent use or disclosure of the limited data sets other than as provided for by this Agreement;
   c. Report to DCS any use or disclosure of the limited data sets not provided for by this Agreement of which the Insurance Company becomes aware;
   d. Ensure that any agents, including a subcontractor, to whom the Insurance Company provides the limited data sets agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
   e. Not identify the limited data sets or contact the individuals.

Limited data sets are proprietary business information of the Insurance Company.

Insurance Company obligation. Insurance Company agrees that it shall:

1. not use or further disclose the PHI other than as permitted by this Agreement or required by law;
2. use appropriate safeguards to prevent use or disclosure of PHI other than as permitted or required by this Agreement;
3. report to DCS any use or disclosure of any PHI of which we become aware that is not permitted by this Agreement;

4. ensure that any subcontractor or agent to whom the Insurance Company provides any PHI agrees to the same restrictions and conditions that apply to the Insurance Company with regard to the use and/or disclosure of PHI pursuant to this section;
5. respond to individuals' requests for access to PHI in the Insurance Company's possession that constitutes a Designated Record Set in accordance with HIPAA;
6. incorporate any amendments or corrections to the PHI in the Insurance Company's possession that constitutes a Designated Record Set in accordance with HIPAA;
7. provide to individuals an accounting of disclosures, in accordance with HIPAA;
8. make the Insurance Company's internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of HHS for purposes of determining your compliance with HIPAA; and
9. except as provided for herein or as required by law, upon termination of this Agreement, destroy the PHI and retain no copies in any form, if feasible. If the Insurance Company determines that returning or destroying the PHI is infeasible, Insurance Company agrees to extend the protections, limitations and restrictions of this section to such PHI and to limit any further uses and/or disclosures of such PHI retained to the purposes that make the return or destruction of the PHI infeasible, for as long as the Insurance Company maintains such PHI.

1. **DCS Obligations**. DCS, on behalf of the Council, has amended the plan documents that govern the group health plan to establish the permitted and required uses and disclosures of PHI by DCS and to incorporate the provisions required by 45 CFR 164.50(f)(2). Further, DCS, on behalf of the Council, has certified to the Empire Plan and to Insurance Company that DCS agrees to comply with the provisions required by 45 CFR 164.50(f)(2) and as set forth in the plan documents as amended. Such certification including as amended, is incorporated into this Article by reference.

Termination under HIPAA. This Agreement may be terminated by either party's discretion if either party determines that the other has violated a material term of this Article or of the Agreement with respect to the Insurance Company's obligations under this Article. Prior to termination notice must be given to the other party, and for 60 days following the party's receipt of the notice that party shall have an obligation to cure the defect. Termination shall become effective after 60 days after the party's receipt of the notice if the party that provided such notice reasonably determines that the term(s) alleged to have been violated have not been cured or substantially cured.

This Article shall be deemed effective April 14, 2003.

EXHIBIT 4

UTILIZATION REVIEW PROCEDURES

Review of Provider Claims

The Insurance Company shall identify Provider claims worthy of additional review. The claims are identified through a review of prior history as well as a combination of procedures being billed. The electronic claims processing system bundling edit addresses all bundled procedures prior to claim processing. If additional review is determined, the claim will be pended for review by the nurse consultant. The nurse consultant will review the claim and may contact the Provider. The nurse consultant may request additional information from the Provider of service to confirm procedures(s) rendered and determine benefit payable by the Plan. Claims are adjudicated notifying the participant or Provider of the outcome.

The Fraud and Litigation area shall review individual Provider practices when questionable practices are identified. The Fraud and Litigation department shall alert claim personnel by electronic warnings/messages assigned to the Provider listing of any special handling required.

UTILIZATION REVIEW OF SELECTED MEDICAL CLAIMS

The Insurance Company will also conduct analyses of selected claims as described below.

Physical Medicine – The Insurance Company will develop and maintain guidelines for the review and approval of chiropractic, physical and occupational therapy claims. Providers will be required to complete information reports which document the amount and level of care rendered. These reports, as well as supporting X-rays, will be evaluated by peer clinical professionals using established practical guidelines to determine covered benefits. Written notification of Utilization Review determinations will be provided to the provider of service. If a benefit determination is appealed, a review will be made by a peer clinical professional.

Nursing Care – When benefits for nursing care are requested, the Home Care Advocacy Program (HCAP) will advise the patient's family, doctor and nursing personnel of the information necessary to determine covered benefits. In conducting concurrent review, HCAP may request and review daily nursing notes to determine the amount and level of nursing care that is or will be covered. If a benefit determination is appealed, a review will be made by a peer clinical professional. That clinical professional will perform rev ews of all pertinent and available information and medical record documentation. It will provide HCAP with a formal report of its findings with recommendations which will either support HCAP's decision or offer a different conclusion.

Surgery –Claims for surgical services rendered by a non-participating provider will first be subjected to the test of reasonable and customary against the statistical data contained in the Insurance Company's system. If surgical expenses exceed these guidelines, the reasonable & customary allowar ce shall be paid subject to applicable deductible and coinsurance with written notification to the enrollee and/or provider. When necessary, the narrative report of surgery will be requested and reviewed by the Insurance Company's medical consultant to ensure the appropriate coding, and to obtain information on extenuating circumstances or complications that may have occurred.

Infertility – When benefits for infertility treatment are requested, the patient/provider is required to notify the Insurance Company. The Insurance Company will review the treatment plan outlined and determine covered benefits, subject to the lifetime benefit maximums.

Durable Medical Equipment – When benefits for durable medical equipment are requested, the patient/provider notifies the Home Care Advocacy Program (HCAP) of any durable medical equipment needs prior to purchase/rental. HCAP staff, which includes medical personnel, review such requests to determine covered benefits.

MRI – The Insurance Company will develop and maintain guidelines for review of MRI procedures. When benefits for elective MRI are requested, the patient/provider notifies the Insurance Company prior to undergoing an MRI procedure. The Insurance Company will evaluate the request to determine covered benefits. The evaluation may include peer-to-peer dialogue with the patient's physician. Written notification of the determination will be provided to the patient and provider.

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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 $15,000 (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 $30,000 (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, AESOB, 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 $1 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, Division for Small Business, 30 South Pearl Street; Albany New York 12245, 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 May 2003

APPENDIX B

CONTRACTOR COMPLIANCE WITH EXECUTIVE ORDER NO. 127 The Contractor certifies that all information that it has provided or will provide to the Department with respect to Executive Order No. 127 is complete, true, and accurate.

The Contractor shall demonstrate its compliance with Executive Order No. 127 throughout the term of the Agreement by disclosing to the Department information on every person or organization retained, employed, or designated by or on behalf of the Contractor to attempt to influence the procurement process throughout the term of the Agreement. An "*attempt to influence the procurement process*" means any attempt to influence any determination of a member, officer or employee of the Department or any other New York State Executive agency with respect to the solicitation, evaluation or award of a procurement contract, or the preparation of specifications or request for submission of proposals for a procurement contract. The Contractor also shall disclose whether such persons or organizations have a financial interest in the procurement. "*Financial interest in the procurement*" means that a person or organization (i) owns or exercises direct or indirect control over, or owns a financial interest of more than one percent in, a contractor or other entity that stands to gain or benefit financially from a procurement contract; (ii) receives, expects or attempts to receive compensation, fees, remuneration or other financial gain or benefit from a contractor or other individual or entity that stands to benefit financially from a procurement contract; (iii) is being compensated by, or is a member of, an entity or organization which is receiving, expecting, or attempting to receive compensation, fees, remuneration or other financial gain from a contractor or other individual or entity that stands to benefit financially from a procurement contract; (iv) receives, expects or attempts to receive any other financial gain or benefit as a result from the procurement contract; or (v) is a relative of a person with a financial interest in the procurement as set forth in clauses (i) through (iv) of this paragraph. For purposes of this paragraph, "*relative*" means spouse, child, stepchild, stepparent, or any person who is a direct descendant of the grandparents of an individual listed in clauses (i) through (iv) of this paragraph, or of the individual's spouse. The Contractor is required to inform the Department of any and all persons or organizations subsequently retained, employed, or designated by or on behalf of the Contractor before the Department or any other New York State Executive agency is contacted by such persons or organizations. The Contractor is required to submit this information in the manner specified by the Department for that purpose, by use of the form set forth on Page 2 of this Appendix B.

In addition to the bases for termination set forth in the Agreement, the Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with Executive Order No. 127 was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor.

State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

ADMINISTRATIVE SERVICES DIVISION

Procurement Disclosure – Offeror/Contractor Disclosure of Contacts

ADM-524.1 (1/04L)

INSTRUCTIONS:

OFFERORS are required to demonstrate compliance with New York State Executive Order No. 127, "Providing for Additional State Procurement Disclosure" by completing this form at the time the Offeror's Proposal is submitted to the Department, and to provide such additional information throughout the procurement until the date of the final contract award, as necessary to ensure compliance with the Executive Order. Failure to complete and submit this form may result in a determination of non-responsiveness and disqualification of the Offeror's proposal. This information will be maintained in the Procurement Record and will be available for inspection as a public record.

CONTRACTORS are required to use this form to update this information throughout the term of any contract awarded to the Contractor by the Department. This information will be maintained in the record for the contract(s) for which the Contractor provides services and will be available for inspection as a public record.

Date of Submission: _____

Name of Offeror/Contractor: _____

Address: _____

Name and Title of Person Submitting this Form: _____

Please specify whether this is an initial filing in accordance with Section II, paragraph 1 of Executive Order No. 127 or an updated filing in accordance with Section II, paragraph 2 of Executive Order No. 127. (Please check):

☐ Initial filing ☐ Updated filing

The following person or organization was retained, employed, or designated by or on behalf of the Offeror/Contractor to attempt to influence the procurement process:

Name: _____

Address: _____

Telephone Number: _____

Place of Principal Employment: _____

Occupation: _____

Does the above named person or organization have a financial interest in the procurement? (Please check):

☐ no ☐ yes

PLEASE USE ADDITIONAL SHEETS AS NECESSARY AND ATTACH THEM TO THIS PAGE

PERSONAL PRIVACY PROTECTION NOTIFICATION **- The information you provide on this form is requested for the principal purpose ensuring compliance with Executive Order No. 127. Failure to provide the information may interfere with the Department's ability to administer the procurement to which the request for information relates. The information will be maintained by the Procurement Manager for the subject procurement, Department of Civil Service, The State Campus, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. For information about the Personal Privacy Protection Law, call (518) 457-9375. For information about this form, call the Procurement Manager.**

THIS AMENDMENT WILL BE ATTACHED TO AND FORM A PART OF THE GROUP POLICY SHOWN BELOW. IT IS ISSUED BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, ISLANDIA, NEW YORK TO THE EMPLOYER SHOWN BELOW.

Employer — STATE OF NEW YORK

Policy Number — 30501-G
Effective Date of Amendment — January 1, 2003

The terms of the policy in effect are amended as of the Effective Date shown above as follows:

Schedule of Premiums

For the period January 1, 2003 through December 31, 2003 or when new premiums are designated by the Insurance Company in accordance with the provisions of the Group Policy, the premium each month for the insurance under the said policy for each Employee insured thereunder shall be as stated in the Schedule of Premiums to the Group Policy. Amendment Exhibit A is how amended Schedule of Premiums set forth in the Group Policy will appear on the substituted pages that will be inserted in the Group Policy.

Article XV Performance Standards

Article XV. Performance Standards is amended to extend the effective dates of the performance standards for the period January 1, 2003 through December 31, 2003. Amendment Exhibit B is how Article XV will appear on the substituted pages that will be inserted in the Group Policy.

This amendment will not affect any of the terms, provisions or conditions of this policy except as stated above.

This amendment will take effect on the Effective Dates shown above.

Dated at Albany, New York on 12/3/04.

STATE OF NEW YORK

[redacted]

Official Title Commissioner

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

[redacted]

President and CEO

[redacted]

Policy Registrar
United HealthCare Service LLC,
Administrator for
United HealthCare Insurance Company of New York

Amendment
Exhibit A

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2003 through December 31, 2003:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$20.09/$9.25	$48.52/$22.33

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 January 1, 2003 premium rates 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 2003 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 2003 earned premium or the amount of the deficit.

It is further agreed that should a surplus result from 2002 experience, up to [redacted] of margin, shall be retained by the Insurance Company for the purpose of funding any deficit in 2003 that might occur. The Insurance Company will advise the Employer of any payment due in conjunction with delivery of the 2003 quarterly statements on April 15, July 15, and October 15, 2003 and January 15, 2004. Should there be a deficit at the end of any or all quarters, the Insurance Company shall apply a portion of the 2002 surplus funds to 2003 premium up to the lesser of [redacted] of the 2003 earned premium or the amount of the loss. The final 2003 accounting will occur on March 15, 2004. The transaction date for these payments shall be the notification date.

Amendment
Exhibit B

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2003 through December 31, 2003.

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 misp[redacted]yment 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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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] 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:

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

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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time- The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2003 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.
- The maximum penalty for this measurement will 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]

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 judgement 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.

INSERT PAGES TO GROUP POLICY 30501-G

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2003 through December 31, 2003:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$20.09/$9.25	$48.52/$22.33

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 January 1, 2003 premium rates 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 2003 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 2003 earned premium or the amount of the deficit.

It is further agreed that should a surplus result from 2002 experience, up to [redacted] of the 2003 plan year premium, shall be retained by the Insurance Company for the purpose of funding any deficit in 2003 that might occur. The Insurance Company will advise the Employer of any payment due in conjunction with delivery of the 2003 quarterly statements on April 15, July 15, and October 15, 2003 and January 15, 2004. Should there be a deficit at the end of any or all quarters, the Insurance Company shall first apply a portion of the 2002 surplus funds to 2003 premium up to the lesser of [redacted] of the 2003 earned premium or the amount of the loss. The final 2003 accounting and declaration of any retained 2003 dividend will occur on March 15, 2004. The transaction date for the application of any portion of the 2002 surplus funds to 2003 premium shall be the notification date.

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The Insurance Company shall at the Employer's request search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Employer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would jeopardize the Insurance Company's competitive position, except that this provision does not apply to Insurance Company Information necessary ("Necessary Information") to complete an audit. Employer in such situation will have access to such Necessary Information but only pursuant to Exhibit 9/External Access and Nondisclosure Agreement.

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2003 through December 31, 2003.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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 [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] 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:

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

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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time - The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2003 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.

- The maximum penalty for this measurement will 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]

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 judgement 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.

THIS AMENDMENT WILL BE ATTACHED TO AND FORM A PART OF THE GROUP POLICY SHOWN BELOW. IT IS ISSUED BY UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, ISLANDIA, NEW YORK TO THE EMPLOYER SHOWN BELOW.

Employer — STATE OF NEW YORK

Policy Number — 30501-G
Effective Date of Amendment — January 1, 2004

The terms of the policy in effect are amended as of the Effective Date shown above as follows:

Schedule of Premiums

For the period January 1, 2004 through December 31, 2004 or when new premiums are designated by the Insurance Company in accordance with the provisions of the Group Policy, the premium each month for the insurance under the said policy for each Employee insured thereunder shall be as stated in the Schedule of Premiums to the Group Policy. Amendment Exhibit A is how amended Schedule of Premiums set forth in the Group Policy will appear on the substituted pages that will be inserted in the Group Policy.

Article XV Performance Standards

Article XV. Performance Standards is amended to extend the effective dates of the performance standards for the period January 1, 2004 through December 31, 2004. Amendment Exhibit B is how Article XV will appear on the substituted pages that will be inserted in the Group Policy.

This amendment will not affect any of the terms, provisions or conditions of this policy except as stated above.

This amendment will take effect on the Effective Dates shown above.

Dated at Albany, New York on 6/15/05.

STATE OF NEW YORK

[redacted]

Official Title President

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

[redacted]

President and CEO

[redacted]

Policy Registrar
United HealthCare Service LLC,
Administrator for
United HealthCare Insurance Company of New York

CAROL A. BERRY
Notary Public, State of New York
No. 01BE6002736
Qualified in Saratoga County
Commission Expires February 17, 20 06

[redacted]

Amendment
Exhibit A

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2004 through December 31, 2004:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$19.61/$9.00	$46.72/$21.45

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.

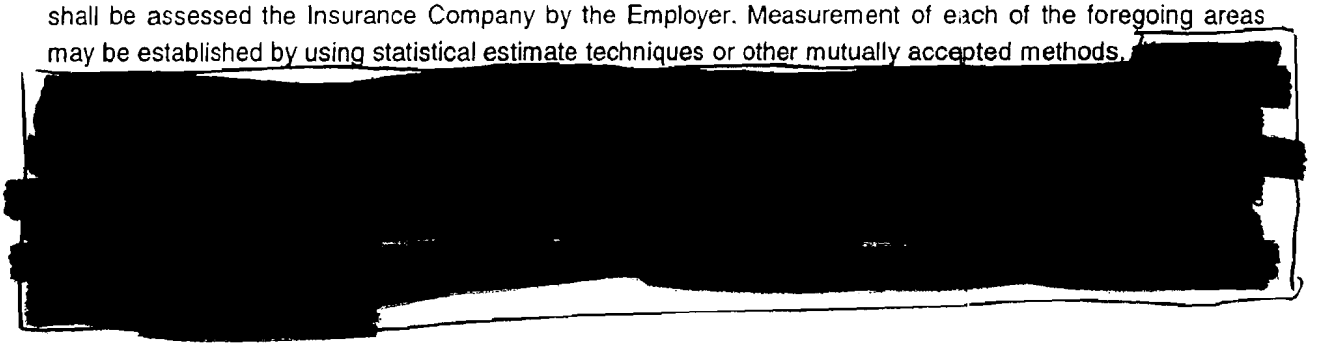
The January 1, 2004 premium rates have been established with a [redacted] margin. The Employer guarantees an additional margin payment equal to the difference between [redacted] margin and [redacted] margin. In the event that the emerging 2004 experience results in a deficit, the Employer agrees to make additional premium payments upon notification by the Insurance Company equal to the lesser of [redacted] of the 2004 earned premium or the amount of the deficit. The due date on this additional payment, if applicable, is April 15, 2005.

Amendment
Exhibit B

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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.



This Article shows standards for the period beginning January 1, 2004 through December 31, 2004.

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:

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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] 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:

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

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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time- The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2004 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.
- The maximum penalty for this measurement will 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]

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 judgement 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.

INSERT PAGES TO GROUP POLICY 30501-G

SCHEDULE OF PREMIUMS

MEDICAL/SURGICAL

BENEFITS INSURANCE

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

For the period January 1, 2004 through December 31, 2004:

	Premium Rate per Employee	
Employee Group	Personal Insurance Only (Monthly/Biweekly)	Personal and Dependent Insurance (Monthly/Biweekly)
New York Medical Enhancement Benefits	$19.61/$9.00	$46.72/$21.45

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 January 1, 2004 premium rates 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 2004 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 2004 earned premium or the amount of the deficit. The due date on this additional payment, if applicable, is April 15, 2005.

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The Insurance Company shall at the Employer's request search the Insurance Company's files, pull and provide to the Employer's auditors such documentary evidence as they require. Sufficient Insurance Company resources shall be made available for the efficient performance of audit procedures.

The Insurance Company shall respond in writing within 30 days of receiving any audit report from the Employer. The response will specifically address each audit recommendation. If the Insurance Company is in agreement, the response will include the workplan to implement the recommendation. If the Insurance Company disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.

All records, documentation, etc. described in this Article for the use of the Emp oyer's auditors pertain to the financial experience and administration of this Policy only. The Employer's auditors may not access any such records, documentation, etc., which pertain to another policyholder.

Notwithstanding the foregoing, the Insurance Company will not permit the Employer to audit any item which would jeopardize the Insurance Company's competitive position, except that this provision does not apply to Insurance Company Information necessary ("Necessary Information") to complete an audit. Employer in such situation will have access to such Necessary Information but only pursuant to Exhibit 9/External Access and Nondisclosure Agreement.

ARTICLE XV. 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.

If the Insurance Company's level of performance falls below the established standards, 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]

This Article shows standards for the period beginning January 1, 2004 through December 31, 2004.

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:

$$\text{Customer Service Accuracy Rate} = \frac{\text{Number of Claims With No Customer Service Errors}}{\text{Number of Claims Reviewed}}$$

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:

$$\text{Turnaround Time Rate} = \frac{\text{Number of Claims Within the Standard}}{\text{Number of Claims Reviewed}}$$

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 $300,000 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 [redacted] 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:

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

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 [redacted] 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.

(g) Pre-Determination of Benefits Turnaround Time - The Pre-Determination of Benefits Turnaround Time Performance Standard is not applicable to the time period, January 1, 2000 through December 31, 2004 however, the Employer reserves the right to audit the turnaround time for predetermination of benefit claims on a retrospect basis and assess and receive applicable penalties for the period January 1, 1998 through December 31, 1999.

The standard is defined as follows:

Pre-Determination of Benefits Turnaround Time shall measure the number of calendar days elapsed between the day the Insurance Company receives a request for Predetermination of Benefits and the date notification of the determination is mailed to the enrollee and/or physician. Requests providing incomplete or insufficient documentation shall not be counted until the date of receipt of all information necessary to make the determination. Predetermination of Benefits Turnaround Time shall be tracked and reported by the Kingston Service Center.

Formula for Pre-Determination of Benefits:

$$\text{Pre-Determination of Benefit Rate} = \frac{\text{Number of Pre-Determination of Benefits Within the Standard}}{\text{Number of Pre-Determinations Reviewed}}$$

Standard for Pre-Determination of Benefits Turnaround Time:

- [redacted] of Pre-Determination of Benefits received by the Insurance Company in a calendar year must be processed within [redacted] of receipt. (Participating Provider Program and Basic Medical Program excluding the Home Care Advocacy Program and the Managed Physical Medicine Program)

Performance Penalty:

- 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 for a calendar year, a performance penalty of [redacted] will be assessed.

- The maximum penalty for this measurement will 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]

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 judgement 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.