THIS AMENDMENT AGREEMENT NUMBER 3 (the "**Amendment Agreement**") is made the 1st day of April, 2011.

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, represented by the Minister of Health

(the "**Province**") at the following address:

Health Insurance BC -
Business Management Office
Strategic Initiatives and Corporate Services
Ministry of Health
5th Floor – 1483 Douglas St
Victoria BC V8W 3C8

AND:

MAXIMUS BC Health Inc. (**"MAXIMUS Prime"**), a company organized under the laws of British Columbia, MAXIMUS BC Health Benefit Operations, Inc. (**"MAXIMUS Sub"**, and collectively with MAXIMUS Prime, the **"Service Provider"**), MAXIMUS Canada Inc. (**"MAXIMUS Canada"**), MAXIMUS, Inc. (**"MAXIMUS US"**)

(the "**Contractor**") at the following address:

MAXIMUS BC Health Inc
716 Yates St
Victoria BC V8W 1L4

BACKGROUND

A. The Parties entered into a Master Services Agreement (MSA) dated November 4, 2004, and subsequently amended January 16, 2006, and November 20, 2006, (the "Agreement").

B. Schedules "E" and "F" of the Agreement refer, in whole or in part, to the description of basic Services, Service Level Requirements (SLRs) and Service Level Objectives (SLOs).

C. The Parties have agreed to amend Schedules "E" and "F" of the Agreement to reflect changes to the SLRs and SLOs as described below including elimination of some SLOs and the elimination of 1 SLR.

Schedule "F" of the Agreement contains 27 SLRs and 42 SLOs that define expected Service Levels for the Medical Services Plan and PharmaCare Services provided by the Service Provider. The Agreement provides for annual review of SLRs and SLOs to ensure they continue to remain appropriate.

Service Level Objectives
A review of the full set of SLOs, which had not been changed since handover, was carried out by the Province and the Service Provider in 2008/09. Each SLO was examined according to the following criteria: 1 key measure per activity, clarity, redundancy with SLRs, consistency with operational procedure, approved post-handover changes to operational procedure, alignment with program area objectives, dependencies on other parties, measurability/suitability, and feasibility of reporting.

As a result of the review, it was recommended that Service Levels for 19 SLOs be modified or clarified and 16 be eliminated. In addition, it was recommended that several document types in SLO 38, *Document Inventory*, be moved without affecting Service Levels to related SLOs to improve the Service Provider's internal management. These changes are shown in Attachment 1.

Changes to reporting methods were defined for several SLOs, as outlined in Attachment 2. Where data collection procedures permitted, monthly reporting was maintained. Where it was difficult for the Service

Provider to measure an SLO or implement a data collection process, reporting was changed to a complaint and/or audit basis.

Joint Executive Committee approved the changes on December 10, 2010, subject to final signoff by the program areas, which was obtained in June 2011.

Service Level Requirements
SLR 7, *Non-imaged Document Processing*, has been eliminated as a housekeeping change. The document types formerly included in this Service Level are now imaged and included in SLR 6, *Beneficiary Account Maintenance*. This change was approved at the same time as the changes to the SLOs.

The SLRs for processing provider claims have been amended to address 2 main issues:

- The Province's concerns about the backlog of unprocessed manually adjudicated claims and high interest payments. The SLR for manual adjudication of provider claims (SLR13), which was based on the turnaround time for processing claims, was not operating as expected when the Agreement was signed and was ineffective in preventing backlogs.
- The difficulty the Service Provider would have in achieving the higher Service Levels set to come into effect after the transformation of the claims system (referred to as 'implementation of CAPS' in Schedule F of the Agreement). Claims transformation involves back-end automation of business rules and interface changes to accommodate the new "Medigent" enrolment system. The transformation design has changed over time with the Province's approval and the initial assumption was subsequently determined to be invalid.

The following recommendations to change the provider claims SLRs were approved by Joint Executive Committee in June 2011:

- Remove post transformation requirements for in-province auto-adjudicated claims (SLR 12). Maintain the pre-transformation Service Levels and increase processing rates as stakeholders (Medical Services Branch, the Service Provider, Medical Services Commission and British Columbia Medical Association) agree to approaches that will increase automation or reduce processing time.
- Change the Service Level for manual adjudication (SLR 13) to a productivity measure requiring a minimum number of claims processed per month (50,000) and an annual target of 964,000 claims. A productivity model has been used on a project basis since 2008.
- Combine SLRs 14 and 15 for peak and non-peak periods for out of country travel claims into SLR 14(a) and apply the shorter processing time for non-peak claims to all claims. Remove the post transformation requirements.
- Combine SLRs 16 and 17 for routine and complicated pre-authorizations for cosmetic procedures into one SLR 16(a) and apply a mid-range processing time for all pre-authorizations.
- Increase the average telephone response time for provider billing enquiries from less than 1 minute to less than 3 minutes, in order to increase the amount of time available for manual claims adjudication. This response time was introduced in 2008 on a project basis and has not resulted in increased complaints. Create a separate SLR for this queue, SLR 10(a).
- Adjust penalties for SLRs with changed structures (other than the removal of post transformation requirements). Adjustments are based on maintaining a similar risk structure for the Service Provider and staying in line with penalties for other non claims SLRs.

The changes to claims SLRs and penalties are shown in Attachment 1. No changes to fees occur as a result of these changes.

AGREEMENT

NOW THEREFORE THIS AMENDMENT AGREEMENT WITNESSES that in consideration of the sum of One Dollar and other valuable consideration (the receipt and sufficiency of which is hereby acknowledged by each Party), the Parties agree as follows:

(1) Terms used but not defined in this Amendment Agreement will have the same meaning herein as in the Agreement.

(2) That pages F-6 to F-8 and F-11 to F-21 of Schedule "F" to the Agreement shall be amended as per the attached (Attachment 1).

(3) That pages E-4, E-10 to E-14, E-18, E-20, E-22, E-24, E-25, E-27 to E-40, E-42 to E-55, and E-57 of Schedule "E" to the Agreement shall be amended as per the attached (Attachment 2).

(4) In all other respects, the Agreement is confirmed.

(5) Notwithstanding the date of execution and delivery of this Amendment Agreement, this Amendment Agreement will be deemed to take effect as of April 1, 2011.

(6) This Amendment Agreement is governed by and will be construed in accordance with the laws of the Province of British Columbia and the laws of Canada applicable therein.

(7) This Amendment Agreement may be executed in any number of counterparts, each of which will be deemed to be an original and all of which taken together will be deemed to constitute one and the same instrument.

THE PARTIES have duly executed this Amendment Agreement the 11th day of April, 2012

SIGNED AND DELIVERED on behalf of the Province by an authorized representative of the Province

(Guy Cookson, Executive Director/Contract Manager)

Date:

SIGNED AND DELIVERED by or on behalf of the Contractor (or by an authorized signatory of the Contractor if a corporation)

(R. Duff Lang, President and Project Director)

Date: April 11, 2012

SCHEDULE F

SERVICE LEVELS

1. General Principles

The Parties agree as follows:

(a) This Schedule defines and describes the Service Levels, being comprised of Service Level Requirements and Service Level Objectives, which have been mutually developed and agreed to by the Province and the Service Provider.

(b) Service Level Requirements have been established between the Service Provider and the Province with respect to the certain Services set out in Paragraph 4 below.

(c) Service Level Objectives have been established between the Service Provider and the Province with respect to all other Services for which Service Level Requirements have not been established.

(d) Subject to Paragraph 1(e) below, commencing on the Hand-Over Date and during the Term, the Service Provider will meet or exceed the Service Level Requirements and the Service Level Objectives.

(e) Each Service Level Requirement is to be measured as described in Paragraph 4 below. Certain Service Level Requirements will only be in effect during certain periods of the Term specified in Paragraph 4. The Service Provider will not be required to meet or exceed a Service Level Requirement which is designated as a Phased SLR until the Phase-In Date for such Service Level Requirement. From the Hand-Over Date until the applicable Phase-In Date, the Service Provider will perform each Service having a Phase SLR at or above the Service Level Requirement expressly specified for such period or where no Service Level Requirement is specified then at the standard and level which was actually achieved by the Province in the performance of such Service to the applicable Province Customers or Stakeholders immediately prior to the Hand-Over Date with such level being deemed to be a Service Level Requirement. The Service Provider agrees that such performance standard and level shall be determined by the Province to the extent reasonably reliable data is available with respect thereto including, without limitation, Province Customer and Stakeholder feedback received by the Province, complaint logs, or similar information.

(f) Measurements of Service Levels will take effect on the Hand-Over Date and continue for the duration of the Term.

(g) The Service Provider will provide Service Level Credits against Fees payable by the Province if the Service Provider fails to meet or exceed Service Level Requirements. Commencing on the Hand-Over Date and subject to the At Risk Amount limit and Paragraph 1(e) above, the Service Provider will credit the

Province with Service Level Credits for SLR Failures in accordance with Paragraph 8 below and Articles 8 and 12 of the Agreement.

(h) Subject to Paragraph 1(i), the At Risk Amount will be adjusted within 30 days of the end of each Contract Year such that the At Risk Amount for the then current Contract Year equals 17.5% of the Average Annual Fee as of the end of the prior Contract Year, divided by 12.

(i) The At Risk Amount will only be adjusted pursuant to Paragraph 1(h) where the Average Annual Fee increases or decreases by at least 10% in aggregate as compared to the Average Annual Fee last used to calculate the At Risk Amount (or, if it has not yet been adjusted, as compared against the Fee initially calculated to be payable in the first Contract Year).

(j) The total Service Level Credits set out in the far right column of the table in Paragraph 4 shall not exceed three times the At Risk Amount. Each time the At Risk Amount is adjusted pursuant to Paragraph 1(h) above, such Service Level Credits shall be automatically adjusted on a pro rata basis in order that the ratio of such Service Level Credits to the At Risk Amount is not changed by such adjustment.

(k) The Uninterruptible Services shall consist of the Services designated as either an IT Uninterruptible Service or Other Uninterruptible Service in the far left column of the table in Paragraph 4.

2. Definitions

Capitalized terms used in this Schedule will have the meanings set forth in this Paragraph 2. Capitalized terms not defined in this Schedule shall have the meanings set forth in Schedule A or otherwise in this Agreement.

(a) "**Average Annual Fee**" means the average aggregate annual Fees payable under this Agreement, calculated at the end of each Contract Year based upon the Fees payable during such Contract Year, including Inflation, taking into account any and all adjustment to the Fees made pursuant to Change Orders but excluding credits granted by the Service Provider to the Province during such Contract Year.

(b) "**At Risk Amount**" means $350,000, as adjusted pursuant to Paragraph 1(h) above.

(c) "**Critical Items**" mean any incident or situation that could lead to service level failure, be harmful to the Province's or the Service Provider's reputation or have material importance to any of the Province Customers or Stakeholders.

(d) "**Full Service State**" means that the system is capable of and achieving all Service Level Requirements in respect of it.

(e) "**Health Authorities**" mean the governing bodies with responsibilities for the planning, coordination and delivery of regional health services, including hospital, long term care and community services.

(f) "**IVR**" means interactive voice response.

(g) "**MSP Payment Cycle**" means the scheduled monthly payment cycle used in connection with the Services whereby a payment is deposited with the payee on the 15th or closest proceeding Business Day and the last Business Day of each month.

(h) "**Payment Period**" means, in respect of the Medical Services Plan, a MSP Payment Cycle period, or, in respect of pharmacies, the weekly payment cycle period used in connection with PharmaCare services.

(i) "**PharmaNet Professional and Software Compliance Standards Library**" means the reference material for all connections to the PharmaNet system, which is housed on the Province's website.

(j) "**Primary Care**" means the alternative payment program for general practitioners as described in Section 2.2 of the Services Schedule.

(k) "**Quality Adjudication**" refers to the level of accuracy in manual claims adjudication and pre-authorizations processing. The results are measured through the Service Provider's quality assurance testing methodology.

(l) **"SLR Failure"** means any failure of the Service Provider to meet or exceed a Service Level Requirement.

(m) "**Service Level Report**" means a monthly report to be provided by the Service Provider to the Province in accordance with Schedule H which:

(i) communicates the results of each Achieved Service Level and any and all failures of the Service Provider to meet or exceed Service Levels (including, for greater certainty, SLR Failures) during the past six months;

(ii) provides a detailed explanation for each such failure, if any; and

(iii) allows the Province to verify the Service Provider's performance and compliance with the Service Levels and to identify trends.

The Service Level Report shall be in the form as the Province may reasonably require from time to time.

(n) "**Services Schedule**" means the schedule describing the Services attached to the Agreement as Schedule E.

3. Interpretation

References to Paragraphs in this Schedule shall refer to the paragraphs of this Schedule. All times and dates set out in this Schedule shall be determined in accordance with Pacific Standard Time or Pacific Daylight Savings Time, as applicable.

4. Service Level Requirements

The Parties agree that the following principles shall apply in respect of Service Level Requirements:

(a) Only completed, submitted documents will be measured when determining Achieved Service Levels;

(b) The Service Level Requirements for processes, namely the service functions numbered 1 to 6 in the table below, shall only be amended by mutual agreement of the Parties as a result of Transformation or as otherwise contemplated in respect of Service Level amendments in the Agreement;

(c) The Service Level Requirement for service function number 19 in the table below excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure;

(d) The Service Level Requirements for systems, namely the service functions numbered 20 to 25 in the table below, exclude downtime due to scheduled maintenance (i.e. maintenance windows) as mutually agreed by the Parties and outages due to a Force Majeure;

(e) The Service Level Requirements for each of service functions for systems, namely the service functions numbered 20 to 25 in the table below, are to be measured on a Contract Year basis and a SLR Failure will occur each time a system outage exceeds four hours or eight hours, as applicable, during the Contract Year provided that:

(i) for service function 20 the Service Provider must first incur a SLR Failure for exceeding the 8.76 hours (in aggregate) of permitted system downtime during the Contract Year; and

(ii) for service functions 23, 24 and 25 the Service Provider must first incur a SLR Failure for exceeding the 43.8 hours (in aggregate) of permitted system downtime during the Contract Year; and

(f) Any Phase-In Date set out for a service function in the table below will apply to each Service Level Requirement in respect of such service function which makes reference to a Phase-In Date.

The following table sets out the Service Level Requirements and their corresponding Service Level Credits for certain Services:

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
Registration:				
1. Medical Providers	Section 2.1	99% within 2 Business Days	N/A	$23,500
2. Pharmacies	Section 3.7	99% within 2 Business Days	N/A	$23,500
3. MSP Enrolment – OTHER UNINTERRUPTIBLE SERVICE	Section 1.1	70% within 20 Business Days prior to the Phase-In Date, 80% within 10 Business Days as of the Phase-In Date 96% within 40 Business Days prior to the Phase-In Date, 99% within 20 Business Days as of the Phase-In Date	3 calendar months after the Hand-Over Date	$23,500 $47,500
4. MSP Premium Assistance	Section 1.1	60% within 20 Business Days prior to the Phase-In Date, 80% within 10 Business Days as of the Phase-In Date 90% within 40 Business Days prior to the Phase-In Date, 99% within 20 Business Days as of the Phase-In Date	3 calendar months after the Hand-Over Date	$23,500 $47,500
5. Fair PharmaCare Paper Registration	Section 3.7	80% within 2 Business Days 99% within 5 Business Days	N/A	$23,500 $47,500
6. Beneficiary Account Maintenance	Section 1.1	40% within 40 Business Days prior to the Phase-In Date, 80% within 10 Business Days as of the Phase-In Date 75% within 180 Business Days prior to the Phase-In Date, 99% within 20 Business Days as of the Phase-In Date	3 calendar months after the Hand-Over Date	$47,500 $47,500

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
7. [intentionally deleted]~~Non-imaged (documents that do not require permanent retention or paper size not compatible with imaging system – high volume/low complexity)~~ Note: This Service Level Requirement (SLR) was eliminated effective April 1, 2011. All documents in this category are now imaged and included in SLR 6.	~~Section 1.1~~	90% within 20 Business Days prior to the Phase-In Date~~,~~ ~~80% within 10 Business Days as of the Phase-In Date~~ ~~99% within 30 Business Days prior to the Phase-In Date, 99% within 20 Business Days as of the Phase-In Date~~	3 calendar months after the Hand-Over Date	~~$23,500~~ ~~$47,500~~
8. Provider Account Maintenance	Section 2.1	80% within 5 Business Days; 99% within 10 Business Days	N/A	$23,500 $47,500
Telephone Inquiry Services (average queue time to a Customer Service Representative (CSR))				
9. Beneficiaries	Sections 1.2, 1.5, ~~2.15~~, 2.16 and 3.14	Less than 3 minutes (during 8:00 am – 4:30 pm, averaged monthly)	N/A	$47,500
10. Provider	Section 2.13, 2.14, 3.13 and 4.8	Less than 1 minute (during 8:00 am – 4:30 pm), averaged monthly	N/A	$23,500
10(a) Billing support Note: SLR 9 changed, and SLR 10(a) added, effective April 1, 2011.	Section 2.15	Less than 3 minutes (during 8:00 am – 4:30 pm), averaged monthly		$5,170
11. Busy rate	Sections 1.2, 1.5, 2.14, 2.15, 2.16, 3.13, 3.14 and 4.8	Less than or equal to 2% (during 8:00 a.m. – 4:30 p.m. averaged monthly)	N/A	$23,500
12. In-province auto adjudicated claims Note: SLR 12 changed effective April 1, 2011	Sections 2.4 and 4.8	96.5% processed within the next MSP Payment Cycle ~~prior to CAPS implementation~~ 98.5% processed within 2nd MSP Payment Cycle ~~prior to CAPS implementation~~ (percentage to increase up to 99% as stakeholders implement measures to increase automation or reduce processing time) ~~99% within the next MSP~~	N/A	$23,500 $47,500

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
		~~Payment Cycle after the implementation of CAPS~~		
13. In-province manually Note: SLR 13 changed effective April 1, 2011	Sections 2.5 and 4.8	23% within 4 Payment Periods and 80% within 8 Payment Periods prior to the Phase-In Date~~, 50% within 4 Payment Periods from the Phase-In Date until the implementation of CAPS, 90% within 2nd scheduled Payment Cycle after the implementation of CAPS~~ 99% within 14 Payment Periods prior to the Phase-In Date~~, 90% within 8 Payment Periods from the Phase-In Date until the implementation of CAPS, 99.5% within 60 calendar days from date of receipt after the implementation of CAPS~~ 50,000 claims processed per month 964,000 claims processed per Contract Year	3 calendar months after the Hand-Over Date	~~$23,500~~ $44,190 monthly $321,703 per Contract Year
14. [intentionally deleted]~~Out-of-country claims (non peak)~~ Note: SLRs 14&15 combined effective April 1, 2011 under SLR 14(a) 14(a). Out of country claims (peak and non peak)	~~Section 2.6~~ Section 2.6	95% within 7 Payment Periods prior to the Phase-In Date, ~~80% within 4 Payment Periods from the Phase-In Date until the implementation of CAPS, 90% within 2 Payment Cycles after the implementation of CAPS~~ ~~95% within 6 Payment Periods from the Phase-In Date until the implementation of CAPS, 99% within 4 Payment Cycles after the implementation of CAPS~~ 80% processed within 4 Payment Cycles 95% processed within 6 Payment Cycles	3 calendar months after the Hand-Over Date	~~$47,500~~ ~~$47,500~~ $47,500 $47,500

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
15. [intentionally deleted]~~Out-of-country claims (peak – June, April & May)~~ Note: SLRs 14&15 combined effective April 1, 2011 under SLR 14(a)	~~Section 2.6~~	95% within 7 Payment Periods prior to the Phase-In Date~~,~~ ~~70% within 4 Payment Periods from the Phase-In Date until the implementation of CAPS, 90% within 3 Payment Cycles after the implementation of CAPS~~ ~~90% within 6 Payment Periods from the Phase-In Date until the implementation of CAPS, 99% within 4 Payment Cycles after the implementation of CAPS~~	3 calendar months after the Hand-Over Date	~~$23,500~~ ~~$47,500~~
MSP Provider Pre-authorizations including notification:				
16. [intentionally deleted]~~Routine~~	~~Section 2.8~~	~~Within 5 Business Days~~	~~N/A~~	~~$23,500~~
17. [intentionally deleted]~~Complicated~~ Note: SLRs 16&17 combined effective April 1, 2011 under SLR 16(a)	~~Section 2.8~~	~~Within 10 Business Days~~	N/A	~~$23,500~~
16(a). Routine & complicated	Section 2.8	100% processed within 7 Business Days		$47,000
18. New Care Card issuance	Section 1.1	99% sent prior to eligibility of benefits	N/A	$47,500

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
19. Health Care Practitioner and Pharmacy payments – Data files transmitted by the Service Provider to the Province to approve and distribute payments (excluding specific situations where Office of the Controller General (British Columbia) is not available to receive the transmission of the file)	Sections 2.3, 3.1, 3.6 and 4.8	MSP claims payments: mid and end of month – 100% on time issued. Pharmacy: weekly - 100% issued on time.	N/A	$71,500
Systems availability:		**These measures are per Contract Year:**		
20. PharmaNet Helpdesk – OTHER UNINTERRUPTIBLE SERVICE	Section 3.13	24/7 99.9% of the Contract Year (i.e. 8.76 hours of downtime permitted per Contract Year) with no single outage > 4 hours after total downtime > .1% during the Contract Year	N/A	$47,500
21. PharmaNet Systems – IT UNINTERRUPTIBLE SERVICE	Section 3.1	24/7 - No single outage > 4 hours.	N/A	$47,500
22. Teleplan Applications accepting claims –IT UNINTERRUPTIBLE SERVICE	Sections 2.3 and 4.8	24/7 - No single outage > 4 hours.	N/A	$47,500
23. Fair PharmaCare Web Registration – IT UNINTERRUPTABLE SERVICE	Section 3.7	24/7 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 4 hours of provided that such 4 hour standard is realized through system recovery testing during Transition, but if not realized upon reasonable commercial efforts made to do the same, then with no outage greater than 8 hours.	N/A	$23,500

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS (INITIAL)
24. IVR Travel Assistance Program Application – IT UNINTERRUPTIBLE SERVICE	Section 1.4.	24/7 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 4 hours of provided that such 4 hour standard is realized through system recovery testing during Transition, but if not realized upon reasonable commercial efforts made to do the same, then with no outage greater than 8 hours.	N/A	$23,500
25. Self service options (web) and other IVR Applications	Item #13 in General Responsibilities and Principles and Section 1.1	24/7 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 8 hours of total downtime.	N/A	$23,500
26. Quality Adjudication	Sections 2.5, 2.6, 2.8 and 4.8	Minimum of 98% accuracy	N/A	$47,500
27. Notification of Critical Items (i.e. information breaches)	Item #9 in General Responsibilities and Principles	2 hours (for initial unconfirmed notice)	N/A	$47,500

5. Service Level Objectives

The Parties agree that the following principles shall apply in respect of Service Level Objectives:

(a) Only completed, submitted documents will be measured when determining Achieved Service Levels;

(b) All references to abandonment rate and the average speed of answer will be based on a monthly average; and

(c) All Service Level Objectives in respect of documents will be measured from the date of receipt by the Service Provider.

The following table sets out the Service Level Objectives for certain Services:

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
Registration:		
1. MSP Beneficiary Registration and Account Maintenance Services Note: this Service Level Objective (SLO) was modified effective April 1, 2011	Section 1.1	95% of replacement CareCards will be mailed within 10 Business Days from the date of the telephone request or from the date a written request is processed.
2. [intentionally deleted]~~MSP Beneficiary Telephone Inquiry Service~~ Note: this SLO was eliminated effective April 1, 2011.	~~Section 1.2~~	~~Abandonment rate < 5% when abandoned after 30 seconds~~ ~~Average speed of answer – 90% four rings 100% 6 rings~~
3. [intentionally deleted]~~SP Beneficiary IVR Services~~ Note: this SLO was eliminated effective April 1,2011	~~Section 1.3~~	~~24/7 availability 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 4 hours (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure)~~
4. [intentionally deleted]~~MSP Beneficiary Travel Assistance Program Automated IVR Service~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 1.4~~	~~24/7 availability 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 4 hours (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure)~~
5. MSP Beneficiary Travel Assistance Program – CSR support Note: this SLO was modified effective April 1, 2011	Section 1.5	~~Abandonment rate < 5% when abandoned after 30 seconds~~ Average speed of answer – < 3 minutes ~~90% four rings 100% 6 rings~~ ~~Requests are processed within one Business Day~~ 100% of all travel assistance correspondence to be processed within 30 Business Days

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
6. [intentionally deleted]~~MSP Provider Registration and maintenance of the Provider Information Database~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 2.1~~	~~Information kits are mailed within 2 Business Days following application processing~~
7. MSP Non-Fee for Service Payments Note: this SLO was modified effective April 1, 2011	Section 2.2	~~Applications and assignment forms are processed within 5 Business Days~~ Payment requests from the Province to Health Authorities and Primary Care sites are processed within one ~~Business Day~~ Payment Cycle from date of receipt of correct and complete invoice. Medical Advisor Sessional and travel expenses are paid within one Payment Cycle from date of receipt of correct and complete invoice. 100% of rural health correspondence is processed within 30 Business Days.
8. MSP Provider Electronic Claims Submission and Payment System Note: this SLO was modified effective April 1, 2011	Sections 2.3 and 4.8	Annual availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure). Accountability will be assigned in accordance with the jointly approved Roles and Responsibilities Matrix. If the primary data centre for the claims system ~~site failure~~ requires a fail over to the DRP~~BCP~~ site, the system files and data must be restored to a point that processing can resume within 12 hours of SSBC provisioning of the DRP site and to Full Service State within 48 hours. Accountability will be assigned in accordance with the jointly approved Roles and Responsibilities Matrix. Service interruption must be restored within one Business Day when only Service Provider Group infrastructure is involved, or within one day of restoration of Province Shared Infrastructure. ~~The Payment Cycle is mid and end of month – 100% on time~~ 95% of paper claims are processed through data entry within ~~10 Business Days of~~ the following Payment Cycle from receipt and

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		100% within the second Payment Cycle following receipt ~~by the Service Provider~~ 100% of the following types of documents are processed within 30 Business Days: • Cheques from other provinces for non-BC patient • Physicians who do not bill by Teleplan
9. MSP Automated claims business rules	Sections 2.4 and 4.8	Continuous development and implementation of appropriate automated rules
10. MSP Provider Manual In-province claims adjudication – including reciprocal and third party claims Note: this SLO was modified effective April 1, 2011	Sections 2.5 and 4.8	Decisions on disputed claims referred to Medical Advisor Committee (MAC), Medical Payment Issues Committee (MPIC) or BCMA Reference Committee are processed ~~implemented~~ within 10 Business Days of receipt from the Province ~~by the Service Provider~~
11. MSP Provider Manual Out of Country travel claims adjudication Note: this SLO was modified effective April 1, 2011	Section 2.6	Reimbursement to Extended Health Insurers – processed within 4 Payment Cycles ~~Processes outcomes of appeals within 10 Business Days of receipt from Province~~
12. MSP Provider Out of Province/Country Pre-authorizations Note: this SLO was modified effective April 1, 2011	Section 2.7	~~Routine completed applications are prepared and referred to Province within 5 Business Days~~ ~~Complex completed applications are prepared and referred to Province within 10 Business Days~~ 80% of requests requiring referral to the Province are prepared and transferred within 10 Business Days and 99% within 20 Business Days of receipt of completed application. 100% of all OOC/OOP pre-authorization requests/documents are processed within 30 Business Days. ~~Requests for additional information is processed within 3 Business Days~~ ~~Payments and notification letter are processed within 10 Business Days of receipt of completed claim~~

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
13. [intentionally deleted]~~MSP Provider Pre-authorizations~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 2.8~~	~~Processes outcomes of appeals within 10 Business Days of receipt from Province~~
14. MSP Provider Retroactive Payment Adjustments Note: this SLO was modified effective April 1, 2011	Sections 2.9 and 4.8	Retroactive payment adjustments processed within 6 weeks of notice from Province to proceed when no implementation date is provided by the Province
15. MSP Provider Online Payment Schedule Amendments Note: this SLO was modified effective April 1, 2011	Sections 2.10 and 4.8	Low volume/low impact – one Business Day from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) Medium volume/medium impact - 5 Business Days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) Large volume/high impact – 20 Business Days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required)
16. [intentionally deleted]~~MSP Provider Payment Advances~~ Note: this SLO was eliminated effective April 1, 2011	~~Sections 2.11 and 4.8~~	~~Advances are processed within the current payment cycle and usually recovered within two payment cycles~~
17. MSP Provider Overage Claims Requests Note: this SLO was modified effective April 1, 2011	Sections 2.12 and 4.8	~~Routine~~ 90% of complete requests are processed within 20 Business Days from date scanned 100% of requests for permission to re-bill will be processed within 30 Business Days
18. [intentionally deleted]~~MSP Provider Inquiry Management Coverage (IVR)~~ Note: this SLO was eliminated effective April 1, 2011	~~Sections 2.13 and 4.8~~	~~24/7 availability 99.5% per Contract Year (i.e. 43.8 hours of downtime permitted per Contract Year) with no outage greater than 4 hours (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure)~~

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
19. [intentionally deleted]~~Teleplan Support Centre~~ Note: this SLO was eliminated effective April 1, 2011	~~Sections 2.14 and 4.8~~	~~Abandonment rate < 5% when abandoned after 30 seconds~~ ~~Average speed of answer – 90% @ four rings 100% @ 6 rings~~
20. [intentionally deleted]~~MSP Provider Claims Billing Support~~ Note: this SLO was eliminated effective April 1, 2011	~~Sections 2.15 and 4.8~~	~~Abandonment rate < 5% when abandoned after 30 seconds~~ ~~Average speed of answer – 90% @ four rings 100% @ 6 rings~~
21. [intentionally deleted]~~MSP Provider General Public Inquiry Support~~ Note: this SLO was eliminated effective April 1, 2011	~~Sections 2.16 and 4.8~~	~~Abandonment rate < 5% when abandoned after 30 seconds~~ ~~Average speed of answer – 90% @ four rings 100% @ 6 rings~~
22. MSP Provider General Correspondence Note: this SLO was modified effective April 1, 2011	Sections 2.17 and 4.8	90% of all general correspondence is processed within 20 Business Days from receipt 99% of all general correspondence is processed within 40 Business Days from receipt General correspondence consists of: • Beneficiary general correspondence • Correspondence with providers • Critical care coverage • Dental claim adjudication correspondence • Orthodontics and dental correspondence • Patient paid, request reimbursement • Physician requesting clarification • Provider adjudication correspondence • Reciprocal billing – BC physician/OOP patient
23. PharmaCare Automated Claims Submission Note: this SLO was modified effective April 1, 2011	Section 3.1	Annual availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure) ~~System response time (to process a transaction)~~ Claims transaction response time including TAC TDU (measured from the time the transaction enters PharmaNet to the time the completed transaction is returned to the Network) less than 2.5 seconds 97% of the time.

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		~~Network response time less than 2.5 seconds on the Province's standard 19.2 network (e.g. the total transaction time from the time a client submits a request to the time it is processed and the appropriate acknowledgement is visible to the client is 5 seconds)~~
24. PharmaCare Manual Claims Processing (offline) Note: this SLO was modified effective April 1, 2011	Section 3.2	Adjudication – 90% within 10 Business Days~~2 weeks;~~ 99% within 20 Business Days ~~4 weeks~~ 100% of PharmaCare Helpdesk correspondence processed within 30 Business Days.
25. PharmaNet Tables Administration Note: this SLO was modified effective April 1, 2011	Section 3.3	Drug prices, Low Cost Alternatives shortages – real time Incorrect prices in Production tables updated within 1 Business Day Other updates including drug price listing changes processed within 10 Business Days Urgent price change requests will be handled on an exception basis based on a mutually agreed to basis.
26. [intentionally deleted]~~PharmaNet External Software Compliance Testing~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 3.4~~	~~Complies with the PharmaNet Professional and Software Compliance Standards Library~~
27. PharmaCare Pre-authorizations Note: this SLO was modified effective April 1, 2011	Section 3.5	Pre-authorization letters prepared and mailed within 7 Business Days of receiving approval by the Prosthetics and Orthotics Committee ~~Creates and forwards the data file to be used by the Ministry of Finance to issue payments within 7 Business Days of receiving Province Approval~~ 100% of orthotics and prosthetics documents/correspondence processed within 30 Business Days

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
28. PharmaCare Plan Registration Services Note: this SLO was modified effective April 1, 2011	Section 3.7	Palliative Care registrations processed within 1 Business Day Consent forms processed within 2 Business Days ~~Pharmacy registrations – 99% within 2 Business Days~~ Process Emergency Department, Hospital and Medical Practice access to PharmaNet within 2 Business Days of receiving the request Process Pharmacy Access request received from the College of Pharmacist within 1 Business Day to initiate work orders for connection site ~~Complete work orders for the date service requested providing 20 Business Days notice~~ Multi-language services in Mandarin, Punjabi and Cantonese during the hours of 9:00 a.m. to 3:30 p.m. and any calls received outside of those hours will have call back service within 1 Business Day (including Saturdays)~~24 hours~~ of receipt of call with IVR enabling the multi-lingual message to be left with commitment to return call within the same time period
29. Fair PharmaCare (FP) Administrative Review Process Note: this SLO was modified effective April 1, 2011	Section 3.8	~~Urgent cases are handled in real time~~ Urgent FP administrative review cases, when the patient is in immediate need of a prescription, are handled in real time as long as all required information is available Routine FP administrative review cases not associated with an urgent need to fill a prescription (such as income reviews, consent revocations, exceptions to automated processes, appeals, requests for retroactive payments) – 95% handled within 20 Business Days 100% of the following correspondence associated with FP Administrative Review will be processed within 30 Business Days: • address changes including PO cards

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		• administrative review tickets • affidavits and income documents • applications for income review • correspondence to FP Administrative Review • Correction of information forms • Canada Revenue Agency letters • FP forms • Income tax filed forms • Monthly deductible payment option • FP appeals • Retro Payment of PharmaCare ~~Incomplete registrations, errors and exceptions are processed within 2 Business Days when patient access to medication is impacted. All others are processed within 10 Business Days~~ ~~Eligibility problems are processed within 2 Business Days. Urgent cases are handled in real time~~ ~~Consent revocations are processed within 10 Business Days~~ ~~Annual automated retroactive payments are processed by end of May each year~~ ~~Individual requests for early retroactive payments are processed within 10 Business Days~~ ~~Appeals processed within 5 Business Days~~ ~~Follow up with client on incomplete appeals within 5 Business Days~~ ~~Second time appeal requests are forwarded to the Province with case background within 10 Business Days of receipt~~
30. Fair PharmaCare Income Verification Process	Section 3.9	Automated income verification process is scheduled weekly. Prior to annual renewal the process is scheduled more frequently
31. PharmaCare Restricted Claimant Program	Section 3.10	Approved restriction and notification letter processed within 5 Business Days Temporary restriction change processed in real time Changes to approved restriction processed in real time

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
32. [intentionally deleted]~~PharmaCare Adjudication Rule Changes~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 3.11~~	~~Processes routine updates within 2 Business Days~~
33. PharmaCare General Correspondence Note: this SLO was modified effective April 1, 2011	Section 3.12	Blood glucose strip certificates processed within 1 Business Day Third Party Insurer requests processed within 5 Business Days Out of Province requests processed with 5 Business Days unless required sooner 90% of all general correspondence is processed within 20 Business Days from receipt 99% of all general correspondence is processed within 40 Business Days from receipt General correspondence consists of the following types of documents: • Drug receipts • PharmaCare General Correspondence • PharmaCare WorkSafe BC cheques • Pharmacy and program maintenance • Pharmacy processing • Plan B correspondence and payment adjustments
34. [intentionally deleted]~~PharmaCare Help Desk – Pharmacists and other Service Providers~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 3.13~~	~~Average speed of answer – 90% @ four rings 100% @ 6 rings~~
35. [intentionally deleted]~~PharmaCare General Public Inquiry Services~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 3.14~~	~~Abandonment rate < 5% when abandoned after 30 seconds~~ ~~Average speed of answer – 90% @ four rings 100% @ 6 rings~~
36. [intentionally deleted]~~Province initiated registrations and payments~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 4.1~~	~~Processes all requests within the timelines provided by the Province. If no, timelines provided, processes the request within the Service Level Objectives stated in this Schedule for the type of transaction.~~

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
37. [intentionally deleted]~~Province Customers and Stakeholders Communications~~ Note: this SLO was eliminated effective April 1, 2011	~~Section 4.2~~	~~Improved understanding of program~~ ~~Minimal repeat requests for information~~ ~~Fewer individuals require information – more uptake from group administrators for self service options enable reduced reliance on personal services from the Service Provider~~
38. Document Inventory Note: this SLO was modified effective April 1, 2011	Section 4.3	All applicable documents are archived on schedule per ORCS 100% of all documents/correspondence covered by a Service Level Requirement processed within 30 Business Days ~~No unprocessed inventory older than 30 Business Days, excluding any aged inventory transferred from the Province to the Service Provider on the Hand-Over Date which is older than 30 Business Days as of the Hand-Over Date~~ 100% of the document type 'Research Review' processed within 30 Business Days Note: Effective April 1, 2011, documentation/ correspondence related to other SLOs was moved to those SLOs.
39. Document ~~Scanning~~ Pre-processing/Mail Room Activities (including registration and scanning)	Section 4.4	Document pre-processing/mail room activities completed within 3 Business Days of receipt
40. Province Access ~~and Reports~~ Note: this SLO was modified effective April 1, 2011	Section 4.5	Provides access to required systems/applications within 2 Business Days of request Withdraws access within 1 Business Day of request ~~Produces standard and ad-hoc reports within timeline requested~~
41. Information Requests Note: this SLO was modified effective April 1, 2011	Section 4.6	95% of correctly submitted Personal Information requests are processed within 20 Business Days from date scanned 95% of correctly submitted ICBC requested listings are processed within 20 Business Days from date scanned 100% of the following documents will be processed within 30 Business Days:

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		• Beneficiary/MSP FOI requests • History printout to settle claims • PharmaCare FOI requests • Provider FOI requests ~~All Province requests are processed within the time period required~~
42. Policy and Procedures (Operations) Manuals	Section 4.7	Procedures manuals are comprehensive and in a current state Updates as a result of policy changes are made within 5 Business Days of receiving approval

For greater certainty, other Service Level Objectives may exist from time to time pursuant to the Agreement including, without limitation, pursuant to Section 8.5 of the Agreement.

6. Monitoring and Reporting

Unless otherwise specified in this Agreement, each Service Level will be measured by the Service Provider on a monthly basis. Without limiting more immediate reporting requirements, the Service Provider will provide to the Province, as part of the Service Provider's monthly deliverables in accordance with Schedule H, a Service Level Report. The Service Provider will provide the Province with direct data access to all Service Level Reports produced by the Service Provider and all of the raw data and detailed supporting information for each Service Level Report. For greater certainty, the Service Provider shall provide sufficient access and system resources to the Province to allow the Province to generate its own reports from such data.

No less frequently than once in each Contract Year nor more frequently than twice in each Contract Year, the Province and the Service Provider will review the Service Levels to ensure they continue to remain appropriate. Such review shall be conducted by the Joint Steering Committee and shall be approved by the Joint Executive Committee upon completion.

7. Service Level Failures

If the Service Provider fails to meet a Service Level in respect of the performance of a Service, the Province shall be entitled to exercise all its rights and remedies provided to it in this Agreement, including, without limitation, the particular remedies set out in this Schedule and in Articles 8 and 21 of this Agreement.

8. Service Level Credits

The Service Provider will issue a Service Level Credit to the Province for every SLR Failure that occurs in a particular month of the Term on the basis set forth below.

(a) For each SLR Failure occurring in a particular month, the Service Provider will credit the Province the corresponding Service Level Credit for the Service Level Requirement in respect of which the SLR Failure occurred set out in the table in Paragraph 4.

(b) The Service Level Credits will be aggregated for all missed Service Levels Requirements in the applicable month and credited to Province, provided such Service Level Credits shall not exceed the At Risk Amount in such month.

(c) If a SLR Failure in respect of a particular Service Level Requirement occurs in consecutive months, the Service Level Credit for such Service Level Requirement will be multiplied by one and half (1.5) times, on a cumulative basis, when calculating the Service Level Credit resulting from such SLR Failure for each consecutive month.

(d) On the occurrence of three or more SLR Failures in respect of a particular Service Level Requirement within a six month period of the Term, the Service Level Credit for such Service Level Requirement will be multiplied by one and half (1.5) times, on a non-cumulative basis, when calculating the Service Level Credit that results from each such SLR Failure that occurs after the second SLR Failure within such six month period.

(e) In no event will the amount of Service Level Credits credited to the Province with respect to all SLR Failures occurring in a single month of the Term exceed, in total, the At Risk Amount.

(f) If one event causes SLR Failures in respect of multiple Service Level Requirements in a particular month of the Term, only the largest Service Level Credit among the Service Level Credits for the Service Level Requirements in respect of which the SLR Failures occurred will be credited to the Province in such month.

(g) In event that 25% of the total possible Service Level Credits for a month are calculated for three months out of any six month period during the Term, such failure shall be deemed to be a Material Breach for the purposes of this Agreement.

(h) The Province will have the right, on 90 days notice, but no more than twice each Contract Year to adjust the Service Level Credits amounts set out in the far right column of the table in Paragraph 4 as long as the aggregate monthly Service Level Credits to which Province is eligible hereunder do not exceed three times the At Risk Amount. For greater certainty, any such adjustment will not be subject to the Change Request Process in Article 7 of this Agreement.

(i) The total amount of Service Level Credits that the Service Provider will be obligated to credit against Fees payable by the Province to the Service Provider, with respect to SLR Failures occurring each month shall be reflected on monthly invoices issued by the Service Provider to the Province. Each Service Level Credit will be reflected on the invoice for the second subsequent month after the month in which the SLR Failure giving rise to such Service Level Credit occurred unless such SLR Failure becomes subject to the review process set out in Paragraph 10(b), in which case, the Service Level Credit will be reflected on the next monthly invoice issued by the Service Provider after the Province makes its decision whether or not to waive any of its rights based on the recommendations of the Joint Steering Committee.

9. Service Level Adjustments

The Province may issue a Change Request to:

(a) add to, delete or change the Services to be measured and/or the corresponding Service Levels for such Services, as the case may be, to reflect changes in Service delivery operations; and

(b) increase the existing Service Levels, where warranted, to reflect operational or technical improvement in delivery of the Services;

in accordance with the Change process set out in Article 7 of this Agreement. The Service Provider will use reasonable commercial efforts to implement any changes to the Services to be measured or the Service Levels which result from such process, in a diligent and expeditious manner in accordance with Article 7 of this Agreement.

10. Excused Performance

(a) The Service Provider shall not be responsible for a failure to meet one or more Service Levels, and shall not be required to pay Service Level Credits or be subject to any remedy by the Province under this Agreement including any right to terminate this Agreement, to the extent and only to the extent such failure is directly attributable to any of the following and not due to a failure of the Service Provider to perform its obligations under this Agreement:

(i) the actions or acquiescence of the Province;

(ii) the actions or acquiescence of the Service Provider, where such actions or acquiescence were expressly directed by the Province and the Service Provider had provided prior notice in writing to the Province that such actions or acquiescence could result in such failure; or

(iii) an event of Force Majeure provided that the Service Provider complies with its obligations in Article 24 of this Agreement.

(b) If a Service Level Report shows an unusual circumstance occurred in connection with a SLR Failure, the Service Provider may require that the Joint Steering Committee consider the unusual circumstance and recommend whether or not the Service Provider should be relieved of its obligations arising from the SLR Failure because of the unusual circumstance. Based on the review of the unusual circumstance conducted by the Joint Steering Committee and its recommendations in respect thereof, the Province may, in its sole discretion, waive the Service Provider's obligation to provide Service Level Credits in respect of such SLR Failure or any other of the Province's rights pursuant to this Agreement.

(c) If a failure to meet one or more Service Levels is directly attributable to the termination of this Agreement where such termination is a result of termination by the Province for convenience or results from no fault of the Service Provider, the Service Provider may require that the Joint Steering Committee consider such failure and recommend whether the Service Provider should be relieved of its obligations arising from the SLR Failure. Based on the review of the failure conducted by the Joint Steering Committee and its recommendations in respect thereof, the Province may, in its sole discretion, waive the Service Provider's obligation to provide Service Level Credits in respect of such failure or any other of the Province's rights pursuant to this Agreement.

11. Cooperation

The achievement of the Service Levels by the Service Provider may require the coordinated, collaborative effort of the Service Provider with its Subcontractors and Suppliers. The Service Provider will provide a single point of contact for the prompt resolution of all Service Level failures and all failures to provide high quality Services to the Province, regardless of whether the reason for such Service Level failures, or failure to provide high quality Services to Province, was caused by a Subcontractor or Supplier.

SCHEDULE E

DESCRIPTION OF BASIC SERVICES

Service Deliverables, Roles/Responsibilities, Service Outcomes and Reporting

GENERAL RESPONSIBILITIES AND PRINCIPLES:

1. From and after the Hand-Over Date during the Term, the Service Provider will perform the Basic Services described in Sections 1 to 4 of this Schedule. Each Party will be responsible for its designated responsibilities in respect of each Basic Service category as described below (the general description of each Basic Service category being a description of Basic Services as provided by the Province immediately prior to the Hand-Over Date) and for greater certainty, the Service Provider will be responsible for meeting the reporting requirement set out below for each Basic Service category. In respect of the Basic Services described in this Schedule, the Service Provider will meet or exceed the Service Levels referenced in this Schedule and set out in Schedule F to this Agreement.

2. As described in Article 6.2 of this Agreement - Included or Inherent Services of the Master Services Agreement, there are functions or tasks not specifically listed or described in this Schedule that are customarily required for the proper performance and provision of the Basic Services and such functions are inherent or included in the Services. Without limiting the foregoing, such functions or tasks shall be deemed to be implied or included in the scope of the Basic Services to the same extent and in the same manner as if those functions or tasks had been specifically described in this Schedule.

   Basic Services to be delivered include all those business processes currently carried out by the Province as a part of HBO that have not been designated as out of scope. The tables below identify core business processes that are material, require specific Service Level Requirements or require specific Service Level Objectives.

3. The Province will provide the Service Provider with all relevant existing Policies and precedents and updates on a timely basis and provide policy clarification or interpretation as required.

4. The Province will Approve and be the contracting party in respect of all data/information-sharing agreements. The Service Provider will processes requests in respect of such agreements in accordance with the provisions of this Agreement.

5. The Service Provider will implement and maintain a Quality Assurance Program and Training Plan to ensure the accuracy and quality of work performed by its Personnel as described in Sections 4.9 and 4.11 of the Proposal and Section 6.13 of this Agreement.

6. The Service Provider will develop and maintain the Manual as described in Section 4.10 of the Proposal and Section 6.15 of this Agreement and obtain the Province's Approval for all material amendments.

7. Without limiting the other obligations in respect of data quality and integrity set forth in this Agreement, the Service Provider will implement and maintain commercially reasonable processes to ensure data quality and integrity.

8. The Service Provider will provide and refresh technology to support the functions outlined in this Schedule in the manner described in this Agreement including as described in Schedule J and Article 5 of this Agreement.

9. Without limiting the notification provisions otherwise set forth in the Agreement, the Service Provider will immediately alert the Province of any material service complaints or interruption of Services and of any caller threatening to go to the media or senior government officials.

10. The Service Provider will implement processes to identify potential fraudulent cases, prepare case files and notify the Province of suspected fraud.

11. The Service Provider will notify the Province of material changes to operational procedures or processes.

12. The Service Provider will refer all Ministers, MLA, ombudsman, other politicians and media inquiries to the Province. The Service Provider will assist the Province in responding to those inquiries.

13. The Service Provider will promote and facilitate self service of information whenever reasonably possible.

14. The Service Provider will implement and maintain a thorough administrative review process to respond to all complaints/disputes arising from its responsibilities under this Agreement. The Service Provider will be immediately refer to the Province appeal requests (in accordance with Schedule K of this Agreement) following an administrative review or receipt of health care practitioner claims beyond its authority as identified in this Schedule E. The Service Provider will subsequently implement the Province's decisions related to the referral of such matters.

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DEFINITIONS AND INTERPRETATION:

Capitalized terms used in this Schedule will have the meanings set forth below or, where not defined below, as otherwise defined in this Agreement:

Available Amount" means the total amount of funding available each fiscal year to the Medical Services Commission for medical practitioner fee-for-service claims.

"Clinic" means a physical location at which a group a medical practitioners provide medical services.

"Eligibility" means, in respect of a Medical Services Plan beneficiary or a health care provider, meeting the criteria set out in the *Medicare Protection Acts* and regulations, and, in respect of a PharmaCare Plan beneficiary, being a beneficiary of the Medical Services Plan and meeting the criteria set out for both the Medical Services Plan and the PharmaCare Plan.

"Emergency Payment Program" means the routine creation every payment period of an emergency payment file that is ready to be executed in the case of system failure resulting in the inability to issue payments to medical practitioners, a Force Majeure or a labour disruption. The details of the program are described in the Medical Services Plan's Business Continuation Plan.

"Group Administrators" means employers or pension plan administrators who have applied and been approved by the Province to receive from their employees or members their MSP premium payments and pay those premiums directly to the Ministry of Provincial Revenue.

"**HBO**" means the Health Benefits Operations of the Province.

"Health Authority" means a governing body with responsibilities for the planning, coordination and delivery of regional health services, including hospital, long term care and community services.

"Medical Advisor" means a medical practitioner that provides expert advice to the Province on complex medical claims that have been referred by a claims adjudicator. Each such practitioner is paid on a sessional basis and reports to the Medical Consultant for Medical and Pharmaceutical Services, Ministry of Health Services.

"Medical Advisory Committee" (MAC) means a Ministry of Health Services committee chaired by the Medical Consultant and attended by the Medical Advisors, the Payment Schedule Administrator and the Service Provider's Key Role for complex claims adjudication to review and determine payment of complex medical practitioner claims referred by the Service Provider's claims adjudicators. The committee meets monthly and may, infrequently, be required to meet on an ad hoc basis.

"Medical Consultant" means the Medical Practitioner employed by the Ministry of Health Services designated as accountable for issues arising from the Medical Services Commission's Payment Schedule and its related policies and Out of Country Pre-authorizations.

"Medical Payment Issues Committee" (MPIC) means a Ministry of Health Services committee comprised of the Medical Consultant, Payment Schedule Administrator and representatives from the Service Provider with expertise in claims adjudication. The purpose of the committee is to review issues where policies or precedent is weak or non-existent and direction from the Province is required. The committee meets monthly but may meet more frequently, if required.

"Operational Records Classification System" (ORCS) means the Province's records retention, storage and disposal policies and procedures.

"Payment Cycle" or **"Payment Period"** means, in respect of pharmacies, the weekly payment cycle used in connection with PharmaCare services, or otherwise, the scheduled MSP monthly payment cycled used in connection with the Services whereby a payment is deposited with the payee on the 15th or closest Business Day and the last Business Day of each month.

"**Payment Schedule"** means the tariff for services and related payment policies described in the Medical Services Commission Payment Schedule for medical practitioners or the tariff for services and related payment policies as negotiated with certain other health care practitioners associations.

"Point Assessment' means the calculation of points for medical isolation, living factors, designated specialities, and road distance for the purpose of determining the premium fee payable under the Rural Retention Program.

"Primary Care" means the alternative payment program for general practitioners as described in Section 2.2 of this schedule.

"Rural Health Program" means the program within the Ministry of Health Services dedicated to providing leadership and support for the delivery of health services in BC's rural communities. Rural Health oversees a number of key programs and initiatives for physicians.

"Rural Retention Program" means the incentive program that provides fee-for-service and flat sum premiums for eligible physicians living and practicing in certain BC communities. This incentive pays doctors additional funds for providing services in eligible rural communities throughout BC.

"**Service Levels Schedule**" means the schedule describing the Service Levels, attached as Schedule F to the Agreement.

“Sessional Payment” means the rate paid to a medical practitioner for each 3.5 hours of work as negotiated between the Province and the British Columbia Medical Association.

“Special Authority” means the granting of full benefit status to a medication that would otherwise be a partial or a limited coverage drug under PharmaCare.

“Specialty Designation” means that a medical practitioner has received certification by the Royal College of Physician and Surgeons of Canada and is so recognized by the College of Physician and Surgeons of British Columbia in a particular medical specialty.

All times and dates set out in this Schedule shall be determined in accordance with Pacific Standard Time or Pacific Daylight Savings Time, as applicable.

SECTION 1 – MSP BENEFICIARY SERVICES

1.1 MSP Beneficiary Registration and Account Maintenance Services

General Description: Includes processing of enrolment applications and issuance of CareCards, updates to beneficiary account information, assistance with benefit inquiries, processing and assistance with premium assistance applications, enrolment, and verification of income and premium assistance eligibility. Enrolment includes a 3-month waiting period to meet the BC residency requirement. Under limited circumstances, the Medical Services Commission may waive the required wait period. While the Medical Services Plan (MSP) determines eligibility for coverage and enrols individuals, establishes the contract and sets the premium rate, the Ministry of Provincial Revenue is responsible for the billing and collection of premiums and the temporary premium assistance program. This partnership results in a number of dependencies and linkages between the two organizations. There are some shared systems and processes such as the billing component of the R&PB database, document management, bill messages, client services etc. Self-service options are available for Group Administrators permitting them to electronically add new and cancel dependents, address changes, cancel accounts, etc. MSP also exchanges registration information with other provinces and territories on residents that have moved to another province.

Responsibilities:

Province	Service Provider
Ministry of Health (MoHS): • Sets all policies • Reviews performance reports • Determines eligibility criteria for enrolment and premium rates • Advises Service Provider of various policy waivers, e.g. wait periods • Manages Memorandum of Understanding (MOU) with Canada Revenue Agency (CRA) • Approves any required changes by CRA • Adjudicates requests for waivers, e.g. wait periods • Conducts residency investigations to ensure beneficiary eligibility • Conducts Eligibility Appeals • Sets standards, e.g. authentication for self-service options • Reviews and investigates suspected fraud cases submitted by the Service Provider • Determines and revises data access requirements and provides to	• Adheres to policies and standards set by the Province • Processes enrolment applications and assigns appropriate premium rates • Manages the de-enrolment and opting out processes • Processes relevant updates to beneficiary account information, e.g. address changes, payer arrangements, additions and deletions for dependents • Processes premium assistance applications • Administers self service options available to Group Administrators • Implements strategies to increase the number of Group Administrators using self service options • Identifies and implements self-service options for the general public • Follows appropriate authentication guidelines for self-service options

Province	Service Provider
the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule. Ministry of Provincial Revenue (MPR): • Bills and collects premiums • Manages billing component of Registration and Premium billing database	• Corrects errors and processes exceptions resulting from automated processes • Prepares supporting case briefs, participates in hearings as required and processes decisions for Eligibility appeals • Prepares and processes inter-provincial reciprocal information exchanges • Produces and issues new and replacement CareCards • Exchanges information with CRA and verifies and/or adjusts that information • Conducts audits as prescribed in the CRA MOU and reports outcomes to Province • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA • Administers interfaces and processes shared with MPR, and other agencies and provincial health care plans related to beneficiary services. For example, as a result of a collections activity, MPR may be advised of an out of province move or a request for premium assistance. The case is referred to Beneficiary Services for processing. • Notifies the Province of material changes to operational procedures or processes • Responds to requests from beneficiaries for Personal Information • Maintains a quality assurance program to ensure document processing accuracy • Administers Group Administrator registration and account update processes • Maintains and regularly updates databases necessary to support beneficiary services functions • Identifies and implements processes to ensure regulation integrity • Prepares case files for suspected fraud cases and forwards file to the Province for investigation

Province	Service Provider
	• Responds to requests for information from the Province and its designated Stakeholders

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 3, 4, 6~~, 7~~ and 18 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objective** See item 1 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on inventory and document processing time by document category for enrolment applications, premium assistance applications, and account maintenance requests. • Reports monthly on number and percentage of total documents received that are incomplete or duplicates • Reports monthly on number of replacement CareCards issued • Reports quarterly on Quality Assurance (QA) reviews • Reports quarterly on Service Level Objective item 1

1.2 MSP Beneficiary Telephone Inquiry Service

General Description: Includes providing telephone access to the general public and a variety of internal and external Stakeholders.

Responsibilities:

Province	Service Provider
• Reviews performance reports • Provides, as required, information on new policies or legislation and responds to requests for policy interpretation/ clarification in a timely manner	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday to respond to all calls from the general public and provides dedicated high priority telephone support for Group Administrators, the B.C. Ministry of Provincial Revenue and agents of the Province • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~Service Level Objectives:~~ ~~See item 2 set out in the table in Paragraph 5 of the Service Levels Schedule~~.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports quarterly on QA reviews • Reports quarterly on potential policy improvements identified • Tracks and reports semi-annually on potential requirements for multi-language services • Reports on results of periodic client surveys

1.3 SP Beneficiary Interactive Voice Response Services

General Description: A variety of services are made available to callers such as ordering CareCards replacements, account balance, etc.

Responsibilities:

Province	Service Provider
• Reviews and approves scripts • Review performance reports	• Maintains or enhances the current suite of services available

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objectives:**~~ None. ~~See item 3 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on uptake, abandonment and success rates • Reports monthly on number of transfers for information available on IVR • Reports quarterly on numbers of transfers to CSR for reason of language

1.4 MSP Beneficiary Travel Assistance Program Automated IVR Service

General Description: Automated service for travel assistance. The Province provides the approval and supporting administration. Private and public travel partners provide travel discounts.

Responsibilities:

Province	Service Provider
• Sets the eligibility criteria • Determines edit rules for automated processing • Manages the relationship with the travel partners • Reviews performance reports	• Administers the automated service in accordance with the criteria established • Conducts annual compliance review using the claims data to validate to travel to obtain medical services

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See item 24 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~Service Level Objective:~~ ~~See item 4 set out in the table in Paragraph 5 of the Service Levels Schedule~~.	• Reports monthly on approvals, denials, location of patient, location of service, type of physician seen and mode of travel • Reports on annual compliance review outcomes

1.5 MSP Beneficiary Travel Assistance Program – CSR support

General Description: Requests unable to be processed by the automated service are directed to a Client Service Representative for handling.

Responsibilities:

Province	Service Provider
• Sets the eligibility criteria • Manages the relationship with the travel partners	• Processes requests according to established criteria • Responds to general inquiries on the Travel Assistance Program

Province	Service Provider
• Reviews performance reports	• Maintains a quality assurance program to ensure high quality client service and the accuracy of the decisions

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objective:** See item 5 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on approvals, denials, location of patient, location of service, type of physician seen and mode of travel • Reports quarterly on QA reviews • Reports monthly on Service Level Objective item 5

SECTION 2 – MSP PROVIDERS SERVICES

2.1 MSP Provider Registration and maintenance of the Provider Information Database

General Description: Includes registration services for all eligible health care providers, health care facilities, allied health care providers supporting Primary Care, processing a variety of applications forms such as assignment of payment, direct bank deposit, etc. and maintaining the accuracy of practitioners profiles such as specialty designations, practice status, etc. The Province is also legally obligated to process certain third party demands, such as garnishees from the Receiver General of Canada, Family Maintenance Program, etc.

Responsibilities:

Province	Service Provider
• Creates and communicates related policies • Provides, as required, policy interpretations/clarifications • Approves application information kit content within 10 Business Days of receipt from Service Provider	• Processes registration applications • Assigns new registrants practitioner and payments numbers • Processes applications for electronic billing • Provides new applicants with information kits

Province	Service Provider
• Reviews performance reports • Determines and revises data access requirements and provides to the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule.	• Attends resident days to provide information workshops for graduating physicians on registration procedures, billing procedures for incentive programs, etc. • Processes all relevant practitioner information updates such as address changes, specialty designation, assignment forms, direct deposit applications, practice status, third party demands, etc. • Processes requests for additional payments numbers • Processes requests to opt out of MSP • Maintains an accurate and up to date practitioner information database • Manages all information interfaces with internal and external parties to ensure current and accurate practitioner information required for the proper processing of claims • Provides information as requested in accordance with data access agreements • Maintains a quality assurance program to ensure the accuracy of document processing

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 1 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~Service Level Objectives:~~ ~~See item 6 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly volumes, Service Levels and inventories by type of activity. • Reports quarterly on QA reviews

2.2 MSP Non-Fee for Service Payments

General Description: MSP operational responsibilities include administration of a number of services on behalf of other programs delivered by the Province such as a rural locum program, rural retention program, provides 1st level technical support to the Primary Care Program, Northern Isolation and Travel Assistance Outreach Program (NITAOP), etc. The MSP Provider Payment System is also used to process bulk payments to British Columbia Health Authorities.

The Rural GP Locum Program assists General Practitioners (GPs) in small rural communities, with seven or fewer physicians, to obtain locums for up to 28 days per year for vacation relief and Continuing Medical Education (CME) purposes. Locums are paid by the program and receive travel honorarium and guaranteed daily rate. Host physicians retain 40% of the MSP paid claims to cover overhead. A locum is hired as an independent contractor.

The Northern and Isolation Travel Assistance Outreach Program (NITAOP) provides funding for travel and travel time for visiting specialists, family doctors, and general practitioners who deliver medical services in eligible rural communities. The Joint Standing Committee on Rural Issues determines annually the number of funded visits per community. The NITA component for specialist travel expenses is funded from the Available Amount. BC's regional health authorities submit yearly funding requests to Rural Health . Once approved, visiting physicians are contacted and outreach visits are organized. Visiting physicians are reimbursed directly under this program, upon submitting the application for expenses.

The Rural Retention Program (RRP) provides fee-for-service and flat fee premiums for eligible physicians living and practicing in certain BC communities. This incentive pays doctors additional funds for providing services in eligible rural communities throughout BC.

Primary Health Care Program is an alternative incentive program, where funding is calculated on the Primary Health Care Practice's expected annual funding based on the needs-adjusted classification of its registered patients. The Practice's population-based funding level is re-calculated quarterly to adjust for changes in the size of the patient register, and changes in patient outflows. Fee-for-service payments continue under MSP's current funding rules, and payments, included funding adjustments, are dispersed semi-monthly.

Medical Advisors are hired to assist the Province with complex claims unable to be processed by the Service Provider. The external physicians are paid on a sessional basis (3.5 hours per session) and are compensated for the travel expenses. Invoices are approved by the Province and forwarded to the Service Provider for payment.

Responsibilities:

Province	Service Provider
General: • Overall responsibility for all program administration • Primary contact for all inquiries related to these programs • Provides policy and interpretation • Reviews performance reports **Health Authority Bulk Payments:** • Provides Service Provider with written request of amount of bulk payment or adjustments to be made **Rural Locum Program:** • Manages all locum contracts • Manages all aspects of the locum recruitment process including, without limitation, processing locum applications (including arranging interviews, sending out contracts, verifying billing numbers, etc.) • Manages the locum coverage request administration, including, without limitation, processing requests for a locum and arranging work assignments (including contacting both the locum and host physician, sending confirmation information, etc.) • Forwards to Service Provider case files and related documents to complete transaction to facilitate payment • Produces the Rural GP and Specialist Locum Program Financial Summary Report **NITAOP:** • Provides Service Provider with approved applications for travel expenses **Rural Retention Program:** • Coordinates with Health Authorities and Clinics the amount, distribution and calculation of Rural Retention Premium and on call premiums **Primary Care Program:** • Provides the necessary data through system interfaces for patient	**Health Authority Bulk Payments:** • Processes, tracks and reports on bulk payments to Health Authorities and certain alternative payment functions **Rural Locum Program:** • Informs physicians of billing procedures • Processes assignment of payment forms • Updates Practitioner Information file with payment adjustments • Calculates and processes payment of daily rate and top-up. • Processes travel expenses • Initiates system recovery of fee for service claims paid in error at 100% • Tracks and reports on payments **NITAOP:** • Processes approved applications for travel expenses • Maintains and monitors the travel budget for the program • Initiates refusal letters or explanation of payment to providers denied access to the funds • All costs are entered into spreadsheet per Health Authority, Community and Specialty **Rural Retention Program:** • Update claims payment system tables, which contain the community Point Assessment. • Processes payment advances, if necessary • Reports on payments to Health Authorities from rural retention premiums **Primary Care Program:** • Provides the technical infrastructure for electronic FFS and encounter claim processing • Processes payee status changes • Maintains Primary Care encounter service codes • Registers allied care providers such as nurse practitioners

Province	Service Provider
Register maintenance and Primary Health Care payment calculations • Resolves complex technical issues referred by the Service Provider • Approves new sites for registration **Medical Advisor Sessional Payments** • Approves on sessional payments and travel expenses and provides invoice to Services Provider	• Provides first level technical help desk support for the Primary Care sites by monitoring refusals, establishing Teleplan web accounts for submission of patient services encounters, assisting providers who bill third party claims such as WCB or ICBC and responding to general inquiries • Refers complex technical issues unable to be resolved by the help desk to the Province for resolution • Processes manual cheque requisitions to providers, whenever there are problems with automated adjustment updates to payment details recorded on the practitioner information file **Medical Advisor Sessional Payments** • Process approved sessional payments and travel expenses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 7 set out in the table in Paragraph 5 of the Service Levels Schedule.	**Rural G.P. Locum Program** • Reports each payment period on total expenditures by community, by locum practitioner, by host physician, by days • Reports each payment cycle on monies recovered for services provided by locum in host physicians office (60/40 split). Reported by community, by payee, by locum physician and by host physician **NITAOP** • Reports each payment cycle the total fiscal expenditures by HA, by community, by specialty, by practitioner to date • Reports each payment cycle the total fiscal expenditures by applicable adjustment codes to date **Rural Specialist Locum Program** • Reports each payment cycle on monies recovered at 100 % for fee for service provided by locum physicians for providing on-call in

	hospital. Reported by community, by payee, by physician, by host physician payee number and name • Reports each payment cycle on monies recovered for services provided by specialty locum in host physicians office (60/40) split. Reported by community, by payee, by locum physician, by host physician **Medical Advisor Sessional Payments** • Reports monthly on sessional payments and travel expenses by medical advisor **Service Level Objective item 7** • Measures processing of payment requests on a complaint basis and retains records for audit • Measures payment of Medical Advisor sessional and travel expenses on a complaint basis and retains records for audit • Reports monthly on processing of rural health correspondence

2.3 MSP Provider Electronic Claims Submission and Payment System

General Description: MSP operational responsibilities include administration of the mandatory electronic claims billing and payment/reconciliation system that links BC's medical and health care practitioners to MSP. There are limited exceptions to electronic claims submission by enrolled health care practitioners requiring the printing, mailing and data entry of card claims. The electronic billing system employs a DOS based (which is being phased out) and a Web based submission channel, program specific authentication process, nightly claims edits, nightly returns claims failing the edits, twice monthly rules based adjudication and payment systems, the fee item utilization program, a remittance and broadcast message program and provides a variety of downloadable electronic files. Many of the subsystems have published software specifications. Payment cycle follows a specified processing schedule dependent on the Office of Comptroller General and their primary financial institution. In the case of failure to meet the cycle payment, there is an emergency payment program.

The Claims system is also dependent on multiple databases such as the practitioner information file, the diagnostic facility database, the fee schedule master, etc., and has responsibilities to additional systems.

Claims payment policies require 18 months claims history to be available in the adjudication process. In addition, the Province stores a 7 year reduced claim history for information requests made by ICBC or through court orders.

Changes to the electronic claims systems that impact physicians are subject to terms and conditions set out in the negotiated agreement with the British Columbia Medical Association (BCMA) and the Province.

The Claims systems also process third party claims such as WCB, ICBC, Primary Care encounter records, etc.

Responsibilities:

Province	Service Provider
• Sets the policies, claims submission format, required claims data elements, and payment schedules • Review and approves all remittance broadcast messages • Participates on the Medical Software Vendors Association/Ministry (MSVA) Liaison Committee. The purpose of the committee is to deal with operational issues and share information on future changes • Approves specifications for printing paper claims • Approves potential new third parties interested in using the MSP system • Includes the partner in planning of future initiatives • Set the criteria for the emergency payment program and approves if implementation is required • Approves requirements for material changes to the functionality of the processing system • Review performance reports	• Administers the mandatory electronic claims billing and payment systems and all related sub systems and interfaces • Creates and provides the twice monthly data file to be used by the Ministry of Finance to issue payments to physicians, health care practitioners and beneficiaries • Administers the inter-provincial reciprocal billing and payment processes • Maintains a data entry process for paper claims • Prints or subcontracts the printing of contract for paper claims according to the specifications approved by the Province • Maintains the electronic billing specifications and ensures all new software vendors are compliant • Ensures the accuracy and relevance of all automated business rules • Maintains accurate and current system documentation • Chairs an annual MSVA meetings (see previous column) • Notifies the Province of any material technical problems • Seeks approval from the Province if there is a potential requirement to implement the emergency payment program • Provides the same or similar level of functionality as the current processing system • Seeks approval from the Province if system changes or modification materially alters the functionality of the processing system

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 19 and 22 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 8 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on % claims processed through automated rules • Reports on number and type of change requests from Province for payment schedule amendments or business rule changes, and system improvement requests • Reports quarterly on QA reviews **Service Level Objective item 8** • Reports annual availability on contract year basis • Reports monthly on restoration after fail over • Reports monthly on restoration after service interruption • Reports on a complaint basis on processing of paper claims • Reports monthly on processing of remaining documents

2.4 MSP Automated claims business rules

General Description: The claims processing system employs thousands of automated business rules resulting in approximately 98.5% of claims being automatically processed. These business rules represent legislative requirements, conditions set out in negotiated agreements, Payment Schedule policies and precedent established.

The budgets for medical and health care provider claims are capped and operations is responsible to ensure claims are accurately submitted and paid.

Medical providers and when required, software vendors, are provided “advanced notice” when business rules are modified resulting in a change to how a claim is paid or when claim submission requirements change.

Responsibilities:

Province	Service Provider
• Sets the payment policies • Approves all additions and changes to the automated business rules within 10 Business Days of receipt from Service Provider • Provides policy interpretation/ clarification as required • Approves all communications related to business rules changes or claims submission requirements within 3 Business Days of receipt or earlier if urgent • Reviews performance reports	• Routinely analyzes claims requiring manual adjudication for automated rule development and existing rules for efficiency and accuracy • Recommends new automated business rules or modifications to existing rules to the Province and provides a development and implementation plan • Codes, user tests for desired outcome and implements new or modified business rules approved by the Province • Develops communication material to providers on rule changes and issues the notice once Province approval received • Notifies the Province when material complaints are received about the accuracy of the automated rules

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 12 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 9 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports quarterly on development of any new or modified automated business rules/edit functions initiated either by the Service Provider or Province • Reports monthly on number of exceptions/rejects from rules by type of claim and reject reason as a percentage of total claims processed. To be combined with reports required for manual adjudication • Reports monthly on total number and value of claims by type of specialty processed through automated system. To be combined with reports required for manual adjudication • Reports quarterly on number of claims paid as billed, partially paid, adjusted or refused by claim type • Reports monthly on payments aged greater than 60 days from date of receipt and number and value of claims pending

	processing • Reports monthly on Service Level Objective item 9

2.5 MSP Provider Manual In-province claims adjudication – including reciprocal and third party claims

General Description: The adjudication program is comprised of several subprograms containing thousands of automated business rules processing approximately 98.5% of all claims. Claims failing those business rules require manual intervention by trained adjudication staff.

Rejections can occur because of the complexity of the claim, discrepancies in practitioner claims, input errors, changes in the Payment Schedule, misunderstanding by practitioner of billing processes, conflict with another insurer claim etc. Independent judgment in decision-making may be required. Requires significant training and expertise.

Disputed payments are entitled to administrative review. Claims can be re-submitted electronically with additional supporting information or a written appeal may be sent.

Payment disputes, issues that are unclear or where no policy interpretation exits are referred to formal advisory committees such as the Medical Advisory Committee (MAC) and the Medical Payment Issues Committee (MPIC). If payment decision is upheld, the physician can appeal to the BCMA Reference Committee. For policy disputes, cases are referred to either the BCMA Tariff Committee or the Medical Services Commission. Interest is payable after 60 days on all correctly submitted claims.

In some cases, the adjudicator may be required to request various reports such as operative and consultation reports from physicians to properly adjudicate a claim.

Responsibilities:

Province	Service Provider
• Sets the Payment Schedules and associated payment rules • Governance responsibility for the relationship with the various Practitioner Associations such as the British Columbia Medical Association (BCMA) with respect to Payment Schedule policy and administration • Chairs the formal advisory committees with appropriate Service Provider representation. The purpose of such committees is to provide policy direction and clarification/interpretation on existing business rules	• Adjudicates claims in accordance with established policy or precedent • Prepares case files and refers complex claims requiring a clinical assessment to a Province's medical advisor for adjudication • Tracks and monitors the appropriateness of claims referred by adjudicators to a medical advisor • Makes requests for supporting documentation from practitioners such as operative reports when required to properly adjudicate a complex claim

Province	Service Provider
• Adjudicates claims referred by the Service Provider where no policy exists, billed under miscellaneous fees where no Payment Schedule listing exists or disputes to outcomes of the administrative review process. Develops a mechanism to transfer knowledge of decisions by medical advisors to adjudicators when appropriate • Approves the content of the adjudication-training program • Approves all communications related to Payment Schedule changes, new or amended policies and educational material • Conducts reviews on decisions on an "as and when required basis" to validate and test the training and quality assurance programs • Reviews performance reports	• Implements new or amended policies as directed by the Province • Implements an administrative review process • Prepares necessary documentation and refers all claims where policies or precedent is weak or non-existent including miscellaneous fees to the appropriate advisory committee. Participates on all such committees • Conducts regular analysis of claims failing the automated business rules in order to determine opportunities for further automation and/or opportunities to educate practitioners on proper billing practices • Develops and administers an adjudication training program which includes medical terminology, and quality assurance program to ensure claims adjudicators' decisions are complying with Province Policies and procedures • Prepares background material to support the Province in adjudicating referred claims or disputed payments. Implements Province decisions. • Notifies the Province on emerging trends or suspicious billing practices

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See item 26 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 10 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports every payment period on % of manual claims processed by claim type and processing outcome, e.g. paid as billed, refused, partially paid, etc. Report to also include number and type of claims in the backlog and interest payments by payment period • Reports monthly on number of requests for analysis, information from Province • Reports monthly on the number and type of recommendations for automated rule development, cases referred to the Province

	• Reports monthly on the number of cases referred to the Province's medical advisors, number of cases pending and average processing time • Reports quarterly on the QA reviews • Measures Service Level Objective item 10 on a complaint basis and retains records for audit

2.6 MSP Provider Manual Out of Country travel claims adjudication

General Description: The Province through the MSP reimburses beneficiaries for insured medical services obtained while temporarily traveling outside of Canada. Reimbursement is made up to the rate that would be payable if services were provided in BC. Hospital per diem is reimbursed at a fixed daily rate set by the Province. Often reimbursement is less than 10% of the total bill. Peak time for claim submission currently is March, April and May of each year.

Although MSP is the primary insurer for medical required physician services, there currently are 21 agreements with extended health insurers. The agreements permit the extend health carrier to reimburse the patient directly and then seek reimbursement from the Province for its portion of the claim.
Claims are adjudicated against BC Physician Payment Schedule and subject to the same payment rules as in province claims.

There is no official appeal process however; there is an administrative review process.

Repeated/frequent requests for reimbursement from individuals or families for services obtained in the same location are monitored as the pattern could flag a residency issue.

Responsibilities:

Province	Service Provider
• Sets the policy and payment schedules • Reviews performance reports • Provides policy interpretation/clarification as required • Approves changes to the claim form and brochure	• Processes all claims received directly from beneficiaries or indirectly through extended health insurers • Enters claim details into an online system to create payment and update patient claims history record • Provides beneficiary with a written notice of payment • Implements an administrative review process

Province	Service Provider
	• Responds to general inquiries regarding benefits and claim status • Maintains a quality assurance program to ensure claims adjudicators' decisions are complying with Province policies and procedures and to ensure the quality of written responses. Participates, on an as required basis, at external information workshops • Prints and makes available the necessary claim forms and brochures • Recommends changes to claims forms or brochures • Implement mechanism to identify potential fraud cases, prepares case files and notifies Province of suspected fraud • Monitors patterns of claims to identify any potential residency issues and notifies Province of suspected cases

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items ~~14, 15~~ 14(a) and 26 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 11 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of claims and amounts reimbursed by medical and hospital claim type and location of service • Reports monthly detail on individual claims exceeding $10,000 • Reports annually on number of suspected fraud or residency cases referred to Province • Reports quarterly on QA reviews • Reports monthly on Service Level Objective item 11

2.7 MSP Provider Out of Province/Country Pre-authorizations

General Description: Out of Country medical treatment may be a benefit only when appropriate and acceptable services are not available in Canada. Each case is adjudicated on its own merits. Applications are submitted by the specialist involved in the patient's care and adjudicated by the Province's Medical Consultant. Approved requests are paid at the usual and customary rate. Negotiations to obtain a preferred customer rate are usually undertaken by Province staff.

In addition to the usual provision of an administrative review process, applicants of denied requests are provided with an opportunity for their case to be heard before a panel of the Medical Services Commission (MSC).

Responsibilities:

Province	Service Provider
• Sets the policy and adjudicates all applications • Provides direction when additional information is required to make decision • Provides policy interpretation/clarification as required • Prepares briefing file and presents file to the panel of the MSC • Provide initial approves on the standard referral form and standard response letters or any proposed changes • Reviews performance reports • Adjudicates and advises the Service Provider of decision within 5 Business Days unless the case urgent then decision made within 2 Business Days	• Reviews the request to ensure all required information has been submitted • Requests additional information on incomplete applications which may include requesting an expert opinion from one of the Province's Centres of Excellence, e.g. Cancer Agency • Prepares case file for referral to the Province • Enters details of request on tracking system and monitors cases • Drafts and mails response letter on behalf of the Province • Enters decision outcome on tracking system • Responds to enquiries on benefit coverage and case status • Negotiates a reduced fee on approved cases • Processes payments in Canadian funds when claims received and drafts associated letter • Prepares all background required for the Province's Medical Consultant to prepare briefing file for hearing or to respond to inquiries from media, politicians etc • Attends hearing to provide technical support, if required • Providing ad hoc reports as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 12 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of applications received, number approved and denied and number of cases pending • Reports monthly on Service Level Objective item 12

2.8 MSP Provider Pre-authorizations

General Description: Cosmetic procedures are not benefits under the Medical Services Plan. Occasionally, a cosmetic type procedure is used to remedy a medical condition. This service would be a benefit but requires pre-approval.

Adjudication rules are defined for the majority of procedures. However, due to the complexity of some requests, adjudication may be required by a medical advisor. Individual decisions can set precedent. Infrequently, obtaining pre-approval is not possible. Retroactive approval may be granted under limited circumstances.

There is no formal appeal process but an administrative review process is available on denied applications.

Responsibilities:

Province	Service Provider
• Determines the policy and provides, as required, policy clarification/interpretation • Adjudicates appeals referred by the Service Provider within 15 Business Days of receipt • Reviews performance reports	• Processes routine requests where there are policies or established precedent and advises applicant of decision. Updates the online system with adjudication outcome to enable automated processing • Refers complex requests to a Province medical advisor for adjudication • Provides an administrative review process for appeals on denied claims. Refers appeals on a negative administrative review to the Province • Implements Province decisions on appeals and notifies the applicant • Notifies the Province of repeated suspected inappropriate requests

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 26 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~Service Level Objectives:~~ ~~See item 13 set out in the table in Paragraph 5 of the Service Levels Schedule~~.	• Reports monthly on number and type of requests approved, denied and refer to Province • Reports quarterly on QA reviews

2.9 MSP Provider Retroactive Payment Adjustments

General Description: Retroactive payment adjustments are occasionally required when changes to payment rates are negotiated or approved with a retroactive effective date.

Practitioners and when applicable, software vendors, are provided with an advance electronic notice as to when the retroactive adjustment will be issued.

Requires the capability and capacity to extract millions of paid records and calculate and apply a single or variety % increases to specified paid claims.

Responsibilities:

Province	Service Provider
• Provides direction on the payment rate changes and effective dates • Consults with the Service Provider on the implementation strategy and approves the timelines for issuing the payment adjustment • Approves the communication regarding the adjustment within 2	• Analyzes the effort required to implement the adjustment and advises on the implementation strategy • Processes the retroactive payment including updating the payment schedule database and all impacted paid claim records with the retroactive amount • Validates with the Province the total value of the retroactive

Province	Service Provider
Business Days	adjustment before implementation • Drafts the electronic communication to providers and software vendors as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 14 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports promptly on the final total adjustment amount of the retroactive payment • Measures Service Level Objective item 14 on a complaint basis and retains records for audit

2.10 MSP Provider Online Payment Schedule Amendments

General Description: Operations is required to implement amendments to the various online practitioner payment schedules used in the processing of claims.

Amendments can range for a payment rate change to a single item, modification of a fee item attribute, implementation of a new fee item to implementing a new payment schedule for a specialty or across the board payment rate changes.

Practitioners and when applicable, software vendors, are provided with an advance electronic notice of amendments.

Responsibilities:

Province	Service Provider
• Advises of amendments in writing • Consults with the Service Provider on medium to large volume and medium to high impact changes to determine implementation strategy and timelines • Provides clarification/interpretation as required	• Updates the online Payment Schedule with amendment(s) • On medium to large volume and medium to high impact changes analyzes the effort required to implement and advises the Province on the implementation strategy and timelines • Drafts the communication (for approval by the Province)

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 15 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly all amendments – by number of changes • Measures Service Level Objective item 15 on a complaint basis and retains records for audit

2.11 MSP Provider Payment Advances

General Description: The Province is contractual obligated, under limited circumstances such material software failures, to provide fee-for-service physicians with an interest free advance payment on future claims. Advances are recovered from future remittances.

Responsibilities:

Province	Service Provider
• Determines the criteria for advances • Reviews performance reports	• Processes requests for advances in accordance with established criteria • Issues advance payments and establishes re-payment plans in accordance with guidelines provided by the Province • Tracks and monitors requests for advances

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objective:**~~ None. ~~See item 16 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports quarterly on number of requests and value, number granted and denied and outstanding receivables

2.12 MSP Provider Overage Claims Requests

General Description: Claims must be submitted within 90 days of service rendered. Exceptions may be granted under limited circumstances.

Responsibilities:

Province	Service Provider
• Determines the exception criteria • Reviews performance reports	• Processes requests for overaged claims and advises client of decision • Provides an administrative review process for appeals on denied claims • Tracks and monitors requests

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 17 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volume of requests, number granted and denied • Reports monthly on Service Level Objective item 17

2.13 MSP Provider Inquiry Management – Coverage (interactive voice response)

General Description: Provider Services provides a variety of information related to beneficiary coverage services to health care provider offices.

Responsibilities:

Province	Service Provider
• Approves scripts • Reviews performance reports	• Administers the automated IVR service • Routinely evaluates the effectiveness of scripts and utilization of services available and makes necessary enhancements • Implements new IVR replacement technology (see Schedule J of this Agreement)

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 10 set out in the table in Paragraph 4 of the Service Levels	• Reports monthly on volumes of inquiries by service type

Schedule. ~~**Service Level Objectives:**~~ ~~See item 18 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	

SCHEDULE 5 SECTION 2 – MSP PROVIDER SERVICES

2.14 MSP Teleplan Support Centre

General Description: Provides electronic billing registration services and a variety of related client services to over 4,000 medical sites in British Columbia.
Responds to questions/problems regarding:

- Electronic billing;
- Electronic remittance statements/refusal;
- Hardware/software requirements;
- Access issues, passwords/userid, etc.; and
- Network problems.

Teleplan Support Centre staff often liaise between the medical site and the software vendor. Coordinates vendor software testing. Provides first level support for Primary Care sites. Provides quality assurance testing on changes to the electronic billing software.

Responsibilities:

Province	Service Provider
• Province sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Staffs a contact/call centre providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday with client service representatives that have the appropriate level of knowledge to provide technical and business support for electronic claims submission including hardware and software problem resolution • Maintains a tracking system including escalation management for all calls handled • Processes applications for electronic claims submission

Province	Service Provider
	• Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Immediately alerts the Province of a major failure of the electronic billing system when downtime is expected to exceed 24 hours

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 10 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~**Service Level Objectives:**~~ ~~See item 19 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports quarterly on QA reviews

2.15 MSP Provider Claims Billing Support

General Description: Provides claims billing assistance to health care practitioner offices; first level of administrative review for payment disputes; information on benefits and Payment Schedule policies; researches and responds to enquiries and complaints from physicians and supplementary benefits practitioners; provides information, and advice on payments of fee-for-service claims as well as interpretation of the *Medicare Protection Act* (British Columbia), *Freedom of Information and Protection of Privacy Act (*British Columbia) and Medical Services Commission Payment Schedule.
Position acts as a first level of appeal for adjudication disputes.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday with appropriate client service representatives able to respond to all calls from physicians, health

Province	Service Provider
	care practitioners and their office staff related to claims billing, claims adjudication policies, legislation, etc. • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled • Notifies Province on emerging trends • Immediately alerts the Province on any caller seriously threatening to go to the media or senior government officials

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 10, 10(a) and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~**Service Level Objectives:**~~ ~~See item 20 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports quarterly on QA reviews

2.16 MSP Benefit Inquiry Services - General Public

General Description: Provides telephone access to the general public on wide variety of topics ranging for inquiries on benefits, information and status on Out of Province and Out of Country claims, requests for information on claims paid on their behalf, policy interpretation, FOI requests, etc.

Responsibilities:

Province	Service Provider
• Province sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports • Participates in script review and approval	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday to respond to a wide variety of calls from the general public on MSP benefits, request for Personal Information, complaints etc.

Province	Service Provider
	• Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled • Provide and refreshes technology to support beneficiary services as described in Schedule J attached hereto

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~**Service Level Objectives:**~~ ~~See item 21 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports quarterly on QA reviews • Reports quarterly on the number of FOI requests and the number of requests for claims history listings

2.17 MSP Provider General Correspondence

General Description: Provider Services receives a wide variety of general correspondence from benefit inquiries, Freedom of Information (FOI) requests, requests for listings of services paid by MSP, complaints or tips on potential fraud, requests for reimbursement, etc.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Responds to or acknowledges receipt of all correspondence • Where appropriate, standard responses are developed and used • Notifies Province of emerging trends and of tips on potential fraud • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 22 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Report monthly on volumes of correspondence received, number processed, average processing time and inventory of letters including average number of days outstanding • Reports quarterly on the number of FOI requests and the number of requests for claims history listings • Reports monthly on Service Level Objective item 22

SECTION 3 – PHARMACARE SERVICES

3.1 PharmaCare Automated Claims Submission

General Description: All prescriptions dispensed at community pharmacies are entered on PharmaNet. Claims are submitted electronically, adjudicated in real time and outcome is automatically returned to transmitting pharmacy. Payment is made weekly. Some designated medical supplies are also processed through PharmaNet.

Responsibilities:

Province	Service Provider
• Determines drug benefits and reimbursement policy for each benefit plan	• Maintains the 24/7 operational requirements of PharmaNet • Processes updates to data tables

Province	Service Provider
• Determines the claim detail to be submitted • Determines and approves all new or modified business rules • Ensures the necessary spending authority for processing payments is in place • Determines and revises data access requirements and provides same to the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule. • Reviews performance reports	• Creates and provides the weekly data file to be used by the Ministry of Finance to issue payments to pharmacies weekly • Resolves all service interruptions • Issues immediate alerts on service interruptions to pharmacies, the BC College of Pharmacists, the BC Pharmacy Association and the Province of the service interruption when severity level – high, e.g. PharmaNet unavailable for more than 1 hour • Codes, user tests for desired outcome and implements new or modified business rules approved by the Province

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 19 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 23 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes and expenditures • Reports monthly on number of data table updates • Reports monthly on PharmaNet performance including outages/any service interruptions **Service Level Objective item 23** • Reports annual availability on contract year basis • Reports monthly on claims transaction response time

3.2 PharmaCare Manual Claims Processing (offline)

General Description: A small group of providers do not submit claims via PharmaNet. Prescription/Supplies claims are submitted manually by patient or supplier for reimbursement.

Responsibilities:

Province	Service Provider
• Determines benefits and payment policies	• Processes claims according to payment policies

Province	Service Provider
• Reviews performance reports	

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 24 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes and expenditures by claim type • Reports on inventory of aged claims • Reports monthly on Service Level Objective item 24

3.3 PharmaNet tables Administration

General Description: Database tables used for system access, adjudication, and payments. This includes the production of PharmaNet, Training PharmaNet, and Excel spreadsheets.

Responsibilities:

Province	Service Provider
• Provides required updates to data tables. • Reviews performance reports	• Processes required updates submitted by Province

- **Service Level and Reporting Requirements:**

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 25 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of updates by type • Measures Service Level Objective item 25 on a complaint basis and retains records for audit

3.4 PharmaNet External Software Compliance Testing

General Description: Pharmacies, emergency departments and medical offices software must be compliant with standards for connecting to PharmaNet. The standards are published and available from the Province web site. Testing is initiated at the request of the software developer and re-testing is required if the original test finds deficiencies. Random testing may be required to ensure continued compliance.

Responsibilities:

Province	Service Provider
• Determines and approves changes to the PharmaNet compliance rules • Initiates random testing if required • Reviews performance reports	• Performs tests at request of software developer • Conducts spot audits according to established guidelines • Advises software developer of areas of non-compliance • Conducts follow up to ensure corrective action taken • Prepares report on test results and provides copy to software developer and Province

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objectives:**~~ None. ~~See item 26 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports semi annually on number of compliance tests completed

3.5 PharmaCare Pre-authorizations

General Description: Pre-authorization for Prosthetics and Orthotics over limits set by the Province and Special Authorities is required.
Out of province prescription, under limited situation, can receive pre-approval for coverage (i.e. transplant patients going to out of province for their surgery).

Responsibilities:

Province	Service Provider
• Sets policy • Processes pre-authorization and Special Authorities applications • Approves out of province coverage for transplant patients • Advises the Service Provider of decision on pre-authorizations and out of country transplant cases within 2 Business Days • Reviews performance reports	• Prepares and mails pre-authorization decision letters • Processes out of province coverage payments • Processes payments for pre-authorized prosthetic and orthotics claims

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 27 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes pre-authorization letters • Reports monthly on volumes and expenditures for out of country transplant claims • Reports monthly on Service Level Objective item 27

3.6 PharmaCare Payments

General Description: PharmaCare payments include automated claims received via PharmaNet, manual claims and payments to pharmacies for the following programs:

- Methadone Program;
- Plan B;
- Emergency Contraceptive Pill Program; and
- Rural Incentive Program.

Responsibilities:

Province	Service Provider
• Provides payment authority to release funds for distribution • Provides report on Rural Incentive Program payments • Reviews performance reports	• Processes automated and manual adjustments • Notifies the Province immediately of any payment process failures

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 19 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports weekly on volumes and expenditure by automated and manual claims

3.7 PharmaCare Plan Registration Services

General Description: PharmaCare administers a number of Drug Benefit Plans. Operations is responsible for the automated and manual beneficiary registration to the appropriate PharmaCare Plan(s) and pharmacy, supplier, emergency department and physician registration/access to PharmaNet. Pharmacy registration is also required for Plan B and the methadone program. PharmaCare plans currently include:

Fair PharmaCare - BC families eligible for financial assistance under Fair PharmaCare, based on their net income

Plan B - Permanent residents of licensed long-term care facilities. Enrolment is done through the care facility.

Plan C - Individuals receiving income assistance through the Ministry of Human Resources The pharmacy is paid for the full prescription cost directly by PharmaCare.

Plan D - Individuals registered with a provincial Cystic Fibrosis Clinic

Plan F - Children eligible for medical or full financial assistance through the At Home Program of the Ministry for Children and Family Development. Children receive full benefits for eligible prescription drugs and medical supplies at no charge through PharmaCare.

Plan G - The No-Charge Psychiatric Medication Program. Low-income Province Customers that qualify for MSP Premium Assistance are eligible for financial assistance through mental health centres. The patient's physician or psychiatrist submits an application to a mental health service centre for approval. In exceptional cases, patients without MSP coverage (i.e., new British Columbia residents) may be able to receive Plan G benefits. In such cases, a mental health practitioner may apply for coverage on an individual, emergency basis.

Palliative Care Drug Program:

This plan provides eligible patients with coverage for the costs of medications listed in the *Palliative Care Drug Formulary*.

B.C. Centre for Excellence in HIV/AIDS:

The B.C. Centre for Excellence in HIV/AIDS operates from St. Paul's Hospital in Vancouver. Individuals enrolled with the centre receive their antiretroviral drugs free of charge.

Responsibilities:

Province	Service Provider
• Determines eligibility criteria and associated policies • Reviews performance reports	• Provides a multi-channel registration process for Fair PharmaCare (FP) including web, phone and paper • Processes all FP paper applications and telephone registration requests • Issues, processes and stores all FP consent forms • Provides real-time registrations interfaces and manual back up

Province	Service Provider
	process for Plans C, F and G • Processes manual registrations for the Palliative Care Drug Plan • Provides multi-language services in Mandarin, Punjabi and Cantonese during the hours of 9:00 a.m. to 3:30 p.m. and any calls received outside of those hours will have call back service within 24 hours of receipt of call with IVR enabling the bilingual message to be left with commitment to return call within 24 hours

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 2 and 5 ~~and 23~~ set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 28 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volume by type and average processing time of registrations • Reports monthly on inventory of registrations **Service Level Objective item 28** • Reports monthly on document processing for imaged documents. Otherwise, measures document processing on a complaint basis and retains records for audit. • Measures multilanguage services including wait time for call back on a complaint basis and retains records for audit.

3.8 Fair PharmaCare (FP) Administrative Review Processes

General Description: Provides support to the registration process of families and individuals, resolve eligibility issues, handle specific requests for income review, revocation of CRA consent, retroactive payments, and handle general FP correspondence.

Responsibilities:

Province	Service Provider
• Determines policies • Provides policy interpretation/clarification	• Processes incomplete and non-standard Fair PharmaCare (FP) registrations and consent forms

Province	Service Provider
• Adjudicates formal appeals on administrative review decisions and advises the Service Provider of decision within 10 Business Days • Approves system generated letters • Manages Memorandum of Understanding (MOU) with Canada Revenue Agency (CRA) • Reviews performance reports	• Processes errors and exceptions resulting from automated processes such as the automated MSP Beneficiary Services matching process • Actions eligibility problems resulting from family changes, failure of family to return consent form, or file with CRA • Processes CRA consent revocations • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA • Processes requests for income reviews where family income has changed or for new residents • Process requests for early retroactive payments • Processes informal appeals (i.e. complaints) of earlier administrative review decisions • Prepares case files for formal appeal requests and forwards to the Province • Responds to general FP correspondence and telephone inquiries

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 29 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number and types of reviews, aged inventory, and number of first time appeals and number of scond time appeals forwarded to the Province • Reports quarterly on QA reviews **Service Level Objective item 29** • Measures urgent requests on a complaint basis and retains records for audit. • Reports monthly on routine requests • Reports monthly on processing of correspondence

3.9 Fair PharmaCare Income Verification Process

General Description: The Fair PharmaCare Plan is based on an individual's or family's net income. Net income is self-reported during the initial registration process and verified with the Canada Revenue Agency (CRA) at the time of registration and annually thereafter. In order for CRA to provide an individual's or family's net income PharmaCare must obtain a signed consent. The automated verification process is weekly via FTP. The electronic response from CRA updates the system and generates correspondence.

Exceptions are manually processed according to established policy.

Responsibilities:

Province	Service Provider
• Determines criteria for income verification and appropriate supporting documentation (e.g. consent form) • Provides policy interpretation/clarification • Manages the MOU with the Canada Revenue Agency and reports to CRA outcome of audits • Approves any required changes issued by CRA • Approves system-generated letters	• Administers the income verification process with CRA and makes any necessary adjustments resulting from the verification process. Maintains a contact with the local CRA office for verification as required (for prior tax years) • Conducts audits on the income verification process as prescribed in the CRA MOU and reports outcome to the Province • Refers any required changes by CRA to the Province • Maintains and updates system generated letters • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 30 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes, number of adjustments and letters generated • Reports on Service Level Objective item 30 through a published schedule

3.10 PharmaCare Restricted Claimant Program

General Description: Program assists in reducing misuse of PharmaCare benefits by limiting coverage for certain patients to medications prescribed or pharmacies which prescriptions drugs may be obtained.

Responsibilities:

Province	Service Provider
• Determines the program policies and approves restrictions • Manages all appeals • Reviews patient profiles and approves restriction or removal of restrictions within 5 days of request from the Service Provider • Provides pharmacist support during business hours to review urgent requests	• Processes approved restrictions and advises patient • Provides business hour program coverage for routine processes • Provide 24x7 coverage for emergency changes to restriction • Alerts Province of potential misuse by patient • Provide routine pharmacy and physician changes during business hours – 8:00 a.m. – 4:30 p.m.

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 31 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number and type of restrictions **Service Level Objective item 31** • Measures processing of temporary restriction changes (phone calls) on a complaint basis • Measures processing of approved restrictions and notification letters and changes to approved restrictions on a complaint basis and retains records for audit. • Reports monthly on processing of correspondence.

3.11 PharmaCare Adjudication Rule Changes

General Description: Apply changes in benefits, deductibles, etc.

Responsibilities:

Province	Service Provider
• Initiates and approves all adjudication rules changes • Provides policy interpretations/clarifications • Review performance reports	• Processes updates to online tables, as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objectives:**~~ None. ~~See item 32 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on the number and type of adjudication rules changes

3.12 PharmaCare General Correspondence

General Description: PharmaCare receives a wide variety of general correspondence from benefit inquiries, confirmation of Special Authority by third party insurers, blood glucose strip certificates, requests for listing of drugs paid on their behalf, complaints or tips on potential fraud, requests for reimbursement, etc.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Responds to inquiries in most appropriate manner • Manages a quality assurance program to ensure high quality client service and the accuracy of the responses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 33 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes, type and inventory of written inquiries • Reports quarterly on QA reviews

	Service Level Objective item 33 • Measures processing of blood glucose strips certificates, 3rd party insurer requests and out-of-province requests on a complaint basis and retains records for 18 months for audit. • Reports monthly on processing of general correspondence

3.13 PharmaCare Help Desk – Pharmacists and other Service Providers

General Description: The PharmaCare Help Desk is available 24 hours, 7 days per week. The Help Desk responds to a wide variety of calls from Pharmacies regarding patient benefit eligibility, questions about adjudication results, status of Special Authorities requests, restricted claimants, general inquiries on benefit plans, etc. The Help Desk also provides troubleshooting for system problems such as pharmacy network connection problems, slow response times, gateways down, resetting passwords, etc.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports Note: Fair PharmaCare Self Registration IVR was retired in July 2006	• Staffs a contact/call centre providing 24/7 availability with client service representatives that have the appropriate level of knowledge to provide technical and business support for PharmaNet system including network and software problem resolution and the PharmaCare Program • Monitors open network incidents and response times and escalates problems • Maintains a call tracking system including escalation management for all calls handled • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Immediately alerts the Province of a major failure of the PharmaNet system when downtime is expected to exceed 4 hours

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 10, 11 and **[20]** set out in the table in Paragraph 4 of the Service Levels Schedule. ~~**Service Level Objectives:**~~ ~~See item 34 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports quarterly on QA reviews

3.14 PharmaCare General Public Inquiry Services

General Description: Handles inquiries about eligibility, drugs, benefits, special authorities, etc., provides telephone Fair PharmaCare registration, and specific inquiries around income reviews, retroactive payments, changes to Personal Information, requests for claim information, etc.

Responsibilities:

Province	Service Provider
• Reviews performance reports	• Staffs a contact/call center 8:00 am – 8:00 pm, Monday to Friday, 8:00 am – 4:00 pm Saturdays to respond to all calls from the general public related to PharmaCare including providing phone registration service • Manages a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a call tracking system

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements:	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, average speed to answer and types of calls including

See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. ~~**Service Level Objectives:**~~ ~~See item 35 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	Fair PharmaCare phones registration • Reports quarterly on QA reviews

SECTION 4 – COMMON PROCESSES

4.1 Province initiated registrations and payments

General Description: Periodically the Province may initiate a registration, an amendment to a registration such as waiving the wait period, a provider or beneficiary payment, an adjustment to a payment, a recovery or approve a service as a benefit as a result of an appeal, functions remaining the responsibility of the Province, medical provider or beneficiary audit/investigation or non-precedent setting circumstances.

Responsibilities:

Province	Service Provider
• Provides sufficient written instruction to enable the Service Provider to accurately complete the necessary transactions • Where appropriate, provides reasonable timelines for the completion of the request • Completes the necessary written correspondence to the Province Customer or provides the Service Provider with the approved content to for any written correspondence • Responds to all requests for clarification, as necessary • Responds to referred inquiries related to the decision	• Processes the request according to the instructions and timelines provided • Records the appropriate details of the request • Retains and stores all requests for future retrieval by the Province • Completes and mails any written correspondence as approved by the Province • Confirms any discrepancies with the Province before processing the request • Where appropriate, handles any general inquiries on a Province initiated request and refers inquirer to Province on queries related to the decision

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objective**~~: None. ~~See item 36 set out in the table in Paragraph 5 of the Service Levels Schedule~~.	• Reports monthly on the number and type of Province initiated requests.

4.2 Province Customers and Stakeholders Communications

General Description: MSP and PharmaCare Operations communicates to beneficiaries and medical providers through multiple channels including: Premium bill messages, Group Administrators, brochures, forms, Province website, bulletins, newsletters, fan-out notices, email, electronic broadcast messages, resource manuals, etc. See Schedule K of this Agreement for the Communication Plan and Communication Process.

Responsibilities:

Province	Service Provider
• Responsible for organized public communications regarding the outsourcing agreement and any changes to business. • Consults with the Service Provider in advance of any public communications that could impact business operations. • Responds to all media calls • Approves mechanisms and processes for communications • Approves all materials published and posted to web prior to issuance/launch	• Drafts and/or proposes content, prints, distributes, tracks and reports. • Responds to written inquiries, as per agreed upon protocols, refers to the Province issues requiring escalation, tracks and reports. • Responds in real time to verbal inquiries, refers to Province per agreed upon protocols. • Drafts scripted messages where appropriate. • Refers all media calls to the designated Province contact.

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
~~**Service Level Objectives:**~~ None. ~~See item 37 set out in the table in Paragraph 5 of the Service Levels Schedule.~~	• Reports quarterly on communication activities by channel • Reports on any complaints or issues

4.3 Document Inventory

General Description: Maintains a Document Inventory (including applications, address changes, inquiries, etc.)

Responsibilities:

Province	Service Provider
• Reviews monthly performance reports	• Digitizes all incoming documents requiring processing • Stores and destructs all images in accordance with the Province's Operational Records Classification system (ORCS) and policies • Archives all applicable paper documents in accordance with ORCS

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 38 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of incoming documents processed by type and number unsuitable for digitizing • Report monthly on number of copies of documents retrieved at the request of the Province **Service Level Objective item 38** • Reports monthly on processing of documents/correspondence • Archiving of documents reported through audit

4.4 Document ~~Scanning~~ Pre-processing/Mail Room Activities (including registration and scanning)

General Description: Pre-processing/mail room activities (including registration and scanning) ~~scanning~~ of all relevant MSP and PharmaCare incoming documents

Responsibilities:

Province	Service Provider
• Review performance reports	• Prepares, catalogs, scans and stores all documents requiring processing • Returns originals to submitter, where required or requested

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objective: See item 39 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Report monthly on number of document scanned by type – consolidate with report provided pursuant to Section 4.3 of this Schedule • Reports monthly on Service Level Objective item 39

4.5 Province Access and Reports

General Description: Provision of access to required systems/applications and all operational data to enable the Province to carry out functions remaining with the Province. Provision and support of a reporting tool to enable the Province to 'pull' reports and query the data. Periodically, the production of AD Hoc reports related operational data is required to respond to potential policy changes, analysis on existing policies, Minister inquiries, etc. These reports are varied. Examples are: information on the % of BC residents covered by MSP, number of individuals/families whose premiums are paid through group administrators, number of Fair PharmaCare beneficiaries within certain income bands, number of claims outstanding for a particular provider or reason, number of claims and dollars paid for Out of Country/Province services, etc.

Responsibilities:

Province	Service Provider
• Defines systems and data access requirements, acting reasonably. The initial data access requirements are attached as Appendix 1 to this Schedule. • Approves requests for individual access and advises when access to be terminated • Defines standard and ad hoc reports required, acting reasonably	• Provides access to Province staff to required operational systems/applications • Provides access to all operational data/information through a reporting tool or operational data repository • Assists the Province with interpretation of the data • Produces standard reports as required by the Province • Provides access to subject matter experts, as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 40 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports quarterly on Personnel with access to operational systems/applications • Reports quarterly on number and types of standard and ad hoc reports produced and the time involved to generate • Measures Service Level Objective item 40 on a complaint basis and retains records for audit

4.6 Information Requests: Personal claims history, information requests from third parties, Freedom of Information Requests, Court Orders

General Description: These include requests from patients for their own MSP claim and PharmaNet claims history and/or other documents relating to them, requests for claims history from the Ministry of Children and Families on their client/family, court order requesting claim history and documents on individuals or medical providers, information requests from third parties such as ICBC or WCB, Ombudsman, Coroner's office, Office of the Public Trustee, information requests under the *Freedom of Information and Privacy Act*, information requests from other Province programs, etc.

Responsibilities:

Province	Service Provider
• Approves and manages all Information Sharing agreements with Third Parties	• Processes individual's requests for their own MSP claim and PharmaNet claims history and/or other documents relating to

Province	Service Provider
• Approves and manages all information requests submitted under the *Freedom of Information and Privacy Act* or by the Ombudsman • Approves and manages all information requests submitted by the RCMP, Canadian Security and Investigations Service, court orders, other provincial jurisdictions, etc. • Provides the Service Provider with written instructions, supporting documentation and timelines for the release information to individuals, government Ministries, external agencies and organizations or other provincial or federal jurisdictions • Approves any charges to applicants proposed by the Service Provider for preparing information requests • Approves the data elements maintained in the tracking system	them subject to confirmation of the identity of the individual • Processes requests from ICBC for patient history listings subject to receipt of patient consent and where no revocation exists • Processes requests approved by the Province for release • Maintains a tracking system for all requests and monitors for repeat requests • Retains all individual consents and Province requests and supporting documentation in accordance with ORCS • Promptly notifies the Province if any request appears suspicious

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 41 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on the volumes and types of requests processed and the number outstanding • Reports monthly on Service Level Objective item 41

4.7 Policy and Procedures (Operational) Manuals

Manuals describe the policies, procedures and practices undertaken to deliver the business functions described in this Schedule. The Manuals also describe the methods of operations and procedures use to perform the Services such as, network topologies, security administration, system configurations, call centre processes, human resource functions, business processes and associated documentation. The manuals serve as training and reference tools for both Operations and Province staff.

Province	Service Provider
• Provides copies of all Medical Services Commission minutes,	• Maintains current and comprehensive operational manuals

Province	Service Provider
policy updates and interpretations to the Service Provider to ensure procedures/practices align with current requirements • Approves all changes to manuals within 10 Business Days of receiving amendments	• Updates manuals when advised of policy, legislative or procedural changes • Provide draft changes to the Province for approval prior to publishing any material changes to manuals • Tracks all changes to ensure there is an historical record • Provides Province with all finalized updates (Note that these obligations are in addition to the documentation requirements in the Agreement).

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 42 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports annually on manuals' most current version date • Reports through audit on Service Level Objective item 42

4.8 Third-Party Processing Agent

General Description: The Province has agreements with ICBC and WCB whereby MSP acts as a processing agent for these agencies. Services provided include: claims processing for physician, certain health care provides and hospital services, Province Customer services and communications related to claims processing and developing adjudication business rules and explanatory codes specific to ICBC and WCB claims. Physician claims designated as the responsibility of ICBC are processed without charge.

The Service Provider on behalf of WCB and ICBC may perform additional processing activities unrelated to the core services. The Service Provider will consult with and obtain the Province's approval/support before agreeing to take on additional services.

The Province is a party to a processing services agreement with WCB. In addition, to ICBC, the Province has a Memorandum of Understanding with the Ministry of Human Resources to process physician form fees on their behalf.

Responsibilities:

Province	Service Provider
• Liaise with WCB and ICBC to determine governance	• Acts as sub-contracted processing agent for the Province for

Province	Service Provider
requirements • Manages the Agreements with WCB and ICBC respectively • Recovers funds from WCB for administration of claims processing	physician and certain other health care provider WCB and ICBC claims • Provides client services to physicians, certain other health care provider, labs, hospitals, etc., related to the submission and payment of ICBC and WCB claims • Makes any necessary claims adjustments to reflect the correct insurer designation • Develops/modifies and implements new routine non-complex adjudication business rules that can be easily accommodated • Adds, amends or deletes fee item listings specific to ICBC or WCB • Amends WCB premium payment as required • Provides bi-weekly electronic files on Payment Schedule fee item information, explanatory code information, specialty code information, demographic information on practitioner and payee numbers • Provides various reports as requested by WCB including (aged invoices/forms; available payee (account/billing) codes; • Provides electronic communications to physicians on behalf of ICBC and WCB • Works with WCB and ICBC to identify business and system requirements • Seeks the Province's Approval on any changes initiated by ICBC or WCB

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 10, 11, 12, 13, 19, 22 and 26 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports every payment cycle on number of claims and dollar value and number of claims requiring manual adjudication by insurer type • Reports on number and value of adjustments to correct insurer designation

Service Level Objectives: See items 8, 9, 10, 14, 15, 17, ~~18, 19, 20, 21~~ and 22 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports on the number and type of changes implemented for WCB and ICBC • Identifies potential improvements for WCB and ICBC

THIS AMENDMENT AGREEMENT NUMBER 4 (the "**Amendment Agreement**" or "**Amendment Agreement #4**") is made the 8th day of February, 2013.

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, represented by the Minister of Health

(the "**Province**") at the following address:

Health Insurance BC -
Business Management Office
Strategic Initiatives and Corporate Services
Ministry of Health
5th Floor – 1483 Douglas St
Victoria BC V8W 3C8

AND:

MAXIMUS BC Health Inc. ("**MAXIMUS Prime**"), a company organized under the laws of British Columbia, MAXIMUS BC Health Benefit Operations, Inc. ("**MAXIMUS Sub**", and collectively with MAXIMUS Prime, the "**Service Provider**"), MAXIMUS Canada Inc. ("**MAXIMUS Canada**"), MAXIMUS, Inc. ("**MAXIMUS US**")

(the "**Service Provider**") at the following address:

MAXIMUS BC Health Inc
716 Yates Street
Victoria BC V8W 1L4

A. The Province and the Contractor are Parties to a Master Services Agreement dated as of November 4, 2004 (the "**Agreement**"), as amended by Amendment Agreement Number 1 dated January 16, 2006, Amendment Agreement Number 2 dated November 20, 2006, and Amendment Agreement Number 3 dated April 11, 2011;

B. The Parties wish to amend certain provisions of the Agreement on the terms set out herein;

C. Terms used but not otherwise defined in this Amendment Agreement will have the same meaning herein as in the Agreement.

NOW THEREFORE THIS AMENDMENT AGREEMENT WITNESSES that in consideration of the sum of One Dollar and other valuable consideration (the receipt and sufficiency of which is hereby acknowledged by each Party), the Parties agree effective as of the date of signing of this Amendment Agreement as follows:

Amending Provisions

1. The Agreement is amended as follows:

   (a) In Section 1.11(d), the words "for the Service Provider" are added before the words "to develop".

   (b) In Section 1.11(e), the words "for the Service Provider" are added before the words "to endeavour".

(c) In Section 1.11(f), the words "to have the Service Provider act as its" are replaced with the words "for the Service Provider to act as the Province's".

(d) In Section 1.11(h), the words "for the Service Provider" are added before the words "to provide the Services".

(e) In Section 1.11(k), directly preceding the semicolon, the following words are added ", including without limitation for the Parties to each continue to benefit after the expiration or termination of this Agreement from the business processes, methods for delivery of Services and technology created or developed by the Service Provider in the course of providing the Services hereunder".

(f) Section 2.1 is deleted in its entirety and replaced with the following:

> **"2.1 Term**
>
> The term of this Agreement (the "**Term**") will commence on the Effective Date and will continue until the earlier of:
>
> (a) the date upon which this Agreement is terminated in accordance with the provisions hereof including, without limitation, as set forth in Section 10.10 and as set forth in Article 21; or
>
> (b) the end of the Renewal Term.
>
> The MAXIMUS Group hereby acknowledges that the Province is giving no assurances whatsoever to the MAXIMUS Group, expressed or implied, that this Agreement will be renewed or extended beyond the expiry of the Term. The MAXIMUS Group specifically acknowledges and affirms that it has arranged its business affairs on the assumption that this Agreement will terminate, at the latest, at the end of the Term.
>
> The MAXIMUS Group hereby further expressly acknowledges and affirms that any termination of this Agreement in accordance with its terms, either at the expiry of the Term or as otherwise provided in this Agreement, will not constitute an expropriation or be tantamount to expropriation at domestic or international law (including, but not limited to the *North American Free Trade Agreement*) and will not constitute grounds for asserting any claim whatsoever under domestic law or any international agreement (including, but not limited to, Chapter Eleven of the *North American Free Trade Agreement* and the *General Agreement on Trade in Services*).
>
> The Term of this Agreement together with the Renewal Term, any Extension and the Termination Assistance Period during which the Service Provider provides the Termination Services is collectively referred to as the "**Term**"."

(g) Section 2.2 is deleted in its entirety and replaced with the words "Intentionally Deleted".

(h) Section 2.3 is deleted in its entirety and replaced with the following:

"**2.3 Extension of Term**

The Province shall have the right, upon delivery of written notice to the Service Provider at any time up to thirteen (13) months prior to the expiry of the Term, to extend the Term for up to one (1) year (the "Extension"). Unless otherwise agreed to by the Parties, the terms and conditions of such Extension shall be the terms and conditions in effect at the end of the Term and this Agreement shall apply during any Extension except that the Province agrees to further pay any additional incremental costs of the Service Provider reasonably incurred and that are demonstratable.

If the Parties have made any agreements to amend, change, modify or supplement the terms and conditions of this Agreement, including by way of Change Orders or the addition or subtraction of certain Services as contemplated in this Agreement during the Term, then the Extension shall be on the same terms and conditions as contemplated herein as so amended, changed, modified or supplemented, as the case may be, during the Term."

(i) In Section 3.7(b)(ii)(B) the words "in which event the provisions of Section 3.11 shall apply" are deleted.

(j) In Section 3.9 the words "and any amounts payable pursuant to Section 3.11(e)" are deleted.

(k) In Section 3.13(f) the words ""in which event the provisions of Section 3.11 shall apply" are deleted.

(l) Section 3.11 is deleted in its entirety and replaced with the words "Intentionally Deleted".

(m) Section 6.1 is deleted in its entirety and replaced with the following:

"**6.1 Overview of Services**

Subject to Article 7 hereof, during the Term, the Service Provider shall provide to the Province and the Province Customers and Stakeholders, and the Province shall obtain from the Service Provider, the following services (collectively, the "**Services**" and each a "**Service**"):

(a) the Transition Services;

(b) the Basic Services;

(c) the Transformed Services;

(d) the Additional Transformation Resources;

(e) the Termination Services; and

(f) all such other services as set forth or otherwise described in this Agreement;

Such Services to be obtained and provided upon the terms and subject to the conditions set out in this Agreement."

(n) Section 6.13(f) is deleted in its entirety and replaced with the following:

"it will maintain an ongoing focus on the customer satisfaction of the Province and the Province Customers, demonstrated by knowledge of their requirements, service standards and an adequate complaint resolution process for quality improvements which will include the following management and measurement process:

(i) complaints are logged when received by the Director of Operations (i.e., all complaints are logged when received, including those that are ultimately resolved);

(ii) complaints are acknowledged promptly, addressed according to urgency, and the complainant is kept informed throughout the process;

(iii) complaints are categorized by relevant Service Level Objective as applicable (some complaints may not apply to any Service Level Objective);

(iv) complaints applicable to Service Level Objectives will be reported in the monthly Service Level Objective report;

(v) measurement and categorization of complaints are subject to audit by the Province and the Parties will convene as necessary, or at the Province's request, to review the formal complaints log;

(vi) in the event of dispute between the Parties, the escalation procedures set out in the Agreement apply;

(vii) formal process on how and where to log a complaint is well publicized to customers; and

(viii) formal process for making a complaint and investigating is easy for complainants to access and understand."

(o) Section 6.15(a) is deleted in its entirety and replaced with the following:

"**6.15 Documentation**

(a) The Service Provider will provide ongoing access to the Service Provider's SharePoint (or other electronic data and document storage application) materials in respect of the Service Provider's operational procedures under this Agreement to such personnel of the Province as directed by the Province from time to time. As part of the Termination Services, the Service Provider will deliver a revised, up-to-date, detailed and comprehensive operational procedures manual (the "Manual") subject in form and substance to the Province's prior Approval (such approval or disapproval to be provided within 30 days of the Service

Provider's submission of a draft copy which shall be no later than 90 days from the end of the Termination Assistance Period, or such shorter period as required under the Termination Assistance Plan.

(b) The foregoing SharePoint (or other electronic data and document storage application) materials and Manual will describe the procedures associated with the business processes and technology support services that the service Provider undertakes in order to provide the Services. They will also describe the methods of operations and procedures the Service Provider uses to perform the Services such as, network topologies, security administration, system configurations, call centre processes, human resource functions, business processes and associated documentation (including, for example, operations manuals, user support manuals, job scheduling procedures, specifications and updates of such materials) that provides further details of such activities. The Service Provider will include as part of the foregoing SharePoint (or other electronic data and document storage application) materials and Manual current documentation with respect to the systems, business processes, processes in support of the operations and procedures set forth in this Section 6.15 used to deliver the Services (which documentation will be sufficient to enable the Province, or another service provider that is reasonably skilled in the provision of services similar to the Services, to fully assume the provision of the Services). The SharePoint materials (or other electronic data-document storage application) and Manual are intended to describe to the Province how the Services are performed and will in no event be interpreted so as to relieve either Party of any of its performance obligations under this Agreement.

(p) A new Section 6.21 is inserted as the following:

"Commencing after the start date of Contract Year 11, and continuing thereafter during the Term, the Service Provider shall provide to the Province and to the Province Customers and Stakeholders, and the Province shall obtain from the Service Provider, 6,022.5 hours of Services for each of the five (5) Contract Years (the "**Additional Transformation Resources Hours**") for a total of 30,112.5 hours over the Renewal Term to be used in equal monthly amounts in accordance with the presentation titled "Ministry of Health - MAXIMUS Capacity Planning Model Recommendations 6th December, 2007" presented to the Joint Executive Committee meeting on December 11, 2007 (the "**Total Additional Transformation Resources Hours**") to assist with transformation and other activities (the "**Additional Transformation Resources**"), subject to the following:

(a) Additional Transformation Resources shall be provided only at the request and direction of the Province;

(b) any request by the Province to deploy the Additional Transformation Resources will be in accordance with the procedures in Article 7 as if it were an Ordinary Course Change; and

(c) the Fees associated with the Additional Transformational Resources are included in the monthly Fees set out in Table 1, 2 and 3 in Section 9(e) of Schedule I, based on the agreed Long Term Rate.

(q) Section 7.1(i) is deleted in its entirety and replaced with the following:

"no formal documentation requesting such Ordinary Course Change is required and the Province may request such Ordinary Course Change by any form of written notice (including electronic forms of notice) to the Service Provider and Service Provider shall acknowledge receipt of such notice within five (5) Business Days with a written acknowledgment (including electronic forms of response) from the Service Provider, such acknowledgement shall include the Service Provider's estimated date of response and any revisions to the date of response shall be provided to Province on advance of any such revision;"

(r) The third and fourth paragraphs of Section 8.15 are deleted in their entirety and replaced with the following paragraphs:

"Without limiting the generality of the foregoing, the Parties agree that on or before six (6) months from the effective date of Amendment Agreement #4 (or as mutually agreed by the Parties), the Province and the Service Provider shall work collaboratively to define a mutually acceptable methodology, process and cost for measuring the satisfaction of the Province Customers and Stakeholders with Service Provider's performance of the Services (the "**Customer Satisfaction Plan**") including preparing a customer satisfaction survey (the "**Customer Satisfaction Survey**"). The Parties shall jointly conduct an initial Customer Satisfaction Survey pursuant to the Customer Satisfaction Plan, and such survey shall be administered for a minimum evaluation period of twelve (12) consecutive months, in order to establish a set of customer satisfaction metrics.

The results of each Customer Satisfaction Survey shall be reviewed by the Joint Executive Committee. If the results of any Customer Satisfaction Survey indicate a failure or perceived failure to meet applicable Service Levels or a decrease in the level of satisfaction of the Province Customers or Stakeholders in respect of the Services as compared to prior periods or prior surveys, the Service Provider shall, upon the direction of the Joint Executive Committee, within 6 months of receipt of the survey results, design, propose and implement, following consultation with the Province and issuance of applicable Change Requests and Change Orders, a remedial plan to prevent reoccurrence of the problem and to increase satisfaction of the Province Customers and Stakeholders."

(s) In Section 10.15 in the last line of each of the first, second, third and fourth paragraphs, the words "as the same shall be transformed pursuant to the Transformation" are replaced by the following "as the same shall be transformed pursuant to the Transformation Plan, as amended including by Change Order or Service Request".

(t) In Section 13.1, the words "opportunities to leverage the service platform established for the provision of the Services, gaining economies of scale, taking advantage of the knowledge developed by the Parties in the course of their relationship and otherwise capitalizing on opportunities with third parties to bring benefit to the Parties" are replaced with the words "opportunities for the MAXIMUS Group to leverage the service platform

established for its provision of the Services, gaining economies of scale, taking advantage of the knowledge developed by the Parties in the course of their relationship and otherwise capitalizing on opportunities for the MAXIMUS Group with third parties, in a manner which brings benefit to all Parties".

(u) In Section 13.1(a), the words "Where the MAXIMUS Group uses the infrastructure established in respect of this Agreement for other opportunities" are replaced with "Where the MAXIMUS Group uses the infrastructure established by the Service Provider in the course of providing the Services under this Agreement for other opportunities for the MAXIMUS Group".

(v) In Section 16.2(h), the words "incorporated and validly existing under the laws of Nova Scotia" are replaced with the words "incorporated and validly existing under the federal laws of Canada".

(w) In Section 18.4, in the first paragraph, the word ", non-exclusive" is added before the words "license to the same".

(x) In Section 22.1(b), the words ", or as otherwise specified below:" are added after the words "(the "**Termination Assistance Period**"), the Service Provider will provide to the Alternative Service Provider the following in the time frames reasonably requested by the Province".

(y) In Section 22.1(b)(i), the words "within thirty (30) days of delivery of the Termination Notice" are added after the word "Termination Assistance Plan".

(z) In Section 26.12, the number "3.11" is deleted.

(aa) In the following Sections the words "Initial Term or the Renewal Term" and/or "Initial or the Renewal Term" are replaced with the word "Term":

(i) Section 18.3

(ii) Section 22.1(b); and

(iii) Section 22.3.

2. Schedule A to the Agreement is deleted in its entirety and replaced with Schedule A attached hereto.

3. Schedule E to the Agreement is deleted in its entirety and replaced with Schedule E attached hereto.

4. Schedule F to the Agreement is deleted in its entirety and replaced with Schedule F attached hereto.

5. Schedule H to the Agreement is deleted in its entirety and replaced with Schedule H attached hereto.

6. Schedule I to the Agreement is deleted in its entirety and replaced with Schedule I attached hereto.

7. Schedule N to the Agreement is deleted in its entirety and replaced with Schedule N attached hereto.

8. Schedule Q to the Agreement is deleted in its entirety and replaced with Schedule Q attached hereto.

9. Schedule U to the Agreement is deleted in its entirety and replaced with Schedule U attached hereto.

10. Schedule V to the Agreement is deleted in its entirety and replaced with Schedule V attached hereto.

11. Section 1.29(d) of Schedule X to the Agreement is deleted in its entirety and replaced as follows:

> "MAXIMUS CANADA, a federally incorporated corporation, is wholly owned by, and shall at all times during the Term remain wholly owned by MAXIMUS US, unless otherwise Approved by the Province."

12. The Agreement will be read in conjunction with this Amending Agreement and will be regarded as amended, modified, restated and supplemented accordingly. The Agreement and this Amending Agreement will henceforth have effect as if all the provisions of the Agreement and the Amending Agreement were contained in one document.

13. Each of the Parties hereto acknowledges and agrees that the Agreement, as amended by this Amending Agreement, shall be and continue in full force and effect and is hereby confirmed and the provisions, covenants, conditions and obligations contained in the Agreement apply during the Term *mutatis mutandis* and shall not be affected or prejudiced in any manner except as specifically provided for herein.

14. This Amendment Agreement is governed by and will be construed in accordance with the laws of the Province of British Columbia and the laws of Canada applicable therein.

15. The Parties will execute, acknowledge and deliver such instruments and take such other actions as may be reasonably necessary for the purposes of performing and carrying out the purpose and intent of this Amending Agreement and any other agreements provided for or contemplated hereby.

16. This Amendment Agreement may be executed in any number of counterparts, each of which will be deemed to be an original and all of which taken together will be deemed to constitute one and the same instrument.

THE PARTIES have duly executed this Amendment Agreement the 8th day of March, 2013.

SIGNED AND DELIVERED on behalf of the Province by an authorized representative of the Province

Graham Whitmarsh, Deputy Minister

March 8, 2013
Date

SIGNED AND DELIVERED by an authorized signatory of the Service Provider

[R. Duff Lang, President]

March 8, 2013
Date

SCHEDULE A
DEFINITIONS

In this Agreement, unless something in the subject matter or context is inconsistent therewith, the following capitalized terms shall have the meanings set forth below:

"**Acceptance Date**" shall have the meaning given to it in Section 5.5(f).

"**Acceptance Test**" means a test in respect of a Stage using the procedures set out in Section 5.5 and in the Transformation Plan which is to be used by the Province to determine whether the deliverables for such Stage conform with the Transformation Plan and in particular, the Critical Issues.

"**Acceptance Testing**" means the carrying out of tests in respect of each Stage using the procedures set out in Section 5.5 and in the Transformation Plan in order to satisfy the Province that the deliverables for each Stage conform with the Transformation Plan and in particular, that the Critical Issues are adequately addressed.

"**Achieved Service Levels**" in respect of any Service in any measurement period means the standard and level of performance actually achieved by the Service Provider in the provision of that Service in the measurement period in question as determined in accordance with the process set forth in Schedule F.

"**Additional Transformation Resources**" has the meaning given to it in Section 6.21.

"**Additional Transformation Resources Hours**" has the meaning given to it in Section 6.21.

"**Affiliate**" has the meaning given to it in the British Columbia *Business Corporations Act* and in addition, when used with respect to the Service Provider, shall include any member of the MAXIMUS Group and any Affiliate of the MAXIMUS Group.

"**Agreement**" means this Master Services Agreement, all Schedules annexed hereto and all documents incorporated by reference herein including the Proposal, the Transaction Documents and the JSD Agreement, together with all amendments or supplements made in accordance with the provisions hereof.

"**Alternative Service Provider**" means the Province or any Person or Persons designated by the Province, from time to time, as an alternative service provider for any or all of the Services.

"**Amendment Agreement #4**" means the amendment to this Agreement between the Parties dated **[February 1, 2013]**.

"**Annual Operating Plan**" has the meaning given to it in Section 11.6.

"**Applicable Laws**" means all applicable laws, including any statute, regulation or by-law, treaty, directive, rule, requirement, policy having the force of law, order, judgment, injunction, award or decree of any Governmental Authority which is binding on either of the Parties and in effect from time to time or which are applicable to the performance of the Services.

"**Approval**" means, with respect to any document, budget or action to be taken, that such document, budget or action has the prior written approval of the Project Director for the Service Provider or the Executive Contract Manager of the Province, as applicable, or of such other representatives of such Party designated by such Party in writing to have such approval power in respect of all or certain matters relating to this Agreement; and "Approved" has a similar meaning.

"**Arm's Length**" has the meaning given it in the *Income Tax Act* (Canada) and related jurisprudence.

"**Asset Conveyance Agreement**" means the asset conveyance agreement to be entered into between the Parties in accordance with the terms of this Agreement, the current form of which is attached to this Agreement as Schedule L (other than schedules which will be completed during Transition).

"**Assigned Contract**" means a contract entered into between the Province and a third party supplier for the delivery and provision of goods and services in connection with or relating to the Services contemplated in this Agreement and assigned by the Province to the Service Provider pursuant to the Asset Conveyance Agreement, as expressly listed in the Asset Conveyance Agreement, and which Assigned Contract constitutes a Supplier Contract following such assignment.

"**Associated Costs**" means actual direct variable verifiable costs consistent with expense policies approved by the Joint Executive Committee.

"**At Risk Amount**" has the meaning given to it in Schedule F attached hereto.

"**Basic Infrastructure Amount**" has the meaning given to it in Section 25.2.

"**Basic Services**" has the meaning given to it in Section 6.3.

"**BC Court**" has the meaning given to it in Section 17.8.

"**BCGEU**" means the British Columbia Government and Service Employees' Union.

"**BC Government**" means the government of the Province of British Columbia and all ministries and agents from time to time of the government of the Province of British Columbia.

"**BC Services Card Services**" means the services provided in respect of the British Columbia Services Card as described in the BC Services Card Service Request.

"**BC Services Card Service Request**" has the meaning given to it in Section 10 of Schedule I.

"**Benchmarker**" has the meaning given to it in Section 12.9.

"**Benchmarking**" has the meaning given to it in Section 12.9.

"**Brand**" means a word, name, group of letters, symbol, or a combination of words, names, letters, or symbols created and owned by the Province and adopted and used by the Parties to identify the Services to the Province Customers and Stakeholders, and to distinguish the Services from similar services provided by other Persons.

"**Business Day**" means a day other than Saturday, Sunday or a statutory holiday in British Columbia.

"**Change**" means an Ordinary Course Change or a Material Change.

"**Change Order**" has the meaning given to it in Section 7.7.

"**Change Request**" has the meaning given it in Section 7.6.

"**Change Request Procedure**" has the meaning given to it in Section 7.7.

"**CITS**" means British Columbia Common IT Services or successor organizations, which at the effective date of Amendment Agreement #4 was Workplace Technology Services, Shared Services BC.

"**CPI Adjustment**" means adjustment to monthly Fees as set out in Section 9(f) of Schedule I.

"**CPI Adjustment Difference**" has the meaning given to it in Section 9(f) of Schedule I.

"**Claims**" means all losses, damages, expenses, liabilities (whether accrued, actual, contingent, latent or otherwise), claims and demands of whatever nature or kind including, without limitation, all reasonable legal fees and costs.

"**Communications Plan**" means the communications plan attached as Schedule K hereto.

"**Compelled Party**" has the meaning given to it in Section 17.7.

"**Confidential Information**" has the meaning given to it in Section 17.3.

"**Consequential Damages**" has the meaning given to it in Section 19.6.

"**Consistent Failure**" means a continuing failure by the Service Provider to provide the Services to the standards required by the Service Levels, as determined by the Province, acting reasonably (which concept shall, for greater certainty, not apply to the IT Uninterruptible Services for which any failure to provide continuous service shall give rise to a Material Breach by the Service Provider hereunder).

"**Contaminant**" has the meaning given to it in Section 6.7.

"**Contract Year**" means annual periods that correspond with the anniversary dates of the Hand-Over Date, with the first Contract Year commencing on the Hand-Over Date and ending the day immediately prior the first anniversary of the Hand-Over Date.

"**Control**" of a corporation or other entity is held by a Person where securities of the corporation or other entity to which are attached more than 50% of the votes that may be cast to elect directors or persons acting in a similar capacity of the corporation or other entity are held, other than by way of security only, by or for the benefit of such Person; and "Controlled" and "Controlling" have corresponding meanings.

"**Cost-Only Time and Material Rates**" means Labour Costs and Associated Costs.

"**CRA**" means the Canada Revenue Agency.

"**Critical Issues**" has the meaning given to it in Section 5.3.

"**Custody**" means to have physical possession and immediate responsibility for the safe-keeping, preservation and protection of a Record, including, without limitation, responsibility for establishing accession level control, implementing proper storage techniques and environment, providing handling instructions and managing physical access to a Record.

"**Customer Satisfaction Plan**" has the meaning given to it in Section 8.15.

"**Customer Satisfaction Survey**" has the meaning given to it in Section 8.15.

"**Dedicated Contracts**" means contracts of the Service Provider, with third parties, used in connection with the provision of Services.

"**Dedicated Third Person Software**" has the meaning given to it in Section 18.7.

"**Deficiency**" means a material misstatement or misrepresentation by the Service Provider in its reporting or accounting or record keeping pursuant to this Agreement, a material failure to comply with the provisions of this Agreement including the performance of the Services, or where there has been a material failure to comply with GAAP, the applicable Policies, Applicable Laws or any other applicable requirements of regulatory bodies and authorities, fraud, gross negligence or criminal activity.

"**Designated Assets**" has the meaning given to it in Section 22.8(a).

"**Designated Contracts**" has the meaning given to it in Section 22.8(a).

"**Designated Expedited Arbitrator**" means the arbitrator selected from the list of arbitrators set forth in Schedule Q, selecting from the beginning of the list and moving to the end of the list, as such selection is made pursuant to Section 23.3, and as such list set forth in Schedule Q may be amended or updated from time to time by written agreement of the Parties, and where no Persons are available from the list set forth in Schedule Q and the Parties cannot agree upon a Person, such Person as designated by the British Columbia Arbitration and Mediation Institute or its successor organization in British Columbia.

"**Designated Service**" means a Service designated by the Province as being material.

"**Direct Damages Cap**" has the meaning given to it in Section 19.6.

"**Disaster**" means any event or circumstance that adversely affects (or has the potential to adversely affect) the Services or the ability of the Service Provider, its Subcontractors or Suppliers to otherwise comply with the terms of this Agreement or to otherwise operate their businesses, whether within or outside of the control of the Service Provider, including, without limitation, any Force Majeure event, Labour Dispute, natural disaster, sabotage or equipment failure.

"**Disaster Recovery/Business Continuity Plans**" means the plans set forth in Schedule M, as amended and updated from time to time, which details the back up and recovery procedures in the event of a Disaster, including a Force Majeure or a Labour Dispute and which further includes the Termination Assistance Plan, the Uninterruptible Services Plan and business continuity procedures. For greater certainty, the Disaster Recovery/Business Continuity Plans must include the Province's disaster recovery plan and its business continuity plan in effect immediately prior to the Hand Over Date.

"**Disaster Recovery System Test**" has the meaning given to it in Section 6.6(i).

"**Dispute**" means a dispute, claim, questions, difference or disagreement between the Parties arising out of or related to the Services, this Agreement or any breach hereof but expressly excluding disputes under the Trust Agreement which are specifically addressed therein.

"**Dispute Resolution Process**" means the dispute resolution process set out in set forth in Article 23.

"**Documentation**" means the Manual and any other documentation in respect of the Services.

"**DR Unit Test**" has the meaning given to it in Section 6.6(g).

"**Economic Model**" means the specific economic model prepared by MAXIMUS US as part of its preparation for negotiation of this Agreement as represented in electronic EXCEL format as emailed by David Crane to Keith Spencer on November 4, 2004 at 12:13 a.m. and carbon copied to Leslie Wolfe, Darlene Letendre, Matthew Peters, Janet Lucas, James Straney, Guy Weeks, Roger Kuypers, Paul Armitage, Jan Ruff, Kathryn JohnBull, Stephen Martin and Andre Powell, as updated by the fee payment schedule Approved by the Province and Service Provider for the Renewal Term, with the final form of such fee schedule represented in electronic EXCEL format as emailed by Cheryl Slusarchuk to Lindsay Leblanc on February 8th, 2013.

"**Effective Date**" means the date of this Agreement as indicated on page 1 hereof.

"**Employee Transfer Agreement**" means the employee transfer agreement to be entered into between the Parties in accordance with the terms of this Agreement, the current form of which is attached to this Agreement as Schedule L (other than Schedules which will be completed during Transition).

"**Employee Transition Assistance Fund**" has the meaning given to it in the Employee Transfer Agreement (other than schedules which shall be completed during Transition).

"**Event of Insolvency**" means the occurrence of any one of the following events regarding either the Service Provider, any other member of the MAXIMUS Group and of Persons who Control them or are Controlled by them:

a) if such Person:

(i) other than in connection with a bona fide corporate reorganization which does not otherwise contravene this Agreement, is wound up, dissolved, liquidated or has its existence terminated or has any resolution passed therefore or makes a general assignment for the benefit of its creditors or a proposal under Bankruptcy and Insolvency Act (Canada);

(ii) makes an application to the applicable court for a compromise or arrangement under the Companies' Creditors Arrangement Act (Canada); or

(iii) files any written request, application, answer or other document seeking or consenting to any re-organization, arrangement, composition, re-adjustment, liquidation or similar relief for itself under any present or future law relating to bankruptcy, insolvency, or other relief for or against debtors generally, including any notice of intention to make a proposal pursuant to Bankruptcy and Insolvency Act (Canada);

b) if a court of competent jurisdiction enters an order, judgment, or decree against such Person which approves or provides for any reorganization, arrangement, composition, re-adjustment, liquidation, dissolution, winding up, termination or existence, declaration of bankruptcy or insolvency or similar relief with respect to such Person, under any present or future law relating to bankruptcy, insolvency, or other relief for or against debtors generally and such order, judgment, or decree remains unvacated and unstayed for an aggregate period of 60 days (whether or not consecutive) from the date it is made;

c) if any trustee in bankruptcy, receiver, receiver and manager, liquidator or any other officer with similar powers is appointed for or with respect to such Person and that appointment remains in effect for an aggregate period of 60 days (whether or not consecutive) from the date of the appointment; or

d) if an encumbrance or anyone acting on behalf of an encumbrancer takes possession of all or substantially all of the property of such Person and remains in possession for an aggregate period of 60 days (whether or not consecutive) from the first date of the taking of possession.

"**Excluded Losses**" has the meaning given to it in Section 19.6.

"**Expedited Disputes**" means those Disputes which are expressly designated in this Agreement as being Expedited Disputes and therefore resolved in accordance with Section 23.3.

"**Extension**" has the meaning given to it in Section 2.3.

"**External Personnel**" has the meaning given to it in Section 10.6.

"**Fee Rebate Credit**" means the credit to be provided by the Service Provider pursuant to Section 12.5, calculated in accordance with Schedule I.

"**Fees**" means the fees set out in Schedule I (as amended from time to time), or set out in a Change Order or Service Request, payable by the Province to the Service Provider in consideration for the provision of the Services.

"**Financial Guarantee**" means an irrevocable and unconditional financial guarantee of the liabilities and obligations of the Service Provider under this Agreement and the Transaction Documents to be provided by MAXIMUS US in the form attached hereto as Schedule L.

"**Force Majeure**" means the occurrence of an event or circumstance beyond the reasonable control of a Party that interferes with, delays or prevents performance of the obligations of a Party hereunder, provided that (i) the non-performing Party is without fault in causing or failing to prevent such occurrence and (ii) such occurrence cannot be circumvented through the use of commercially reasonable alternative sources, workaround plans or other means (including, with respect to the Service Provider, by the Service Provider meeting its disaster recovery obligations described in this Agreement). Subject to the foregoing, an event of Force Majeure shall include, without limitation, (i) explosions, fires, flood, earthquakes, catastrophic weather conditions or other elements of nature or acts of God, (ii) acts of war (declared or undeclared), acts of terrorism, insurrection, riots, civil disorders, rebellion or sabotage (iii) acts of federal, provincial (other than the Province of British Columbia), local or foreign governmental authorities or courts, (iv) failures or fluctuations in electrical power or telecommunications service or equipment and (v) delays or failures caused by third-party non-performance (except that the Service Provider shall not be excused for delays caused by its Subcontractors or Suppliers unless the event or circumstance is an event of Force Majeure as to such Subcontractor or Supplier). Notwithstanding the foregoing, in no event will any failure to perform solely as a result of a Party's lack of funds or financial ability or capacity to carry on business or as a result of a Labour Dispute affecting such Party or its Subcontractors or Suppliers be deemed an event of Force Majeure.

"**GAAP**" has the meaning given to it in Section 1.5.

"**Governmental Authority**" means any court or governmental department, commission, board, bureau, agency, or instrumentality of Canada, or of any province, state, territory, county, municipality, city, town, or other political jurisdiction whether domestic or foreign and whether now or in the future constituted or existing having or purporting to have jurisdictions over the business that is the subject of the Services or over any party to this Agreement.

"**GST**" means the tax imposed under Part IX of the *Excise Tax Act* (Canada) as the same may from time to time be amended or replaced.

"**Guarantees**" means the Performance Guarantee and Financial Guarantee.

"**Guarantor**" means each of MAXIMUS US and MAXIMUS Canada, in their capacity as guarantors of the obligations and liabilities of the Service Provider under the Transaction Documents pursuant to either the Performance Guarantee and Financial Guarantee, as applicable.

"**Hand-Over Closing**" means the closing scheduled for the Hand-Over Date at which the Transaction Documents shall be executed and the matters therein contemplated and as otherwise contemplated in Section 3.14 shall be completed.

"**Hand Over Credits**" has the meaning given to it in Section 3.13.

"**Hand-Over Date**" means April 1, 2005 or such other date as adjusted pursuant to this Agreement.

"**HBO Negotiation Team**" means Steve Martin, Leslie Wolfe, Bill White, Janet Lucas, Darlene Letendre and Guy Weeks.

"**Impact Assessment**" has the meaning given to it in Section 7.3.

"**Indemnified Party**" has the meaning given to it in Section 19.3(a).

"**Indemnifying Party**" has the meaning given to it in Section 19.3(a).

"**Intellectual Property**" means intellectual property of whatever nature and kind, including all domestic and foreign trademarks, business names, trade names, domain names, trading styles, logos, patents, trade secrets, industrial designs and copyrights, whether registered or unregistered, and all applications for registration renewals, modifications and extensions thereof, and inventions, formulae, product formulations, processes and processing methods, technology and techniques, know-how, trade secrets, research and technical data, studies, finding, algorithms, instructions, guides, manuals and designs, in all cases whether patented and patentable and whether or not fixed in any medium whatsoever and manuals.

"**IT Uninterruptible Services**" has the meaning given to it in Section 24.1.

"**Joint Executive Committee**" has the meaning given to it in Schedule O.

"**Joint Steering Committee**" has the meaning given to it in Schedule O.

"**JSD Agreement**" means the joint solution definition agreement entered into by the Province and MAXIMUS US as signed by the Province on December 2, 2003.

"**JSRFP**" means the joint solution request for proposal (JSRFP #SATP029) dated July 29, 2003 issued by the Province, a copy of which is attached hereto as Schedule P;

"**Key Position**" means those specific positions designated as such in Schedule O.

"**Key Provider**" has the meaning given to it in Section 10.12.

"**Key Role**" means a key staff position set out in Schedule G attached hereto which is critical to the satisfactory delivery of Services as set out in Section 10.9 and "**Key Roles**" means two or more of such Key Roles or all of such Key Roles, as the context may require.

"**Key Subcontract**" has the meaning given to it in Section 10.12.

"**Key Supplier**" has the meaning given to it in Section 10.14.

"**Key Supplier Contract**" has the meaning given to it in Section 10.14.

"**Labour Costs**" means actual direct verifiable labour costs comprised of salary and direct benefit costs, calculated as a daily rate.

"**Labour Dispute**" means a labour dispute, lockout, strike or other industrial action, whether direct or indirect and whether lawful of unlawful.

"**License Termination Date**" has the meaning given to it in Section 18.3.

"**Long Term Rates**" means the long term rates Approved by the Province.

"**Losses**" means the aggregate of any and all claims, proceedings, suits, actions, losses, damages, liabilities, assessments, levies, duties, finds, expenses, judgments, and costs (including legal fees and costs) of every kind and nature.

"**Manual**" has the meaning given to it in Section 6.15(a).

"**Material Adverse Change**" means an event or circumstance that would reasonably be determined to adversely affect a Person's ability to conduct its business (or conduct material portions of its business) in an manner consistent with the way that it has conducted its business prior to such event or circumstance and with respect to either Service Provider, expressly includes any event or circumstance that would reasonably be determined to adversely affect the ability of such Service Provider to provide any material portion of the Services or to otherwise comply with the terms of this Agreement.

"**Material Breach**" has the meaning given to it in Section 21.1.

"**Material Changes**" has the meaning given to it in Section 7.2.

"**Material Subcontractor**" has the meaning given to it in Section 10.11.

"**Material Subcontract**" has the meaning given to it in Sections 10.11 and 10.12.

"**MAXIMUS Canada**" means MAXIMUS Canada Inc., a federally incorporated corporation.

"**MAXIMUS Group**" means MAXIMUS US, MAXIMUS Canada, MAXIMUS Prime and MAXIMUS Sub and their respective Affiliates and related entities.

"**MAXIMUS Prime**" means MAXIMUS BC Health Inc., a corporation incorporated under the laws of British Columbia.

"**MAXIMUS Sub**" means MAXIMUS BC Health Benefit Operations, Inc., a corporation incorporated under the laws of British Columbia

"**MAXIMUS Technology**" has the meaning given to it in Section 10.15.

"**MAXIMUS US**" means MAXIMUS, Inc., a corporation incorporated under the laws of the State of Virginia.

"**Medical Services Plan**" means the Medical Services Plan of British Columbia which offers universal medical coverage to British Columbia residents and is administered by the Province.

"**MFC Pricing**" has the meaning given to it in Section 12.7.

"**Ministry of Health**" or "**Ministry of Health Services**" means the Ministry of Health Services of the Province of British Columbia and any successor thereto.

"**New Records**" means any Record created by the Service Provider in the performance of the Services which contains Province Confidential Information, or other similar types of Records relating to the Services performed by the Service Provider for the Province hereunder including, without limitation, those Records referred to in Section 14.1.

"**No-Fault Trigger**" has the meaning given to it in Section 21.4(a).

"**Non-Compliance**" means a deliverable in respect of the Transformation not being in compliance with the Transformation Plan or that Critical Issues in respect of such deliverable are not adequately addressed, as determined by the Province acting reasonably.

"**Option Exercise Notice**" means a written notice of the Province to the Trustee notifying the Trustee that the Province is exercising its option to acquire the beneficial interest of MAXIMUS Canada in the shares of MAXIMUS Prime pursuant to the Trust Agreement.

"**Order**" has the meaning given to it in Section 9.4.

"**Ordinary Course Changes**" has the meaning given to it in Section 7.1.

"**Organizational Structure**" has the meaning given to it in Section 10.7.

"**Other Uninterruptible Services**" has the meaning given to it in Section 24.1.

"**Overhead Margin**" means 10%.

"**Owned Software**" means Software owned or directly licensed by the Province together with all Intellectual Property rights thereto.

"**Performance Guarantee**" means an irrevocable and unconditional guarantee of the performance and satisfaction of all liabilities and obligations of the Service Provider under this Agreement and under the Transaction Documents to be provided by the MAXIMUS Canada in the form attached hereto as Schedule L.

"**Permitted Material Changes**" has the meaning given to it in Section 7.2.

"**Person**" means any natural person, corporation, division of a corporation, partnership, joint venture (which includes a co-ownership), association, company, estate, unincorporated organization, society, trust, government, agency or Governmental Authority.

"**Personal Information**" means:

a) all information that:

(i) is about an identifiable individual or is defined or deemed as "personal information" or "personal health information" pursuant to any laws or regulations related to privacy or data protection that are applicable to the Province or to the Service Provider (including, without limitation, any information that constitutes "personal information" as such term is defined, from time to time, pursuant to the *Freedom of Information and Protection of Privacy Act* (British Columbia)("**FOIPPA**") or "personal health information" as such term is defined from time to time, pursuant to the *E-Health (Personal Health Information Access and Protection of Privacy) Act* (British Columbia);

(ii) is transferred to, collected or compiled by, or otherwise under the control or custody of the Service Provider; and

(iii) (A) is about Province Customers or members of the public or employees of or consultants to the Province or the Stakeholders, (B) is in the custody or under the control of the Province or of any "public body" (as such term is defined in FOIPPA), or (C) is otherwise held by the Service Provider on behalf of the Province; and

b) all information that is designated by the Province, acting reasonably, as "Personal Information".

"**Personnel**" has the meaning given to it in Section 10.6.

"**PharmaCare Plan**" means the Fair PharmaCare prescription drug program of the Province of British Columbia administered by the Province.

"**Phase-In Date**" means the implementation date for each Phased SLR as set out in Schedule F attached hereto.

"**Pharmanet Modernization Release 2 Change Order**" has the meaning given to it in Section 10 of Schedule I.

"**Pharmanet Services**" means the services provided in respect of PharmaNet as defined in Change Order 10 dated February 14, 2008, as amended from time to time.

"**Phased SLR**" means a Service Level Requirement that will be performed at the level actually achieved by the Province, as more particularly contemplated in Section 8.3, up to the applicable Phase-In Date, and thereafter shall be performed at the level expressly set forth in Schedule F.

"**Policies**" means the policies of the Province from time to time, including without limitation the Province's policies relating to reporting or data and record keeping, but excluding policies regarding human resource management.

"**Preferred Proponent**" is defined as set forth in the JSRFP.

"**Privacy Impact Assessment**" means a review of processes, procedures and practices to ensure that Province Data is collected, managed, stored and protected in accordance with the applicable privacy legislation, policies and commitments (including FOIPPA) and that any changes to a process, procedure, practice or system will not adversely impact the protection of Province Data.

"**Privacy Obligations**" has the meaning given to it in Section 17.1.

"**Problem**" has the meaning given to it in Section 8.10.

"**Project**" means any project started or initiated by the Province relating to the Services.

"**Project Director**" has the meaning given to it in Schedule O.

"**Project Summary Reports**" mean the disclosure reports required by Policy to be prepared by the Province in respect of the provision of the Services.

"**Proponent**" is defined as set forth in the JSRFP.

"**Proposal**" means the all written and oral presentations (to the extent such oral presentations have been recorded in electronic or paper format) made by the MAXIMUS Group to the Province in respect of the JSRFP including the presentation made by MAXIMUS US to the Province on March 4, 2004 during Joint Solution Definition Phase (as defined in the JSRFP), together with all supporting documentation delivered to the Province in connection with the JSRFP.

"**Province**" has the meaning given to it in the first paragraph of this Agreement.

"**Province Customers**" means the Persons who utilize any of the Services, including, without limitation, British Columbia residents enrolled in the Medical Services Plan and/or PharmaCare Plan.

"**Province Data**" means:

(a) all confidential information of or relating to the Province, Province Customers, or Stakeholders other than confidential information that:

(i) is, pursuant to Section 17.6, not obligated to be treated by the Service Provider as confidential;

(ii) relates solely to the internal business processes of the Medical Services Plan or PharmaCare Plans such as financial reports with respect to the Services (but that does not, for greater certainty, constitute any Personal Information); or

(iii) relates solely to the technical specifications or business processes created solely in connection with the Services (but does not, for greater certainty, contain any Personal Information); and

(b) all Personal Information (regardless of whether the Personal Information is also Confidential Information).

"**Province Default**" has the meaning given to it in Section 21.6.

"**Province Intellectual Property**" means (i) all Intellectual Property owned by the Province prior to the Effective Date; (ii) all Intellectual Property created by or for the Service Provider in connection with or arising out of the Services (other than general upgrades that any member of the Service Provider Group makes to Service Provider Intellectual Property that are not specifically done in contemplation of the Services); (iii) all Intellectual Property created by the Province; and (iv) all Intellectual Property created for the Province other than by the Service Provider or its Subcontractors.

"**Province Marks**" has the meaning given to it in Section 18.9.

"**Province Records**" means all Records of the Province to which the Service Provider is given Custody of during the Term along with all New Records including, without limitation, all drawings, payroll related information and related paper files, contracts, personnel information, records and information of the Province Customers and Stakeholders and all data records relating to any of the above information or records in paper or electronic form relating to the business of the Province relevant to the performance of the Services and other transactions contemplated in this Agreement.

"**Province Shared Infrastructure**" means those parts or components of certain Systems owned and operated by the BC Government or on behalf of the BC Government by third party Persons which are required by the Service Provider to support the delivery and performance of the Services, which Systems are shared resources of the BC Government used to support the delivery and performance of the Services as well as to support other services and for other uses by the BC Government, and includes, in particular, the system of servers and applications used by the Province to enable secured web access to the mainframes and Oracle databases of the Ministry of Health Services, as such Systems are described in Schedule J.

"**Province Supplier Contract**" means a contract entered into between the Province (whether or not executed by the Service Provider as an agent for the Province) and a third party supplier for the delivery and provision of goods and services procured and managed by the Services Provider as agent for the Province pursuant to this Agreement and entered into in the ordinary course of business, but not including any Supplier Contract.

"**PST**" means all applicable provincial sales or service taxes payable pursuant to the *Social Services Tax Act* (British Columbia) as the same may from time to time be amended or replaced.

"**Quality Management Plan**" has the meaning given to it in Section 6.13(d).

"**Record Control**" means the power or authority to manage, restrict, regulate or administer the use or disclosure of a Record.

"**Records**" means books, records, reports, documents, maps, drawings, correspondence, system logs, system development records, accounts, invoices, backup data (including original source documents) and other similar documents, images, writings or information by any means whether graphic, electronic, audio, mechanical or otherwise including, without limitation, Province Data where applicable in the context.

"**Relationship Manager**" has the meaning given to it in Schedule O.

"**Renewal Term**" means the 5 (five) year period commencing on April 1, 2015.

"**Retained Employees**" has the meaning given to it in Section 22.7(d).

"**Risk and Controls Review**" means an independent and objective assessment of a system or other subject matter, the purpose of which, in general, is to determine whether the business/system framework has adequate controls to mitigate business or financial, security and general privacy risks. Such assessment will be based on objectives, criteria and principles defined by generally accepted control frameworks and risk management methodology, including, without limitation, ISO/IEC 27002:2005, as revised or replaced from time to time ("**ISO 27002**"),which is intended to be used as the control framework for this Agreement. The resulting report from such assessment is intended to be used to implement additional controls or introduce strategies to manage the remaining risks.

"**Service Centre**" means an operations centre, including call centre, to be established by the Service Provider in Victoria, British Columbia and to be fully operational by the Hand-Over Date from which the Service Provider is to provide all of the Services (subject to written Approval of the Province otherwise) and as more specifically described in Schedule N attached hereto.

"**Service Level Objectives**" means all of the service levels other than the Service Level Requirements as set forth in Schedule E and Schedule F along with service level commitments as otherwise set forth in this Agreement, in any Transaction Agreements, the Proposal and the JSRFP.

"**Service Level Requirements**" means all of the service levels specifically identified as such as set forth in Schedule E and Schedule F.

"**Service Level Credits**" has the meaning given to it in Section 8.14.

"**Service Levels**" means the Service Level Objectives and the Service Level Requirements as may be amended from time to time in accordance with this Agreement.

"**Service Provider**" has the meaning given to it on the first page of this Agreement as further defined in Section 1.12.

"**Service Provider Default**" has the meaning given to it in Section 21.2.

"**Service Provider Group**" has the meaning given to it in Section 10.2.

"**Service Provider Intellectual Property**" means (i) all Intellectual Property owned by the MAXIMUS Group prior to the Effective Date and that is used, or becomes necessary or advisable to use, in connection with the Services; (ii) all Intellectual Property created by or for the MAXIMUS Group other than Province Intellectual Property; and (iii) all Service Provider Software.

"**Service Provider Spread**" means the Spread (as defined in Schedule I) earned by the Service Provider.

"**Service Provider Software**" means Software developed by or for the Service Provider and owned by the MAXIMUS Group which is used by the Service Provider during the course of performing the Services and excluding, for greater certainty, the Owned Software and any Province Intellectual Property.

"**Service Request**" means a service request for work Approved by the Ministry of Health Business Management Office (BMO) or any successor thereto.

"**Services**" has the meaning given to it in Section 6.1.

"**Shared Infrastructure Credit**" has the meaning given to it in Section 25.7(b).

"**Shared Infrastructure Use Period**" has the meaning given to it in Section 25.2.

"**Share Purchase Option**" means the option granted by MAXIMUS Canada to the Province pursuant to the Trust Agreement to acquire beneficial ownership of all of the shares in the capital of MAXIMUS Prime from MAXIMUS Canada upon Termination.

"**Short Term Rates**" mean the short term rates Approved by the Province and reviewed annually by the Parties.

"**Software**" means software applications and computer programs, including all versions thereof, and all related documentation, manuals, and program files, data files, computer related data, field and data definitions and relationships, data definition specifications, data models, program and system logic, program modules, routines, sub-routines, algorithms, program architecture, design concepts, system designs, program structure, sequence and organization, screen displays and report layouts, technology and techniques, object code and interfaces, together with the Intellectual Property rights necessary to operate and use such software applications and computer programs.

"**Source Code**" means the human-readable form of a computer instruction, including related system documentation, applicable comments and procedural codes such as job control language.

"**Source Code Escrow Agreement**" means the source code agreement between the Province, MAXIMUS US and a third party escrow provider providing for the obligation to deposit a current copy of the Service Provider Software with such escrow agent, to maintain the currency of such escrow deposit and to permit and facilitate the release of such escrow deposit to the Province in certain circumstances.

"**Source Materials**" means, in relation to items of Software, supporting materials that would enable a reasonable skilled programmer to compile, debug and support and/or make improvements to such software in a commercially reasonable manner including (i) any Source Code related thereto, reasonably annotated, (ii) technical and system documentation including detailed design, functional, operational, and technical documentation, flow charts, diagrams, file layouts, report layouts, screen layouts, business rules, data and database models and structures, working papers and reasonably related notes and memoranda in electronic or written format, which were made or obtained in relation to the design and development of such software and compilation instructions related to such software, (iii) listing by name, version and vendor of relevant third Persons' compliers, utilities and other software that are necessary for normal operation of such software to which the Source Materials related including sufficient information to procure a license from such vendors, (iv) a reasonably detailed listing of relevant equipment and information necessary for normal operation of such software, and (v) all other information reasonably necessary to rebuild, install, and otherwise implement the Software in the context of the applicable System(s) including, without limitation, all relevant tools, programs, files, encryptions keys, make files, installation instructions, systems settings, and database settings.

"**Spread Margin**" means 7.5%.

"**Stage**" means each stage of the Transformation as set out in the Transformation Plan.

"**Stakeholder**" means any Person that exchanges data with the Province, relies on the Services or has a direct material stake in the delivery of the Services other than Province Customers, including without limitation, group administrators (i.e. employers, unions and pension plans with a minimum of three British Columbia resident members), physicians and other health care practitioners (e.g. pharmacists physician, surgeons, dentists, podiatrists, midwifes or veterinarians) practicing in British Columbia, travel assistance program partners, the Medical Services Commission and its advisory committees, the British Columbia Health Authorities, the Medical and Health Care Services Appeal Board; British Columbia School Boards, Immigration Canada, Canada Customs and Revenue Agency, British Columbia Medical Association and other applicable health care provider associations, College of Physicians and Surgeons of British Columbia and College of Dental Surgeons of British Columbia; College of Pharmacists of British

Columbia, British Columbia Pharmacy Association, Canadian Association of Chain Drug Stores, Office of the Information and Privacy Commission of British Columbia, The Insurance Corporation of British Columbia and the Workers' Compensation Board of British Columbia.

"**Standard Time and Material Rates**" means Associated Costs, Labour Costs and Overhead Margin and Spread Margin calculated on Labour Costs.

"**Subcontract**" means a contract entered into between the Service Provider and a Subcontractor.

"**Subcontractor**" means any third party Person engaged by the Service Provider to perform any of the Services on behalf of the Service Provider.

"**Successful Proponent**" is defined as set forth in the JSRFP.

"**Supplier**" means a third party supplier for the delivery and provision of goods and services relating to or in connection with the Services contemplated by this Agreement pursuant to a Supplier Contract but expressly excluding Subcontractors, and "Suppliers" means two or more of such third party suppliers or all such third party suppliers under all Supplier Contracts collectively, as the context may require.

"**Supplier Contract**" means a contract entered into between the Service Provider and a Supplier.

"**Supplier/Subcontractor Direct Agreement**" means the form of agreement between the Province and Suppliers and Subcontractors as specifically contemplated by Schedule X.

"**Systems**" means the hardware, equipment, software and communications equipment, which is required or otherwise used for the performance of the Services.

"**SysTrust Report**" has the meaning given to it in Section 14.6.

"**Taxes**" mean any and all taxes, fees, levies, or other assessments, including federal, state, local, or foreign income, capital, profits, excise, real or personal property, sales (including PST), withholding, social security, occupation, use, services, value added (and for greater certainty, including GST and PST), license, net worth, payroll, franchise, severance, stamp, transfer, registration, premium, windfall, environmental, customs duties, unemployment, disability, or any similar taxes imposed by any Taxing Authority together with any interest, penalties or additions to tax and additional amounts imposed with respect thereto (including any fee or assessment or other charge in the nature of or in lieu of any tax) in each case, whether imposed by law, contractual agreement or otherwise) and any liability in respect of any tax as a result of being a member of any affiliated, consolidated, combined, unitary or similar group.

"**Taxing Authority**" means any multinational, national, federal, state, provincial, local, municipal or other government (including any governmental agency, branch, department, official, entity, court or other tribunal and any body exercising, or entitled to exercise, any administrative, executive, judicial, legislative, regulatory or taxing authority or power of any nature) responsible for the imposition or collection of any Taxes.

"**Term**" has the meaning given to it in Section 2.1.

"**Termination**" means the expiry or earlier termination of this Agreement pursuant to the provisions of this Agreement, including, without limitation, expiry at the end of the Term (as applicable) and termination pursuant to Section 10.10 or Article 21.

"**Termination Assistance Period**" has the meaning given to it in Section 22.1(b).

"**Termination Assistance Plan**" has the meaning given to it in Section 22.1(c).

"**Termination Date**" means the effective date of the expiration or termination of the Term.

"**Termination for Convenience Fee**" means the fee payable by the Province if the Province terminates this Agreement for convenience pursuant to Section 21.5 calculated and payable as set forth in Schedule I attached hereto.

"**Termination Notice**" means a written notice of termination given by the Province to the Service Provider.

"**Termination Services**" has the meaning given to it in Section 22.1.

"**Third Person Software**" has the meaning given it in Section 22.1(b)(xii).

"**Transaction Documents**" means collectively the Employee Transfer Agreement, the Asset Conveyance Agreement, the Guarantees, the Trust Agreement, and Source Code Escrow Agreement, together with all other documents executed and delivered in connection with or ancillary to such agreements.

"**Transferring Employees**" means the employees of the Province hired by the Service Provider pursuant to the Employee Transfer Agreement.

"**Transformation**" means the orderly transition of the Services from the form of Services contemplated on the Hand-Over Date to the form of Services set out in the Transformation Plan.

"**Transformation Credits**" has the meaning given to it in Section 5.6.

"**Transformation Plan**" has the meaning given to it in Section 5.2 as amended from time to time including by a Change Order or Service Request, payable by the Province to the Service Provider in consideration for the provision of the Services.

"**Transformation Stage Completion Date**" has the meaning given to it in Section 5.6.

"**Transformed Services**" has the meaning given to it in Section 6.4.

"**Transition**" has the meaning given to it in Section 3.1.

"**Transition Management Team**" has the meaning given to it in Section 3.6.

"**Transition Manager**" has the meaning given to it in Schedule O.

"**Transition Period**" means the period of time from November 4, 2004 to the Hand-Over Date.

"**Transition Plan**" has the meaning given to it in Section 3.4.

"**Transition Requirements**" has the meaning given to it in Section 3.12.

"**Transition Services**" has the meaning given to it in Section 3.3.

"**Treasury Board**" has the meaning given to it in Section 26.1(b).

"**Trustee**" means Valiant Trust Company, a trust company wholly owned by the Canadian Western Bank and organized under the *Loan and Trust Corporations Act* (Alberta).

"**Trust Agreement**" has the meaning given to it in Recital K.

"**Uninterruptible Services**" means certain Services which must be provided to certain Province Customers and/or Stakeholders continuously and without interruption throughout the Term on a 24 hour, 7 days a week, 365 days a year basis notwithstanding any event of Force Majeure, as more particularly described in Section 24.1.

"**Uninterruptible Services Plan**" has the meaning given to it in Section 24.1.

"**WIP**" has the meaning given to it in Section 3.10.

"**WIP Plan**" means the plan in respect of WIP as described in Section 3.10 and Schedule H, which will be included in the working Transition Plan to be delivered by the Service Provider to Province.

"**Working Groups**" has the meaning given to it in Schedule O.

SCHEDULE E
DESCRIPTION OF BASIC SERVICES

[See Attached]

SCHEDULE E

DESCRIPTION OF BASIC SERVICES

Service Deliverables, Roles/Responsibilities, Service Outcomes and Reporting

GENERAL RESPONSIBILITIES AND PRINCIPLES:

1. From and after the Hand-Over Date during the Term, the Service Provider will perform the Basic Services described in Sections 1 to 4 of this Schedule. Each Party will be responsible for its designated responsibilities in respect of each Basic Service category as described below (the general description of each Basic Service category being a description of Basic Services as provided by the Province immediately prior to the Hand-Over Date) and for greater certainty, the Service Provider will be responsible for meeting the reporting requirement set out below for each Basic Service category. In respect of the Basic Services described in this Schedule, the Service Provider will meet or exceed the Service Levels referenced in this Schedule and set out in Schedule F to this Agreement.

2. As described in Article 6.2 of this Agreement - Included or Inherent Services of the Master Services Agreement, there are functions or tasks not specifically listed or described in this Schedule that are customarily required for the proper performance and provision of the Basic Services and such functions are inherent or included in the Services. Without limiting the foregoing, such functions or tasks shall be deemed to be implied or included in the scope of the Basic Services to the same extent and in the same manner as if those functions or tasks had been specifically described in this Schedule.

   Basic Services to be delivered include all those business processes carried out by the Province as a part of the Health Benefits Operations, delivered by the Ministry of Health Services prior to April 1, 2004, that have not been designated as out of scope. The tables below identify core business processes that are material, require specific Service Level Requirements or require specific Service Level Objectives.

3. The Province will provide the Service Provider with all relevant existing Policies and precedents and updates on a timely basis and provide policy clarification or interpretation as required.

4. The Province will Approve and be the contracting party in respect of all data/information-sharing agreements. The Service Provider will processes requests in respect of such agreements in accordance with the provisions of this Agreement.

5. The Service Provider will implement and maintain a Quality Assurance Program and Training Plan to ensure the accuracy and quality of work performed by its Personnel as described in Sections 4.9 and 4.11 of the Proposal and Section 6.13 of this Agreement.

6. The Service Provider will develop and maintain the Manual as described in Section 4.10 of the Proposal and Section 6.15 of this Agreement and obtain the Province's Approval for all material amendments.

7. Without limiting the other obligations in respect of data quality and integrity set forth in this Agreement, the Service Provider will implement and maintain commercially reasonable processes to ensure data quality and integrity.

8. The Service Provider will provide and refresh technology to support the functions outlined in this Schedule in the manner described in this Agreement including as described in Schedule J and Article 5 of this Agreement.

9. Without limiting the notification provisions otherwise set forth in the Agreement, the Service Provider will immediately alert the Province of any material service complaints or interruption of Services and of any caller threatening to go to the media or senior government officials.

10. The Service Provider will implement processes to support identification, reporting and investigation of potential fraudulent cases.

11. The Service Provider will notify the Province of material changes to operational procedures or processes.

12. The Service Provider will refer all Ministers, MLA, ombudsman, other politicians and media inquiries to the Province. The Service Provider will assist the Province in responding to those inquiries.

13. The Service Provider will promote and facilitate self service of information whenever reasonably possible.

14. The Service Provider will implement and maintain a thorough administrative review process to respond to all complaints/disputes arising from its responsibilities under this Agreement. The Service Provider will be immediately refer to the Province appeal requests (in accordance with Schedule K of this Agreement) following an administrative review or receipt of health care practitioner claims beyond its authority as identified in this Schedule E. The Service Provider will subsequently implement the Province's decisions related to the referral of such matters.

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DEFINITIONS AND INTERPRETATION:

Capitalized terms used in this Schedule will have the meanings set forth below or, where not defined below, as otherwise defined in this Agreement:

Available Amount" means the total amount of funding available each fiscal year to the Medical Services Commission for medical practitioner fee-for-service claims.

"Clinic" means a physical location at which a group a medical practitioners provide medical services.

"Eligibility" means, in respect of a Medical Services Plan beneficiary or a health care provider, meeting the criteria set out in the *Medicare Protection Acts* and regulations, and, in respect of a PharmaCare Plan beneficiary, being a beneficiary of the Medical Services Plan and meeting the criteria set out for both the Medical Services Plan and the PharmaCare Plan.

"Emergency Payment Program" means the routine creation every payment period of an emergency payment file that is ready to be executed in the case of system failure resulting in the inability to issue payments to medical practitioners, a Force Majeure or a labour disruption. The details of the program are described in the Medical Services Plan's Business Continuation Plan.

"Group Administrators" means employers or pension plan administrators who have applied and been approved by the Province to receive from their employees or members their MSP premium payments and pay those premiums directly to the Ministry of Finance (or any successor thereto).

"Health Authority" means a governing body with responsibilities for the planning, coordination and delivery of regional health services, including hospital, long term care and community services.

"Medical Advisor" means a medical practitioner that provides expert advice to the Province on complex medical claims that have been referred by a claims adjudicator. Each such practitioner is paid on a sessional basis and reports to the Medical Consultant for Medical and Pharmaceutical Services, Ministry of Health Services.

"Medical Advisory Committee" (MAC) means a Ministry of Health Services committee chaired by the Medical Consultant or designate and attended by the Medical Advisors, the Payment Schedule Advisor or designate, the Business Rules Advisor or designate, and the Service Provider's Key Role for complex claims adjudication to review and determine payment of complex medical practitioner claims referred by the Service Provider's claims adjudicators.

"Medical Consultant" means the Medical Practitioner employed by the Ministry of Health Services designated as accountable for issues arising from the Medical Services Commission's Payment Schedule and its related policies and Out of Country Pre-authorizations.

"Medical Payment Issues Committee" (MPIC) means a Ministry of Health Services committee comprised of the Medical Consultant, Payment Schedule Advisor or designate and Business Rules Advisor and/or designate and representative(s) from the Service Provider with expertise in claims adjudication. The purpose of the committee is to review issues where policies or precedent is weak or non-existent and direction from the Province is required. The committee meets twice per month but may meet more frequently, if required.

"MSP" means the Medical Services Plan.

"Operational Records Classification System" (ORCS) means the Province's records retention, storage and disposal policies and procedures.

"Payment Cycle" or **"Payment Period"** means, in respect of pharmacies, the weekly payment cycle used in connection with PharmaCare services, or otherwise, the scheduled MSP monthly payment cycled used in connection with the Services whereby a payment is deposited with the payee on the 15th or closest Business Day and the last Business Day of each month.

"**Payment Schedule**" means the tariff for services and related payment policies described in the Medical Services Commission Payment Schedule for medical practitioners or the tariff for services and related payment policies as negotiated with certain other health care practitioners associations.

"Point Assessment' means the calculation of points for medical isolation, living factors, designated specialities, and road distance for the purpose of determining the premium fee payable under the Rural Retention Program.

"Primary Care" means the alternative payment program for general practitioners as described in Section 2.2 of this schedule.

"Rural Health Program" means the program within the Ministry of Health Services dedicated to providing leadership and support for the delivery of health services in BC's rural communities. Rural Health oversees a number of key programs and initiatives for physicians.

"Rural Retention Program" means the incentive program that provides fee-for-service and flat sum premiums for eligible physicians living and practicing in certain BC communities. This incentive pays doctors additional funds for providing services in eligible rural communities throughout BC.

"**Service Levels Schedule**" means the schedule describing the Service Levels, attached as Schedule F to the Agreement.

"Sessional Payment" means the rate paid to a medical practitioner for each 3.5 hours of work as negotiated between the Province and the British Columbia Medical Association.

"Special Authority" means the granting of full benefit status to a medication that would otherwise be a partial or a limited coverage drug under PharmaCare.

"Specialty Designation" means that a medical practitioner has received certification by the Royal College of Physician and Surgeons of Canada and is so recognized by the College of Physician and Surgeons of British Columbia in a particular medical specialty.

All times and dates set out in this Schedule shall be determined in accordance with Pacific Standard Time or Pacific Daylight Savings Time, as applicable.

SECTION 1 – MSP BENEFICIARY SERVICES

1.1 MSP Beneficiary Registration and Account Maintenance Services

General Description: Includes processing of enrolment applications, qualifying beneficiaries to receive BC Service Card, updating beneficiary account information, assistance with benefit inquiries, processing and assistance with premium assistance applications, enrolment, and verification of income and premium assistance eligibility. Enrolment includes a 3-month waiting period to meet the BC residency requirement. Under limited circumstances, the Medical Services Commission may waive the required wait period.
MSP determines eligibility for coverage and enrols individuals, establishes the contract and sets the premium rate; the Ministry of Finance (or any successor thereto) is responsible for the billing and collection of premiums and the temporary premium assistance program. This partnership results in a number of dependencies and linkages between the two organizations. There are some shared systems and processes such as the billing component of the registration database, document management, bill messages, client services etc. Self-service options are available for Group Administrators permitting them to electronically add new and cancel dependents, address changes, cancel accounts, etc. MSP also exchanges registration information with other provinces and territories on residents that have moved to another province.
As of the cutover to the BC Services Card, the Ministry of Health will be a partner in an integrated program to issue BC Services Cards to MSP beneficiaries. Under the integrated program, MSP will be responsible for processes related to the management of non-photo cards, and for confirming MSP eligibility to ICBC prior to the issuance of a BC Services Card. ICBC will be responsible for in-person registration and identity-proofing services for photo BC Services Cards, and BC Services Card production and distribution. This partnership results in shared interfaces between ICBC and the Service Provider for real-time interactions and file transfers.

Responsibilities:

Province	Service Provider
Ministry of Health (MoHS): • Sets all policies • Reviews performance reports • Determines eligibility criteria for enrolment and premium rates • Advises Service Provider of various policy waivers, e.g. wait periods • Manages Memorandum of Understanding (MOU) with Canada Revenue Agency (CRA) • Approves any required changes by CRA • Adjudicates requests for waivers, e.g. wait periods • Conducts residency and identity investigations to ensure beneficiary eligibility • Prepares case briefs and conducts Eligibility Appeals	• Adheres to policies and standards set by the Province • Processes enrolment applications and assigns appropriate premium rates • Manages the de-enrolment and opting out processes • Processes relevant updates to beneficiary information, • Processes premium assistance applications • Administers self service options available to Group Administrators • Implements strategies to increase the number of Group Administrators using self service options • Identifies and implements self-service options for the general public • Follows appropriate authentication guidelines for self-service

Province	Service Provider
• Sets standards, e.g. authentication for self-service options • Reviews and investigates suspected fraud cases submitted by the Service Provider • Determines and revises data access requirements and provides to the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule, as amended from time to time. Ministry of Finance (or any successor thereto): • Bills and collects premiums • Manages billing component of Registration and Premium billing database	options • Corrects errors and processes exceptions resulting from automated processes • Processes decisions from Eligibility appeals • Prepares and processes inter-provincial reciprocal information exchanges • Produces and issues new and replacement CareCards (up to the cutover to the BC Services Card) • Exchanges information with the Canada Revenue Agency (CRA) and verifies and/or adjusts that information • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA • Administers interfaces and processes shared with FIN, and other agencies and provincial health care plans related to beneficiary services. For example, as a result of a collections activity, FIN may be advised of an out of province move or a request for premium assistance. The case is referred to Beneficiary Services for processing. • Notifies the Province of material changes to operational procedures or processes • Responds to requests from beneficiaries for general program and account information • Maintains a quality assurance program to ensure document processing accuracy • Administers Group Administrator registration and account update processes • Maintains and regularly updates databases necessary to support beneficiary services functions • Identifies and implements processes to ensure regulation integrity • Supports the identification, reporting and investigation of potential fraudulent cases • Responds to requests for information from the Province and its designated Stakeholders

Province	Service Provider

	• Registers and manages Disclosure Directive documents and calls on behalf of MoH
	• Verifies Premium Assistance information for Ground Patient Transfer files
	• As of cutover to BC Services Card:
	  ○ Qualifies beneficiaries to receive BC Services Card
	  ○ Manages re-enrolment process including re-enrolment notifications and administering modified and exemption processes
	  ○ Receives and exchanges information with ICBC as it pertains to the BC Services Card
	  ○ Responds to enquiries from beneficiaries and resolves failed photo card qualification checks during in-person registration Manages card status information for all BC Services Cards produced
	  ○ Processes requests for replacement and duplicate non-photo cards
	  ○ Manages return of non-photo cards or cancellation, as applicable
	  ○ Administers processes and interfaces shared with ICBC

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 3, 4, 6 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on inventory and document processing time by document category for enrolment applications, premium assistance applications, and account maintenance requests. • Reports monthly results within quarterly Quality Assurance (QA) reviews • As of cutover to BC Services Card: ○ Reports monthly on benefits evaluation and program management indicators to support BC Services Card, as set out in BCSC Project Functional Specification documentation.

1.2 MSP Beneficiary Telephone Inquiry Service

General Description: Includes providing telephone access to the general public and a variety of internal and external Stakeholders.

Responsibilities:

Province	Service Provider
• Reviews performance reports • Provides, as required, information on new policies or legislation and responds to requests for policy interpretation/ clarification in a timely manner	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday, except statutory holidays, to respond to all calls from the general public and provides dedicated high priority telephone support for Group Administrators, FIN and agents of the Province (such as ICBC and Service BC following the cutover to the BC Services Card) • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting

Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 43 and 44 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports monthly results within quarterly QA reviews • Reports quarterly on potential policy improvements identified • Reports on results of periodic customer satisfaction surveys.

1.3 MSP Beneficiary Telephone Self Service

General Description: A variety of services are made available to callers such as, account balance, supplementary benefit information, etc.

Responsibilities:

Province	Service Provider
• Reviews and approves scripts • Review performance reports	• Maintains or enhances the current suite of services available

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
None.	• Reports monthly on uptake, abandonment and success rates Reports monthly on number of transfers for information available on Telephone Self Service

1.4 MSP Beneficiary Travel Assistance Program Self Service

General Description: Automated service for travel assistance. The Province provides the approval and supporting administration. Private and public travel partners provide travel discounts.

Responsibilities:

Province	Service Provider
• Sets the eligibility criteria • Determines edit rules for automated processing • Manages the relationship with the travel partners • Reviews performance reports	• Administers the automated service in accordance with the criteria established • Conducts annual compliance review using the claims data to validate to travel to obtain medical services

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See item 24 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on approvals, denials, location of patient, location of service, type of physician seen and mode of travel • Reports on annual compliance review outcomes

1.5 MSP Beneficiary Travel Assistance Program – CSR support

General Description: Requests unable to be processed by the automated service are directed to a Client Service Representative for handling.

Responsibilities:

Province	Service Provider
• Sets the eligibility criteria • Manages the relationship with the travel partners • Reviews performance reports	• Processes requests according to established criteria • Responds to general inquiries on the Travel Assistance Program • Maintains a quality assurance program to ensure high quality client service and the accuracy of the decisions

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objective:** See item 5 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on approvals, denials, location of patient, location of service, type of physician seen and mode of travel • Reports monthly results within quarterly QA reviews

SECTION 2 – MSP PROVIDERS SERVICES

2.1 MSP Provider Registration and maintenance of the Provider Information Database

General Description: Includes registration services for all eligible health care providers, health care facilities, allied health care providers supporting Primary Care, processing a variety of applications forms such as assignment of payment, direct bank deposit, etc. and maintaining the accuracy of practitioners profiles such as specialty designations, practice status, etc. The Province is also legally obligated to process certain third party demands, such as garnishees from the Receiver General of Canada, Family Maintenance Program, etc.

Responsibilities:

Province	Service Provider
• Creates and communicates related policies • Provides, as required, policy interpretations/clarifications • Reviews performance reports • Determines and revises data access requirements and provides to the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule, as amended from time to time. • Approves content of information workshops for graduating physicians	• Processes registration applications • Assigns new registrants practitioner and payments numbers • Processes applications for electronic billing • Attends resident days to provide information workshops for graduating physicians on registration procedures, billing procedures for incentive programs, etc. • Processes all relevant practitioner information updates such as address changes, specialty designation, assignment forms, direct deposit applications, practice status, third party demands, etc. • Processes requests for additional payments numbers

Province	Service Provider
	• Processes requests to opt out of MSP • Maintains an accurate and up to date practitioner information database • Manages all information interfaces with internal and external parties to ensure current and accurate practitioner information required for the proper processing of claims • Provides information as requested in accordance with data access agreements • Maintains a quality assurance program to ensure the accuracy of document processing

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 1(a) set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly volumes, Service Levels and inventories by type of activity. • Reports monthly results within quarterly QA reviews

2.2 MSP Non-Fee for Service Payments

General Description: MSP operational responsibilities include administration of a number of services on behalf of other programs delivered by the Province such as a rural locum program, rural retention program, provides 1st level technical support to the Primary Care Program, Northern Isolation and Travel Assistance Outreach Program (NITAOP), etc. The MSP Provider Payment System is also used to process bulk payments to British Columbia Health Authorities.

The Rural GP Locum Program assists General Practitioners (GPs) in small rural communities, with seven or fewer physicians, to obtain locums for up to 43 days per year (dependent on the community rurality) for vacation relief and Continuing Medical Education (CME) purposes. Locums are paid by the program and receive travel honorarium and guaranteed daily rate. Host physicians retain 40% of the MSP paid claims to cover overhead and 60% is recovered by the Program up to the guaranteed daily rate. A locum is hired as an independent contractor.

The Rural Specialist Locum Program assists core specialists in designated rural communities to obtain locums for up to 35 days per year for vacation relief and Continuing Medical Education (CME) purposes. Locums are paid by the program and receive a travel honorarium and guaranteed daily

rate. For office based locum assignments, host physicians retain 40% of the MSP paid claims to cover overhead. For hospital based (on-call) locum assignments, there is no overhead component and 100% is recovered by the program up to the guaranteed daily rate.

The Northern and Isolation Travel Assistance Outreach Program (NITAOP) provides funding for travel and travel time for visiting specialists, family doctors, and general practitioners who deliver medical services in eligible rural communities. The Joint Standing Committee on Rural Issues determines annually the number of funded visits per community. The NITA component for specialist travel expenses is funded from the Available Amount. BC's regional health authorities submit yearly funding requests to Rural Health . Once approved, visiting physicians are contacted and outreach visits are organized. Visiting physicians are reimbursed directly under this program, upon submitting the application for expenses.

The Rural Retention Program (RRP) provides fee-for-service and flat fee premiums for eligible physicians living and practicing in certain BC communities. This incentive pays doctors additional funds for providing services in eligible rural communities throughout BC.

Primary Health Care Program is an alternative incentive program, where funding is calculated on the Primary Health Care Practice's expected annual funding based on the needs-adjusted classification of its registered patients. The Practice's population-based funding level is re-calculated quarterly to adjust for changes in the size of the patient register, changes in patient acuity, and changes in patient outflows. Fee-for-service payments continue under MSP's current funding rules for non-core services and services to unregistered patients, and payments, included funding adjustments, are dispersed semi-monthly.

Medical Advisors are hired to assist the Province with complex claims unable to be processed by the Service Provider. The external physicians are paid on a sessional basis (3.5 hours per session) and are compensated for the travel expenses. Invoices are approved by the Province and forwarded to the Service Provider for payment.

Responsibilities:

Province	Service Provider
General: • Overall responsibility for all program administration • Primary contact for all inquiries related to these programs • Provides policy and interpretation • Reviews performance reports **Health Authority Bulk Payments:** • Provides Service Provider with written request of amount of bulk payment or adjustments to be made **Rural Locum Program:**	**Health Authority Bulk Payments:** • Processes, tracks and reports on bulk payments to Health Authorities and certain alternative payment functions **Rural Locum Program:** • Informs physicians of billing procedures • Processes assignment of payment forms • Updates Practitioner Information file with payment adjustments • Calculates and processes payment of daily rate and top-up. • Processes travel expenses • Initiates system recovery of fee for service claims paid in error at 100%

Province	Service Provider
• Manages all locum contracts • Manages all aspects of the locum recruitment process including, without limitation, processing locum applications (including arranging interviews, sending out contracts, verifying billing numbers, etc.) • Manages the locum coverage request administration, including, without limitation, processing requests for a locum and arranging work assignments (including contacting both the locum and host physician, sending confirmation information, etc.) • Forwards to Service Provider case files and related documents to complete transaction to facilitate payment • Produces the Rural GP and Specialist Locum Program Financial Summary Report **NITAOP:** • Provides Service Provider with approved applications for travel expenses **Rural Retention Program:** • Coordinates with Health Authorities and Clinics the amount, distribution and calculation of Rural Retention Premium and on call premiums **Primary Care Program:** • Provides the necessary data through system interfaces for patient Register maintenance and Primary Health Care payment calculations • Resolves complex technical issues referred by the Service Provider • Approves new sites for registration **Medical Advisor Sessional Payments** • Approves on sessional payments and travel expenses and provides invoice to Services Provider	• Tracks and reports on payments • Maintains a quality assurance program to ensure compliance with Province policies and procedures and accuracy of processing **NITAOP:** • Processes approved applications for travel expenses • Maintains and monitors the travel budget for the program • Initiates refusal letters or explanation of payment to providers denied access to the funds • All costs are entered into spreadsheet per Health Authority, Community and Specialty • Maintains a quality assurance program to ensure compliance with Province policies and procedures and accuracy of processing **Rural Retention Program:** • Update claims payment system tables, which contain the community Point Assessment. • Processes payment advances, if necessary **Primary Care Program:** • Provides the technical infrastructure for electronic FFS and encounter claim processing, including retroactive fee-for-service/encounter swaps • Provides the processes to maintain patient registers **[NTD: BMO is following up with Primary Care with regard to this item.]** • Processes payee status changes • Maintains Primary Care encounter service codes • Assigns practitioner numbers to physicians and nursing and allied health professionals • Provides first level technical help desk support for the Primary Care sites by monitoring refusals, establishing Teleplan web accounts for submission of patient services encounters, assisting providers who bill third party claims such as WCB or ICBC and responding to general inquiries

Province	Service Provider
	• Refers complex technical issues unable to be resolved by the help desk to the Province for resolution • Processes practice advance and adjustment payments (level 2 adjustments) and whenever there are problems with automated adjustment updates to payment details recorded on the practitioner information file, processes manual cheque requisitions to providers **Medical Advisor Sessional Payments** • Process approved sessional payments and travel expenses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See item 26 set out in the table in Paragraph 4 of the Service Levels Schedule (Schedule F) **Service Level Objectives:** See item 7 set out in the table in Paragraph 5 of the Service Levels Schedule.	**Rural G.P. Locum Program** • Reports each payment period on total expenditures by community, by locum practitioner, by host physician, by days • Reports each payment cycle on monies recovered for services provided by locum in host physicians office (60/40 split). Reported by community, by payee, by locum physician and by host physician • Reports monthly results within quarterly QA reviews **NITAOP** • Reports each payment cycle the total fiscal expenditures by HA, by community, by specialty, by practitioner to date • Reports each payment cycle the total fiscal expenditures by applicable adjustment codes to date • Reports monthly results within quarterly QA reviews **Rural Specialist Locum Program** • Reports each payment cycle on monies recovered at 100 % for fee for service provided by locum physicians for providing on-call in

	hospital. Reported by community, by payee, by physician, by host physician payee number and name • Reports each payment cycle on monies recovered for services provided by specialty locum in host physicians office (60/40) split. Reported by community, by payee, by locum physician, by host physician • Reports monthly on QA reviews **Medical Advisor Sessional Payments** • Reports monthly on sessional payments and travel expenses by medical advisor • Measures processing of payment requests on a complaint basis and retains records for audit • Measures payment of Medical Advisor sessional and travel expenses on a complaint basis and retains records for audit • Reports monthly on processing of rural health correspondence

2.3 MSP Provider Electronic Claims Submission and Payment System

General Description: MSP operational responsibilities include administration of the mandatory electronic claims billing and payment/reconciliation system that links BC's medical and health care practitioners to MSP. There are limited exceptions to electronic claims submission by enrolled health care practitioners requiring on line claim for submission. The electronic billing system employs a DOS based (which is being phased out) and a Web based submission channel, program specific authentication process, nightly claims edits, nightly returns claims failing the edits, twice monthly rules based adjudication and payment systems, the fee item utilization program, a remittance and broadcast message program and provides a variety of downloadable electronic files. Many of the subsystems have published software specifications. Payment cycle follows a specified processing schedule dependent on the Office of Comptroller General and their primary financial institution. In the case of failure to meet the cycle payment, there is an emergency payment program.

The Claims system is also dependent on multiple databases such as the practitioner information file, the diagnostic facility database, the fee schedule master, etc., and has responsibilities to additional systems.

Claims payment policies require 18 months claims history to be available in the adjudication process. In addition, HIBC Maintains 7 years + current claims history for information requests made by ICBC or through court orders.

Changes to the electronic claims systems that impact physicians are subject to terms and conditions set out in the negotiated agreement with the British Columbia Medical Association (BCMA) and the Province.

The Claims systems also process third party claims such as WCB, ICBC, Primary Care encounter records, etc.

Responsibilities:

Province	Service Provider
• Sets the policies, claims submission format, required claims data elements, and payment schedules • Initiates reviews and approves all remittance broadcast messages • Participates on the Medical Software Vendors Association/Ministry (MSVA) Liaison Committee. The purpose of the committee is to deal with operational issues and share information on future changes • Approves specifications for on line claim forms • Approves potential new third parties interested in using the MSP system • Includes the partner in planning of future initiatives • Set the criteria for the emergency payment program and approves if implementation is required • Approves requirements for material changes to the functionality of the processing system • Review performance reports	• Administers the mandatory electronic claims billing and payment systems and all related sub systems and interfaces • Creates and provides the twice monthly data file to be used by the Ministry of Finance (or any successor thereto) to issue payments to physicians, health care practitioners and beneficiaries • Administers the inter-provincial reciprocal billing and payment processes • Processes claims from Practitioners who submit by mail using the HIBC downloadable "Fill, Print and Mail" format for: o Correctional facilities claims o Dental claims o Reciprocal claims o Claims for patients covered under the Critical Care Coverage Program • Maintains the electronic billing (Teleplan) specifications and ensures all new software vendors are compliant • Ensures the accuracy and relevance of all automated business rules • Maintains accurate and current system documentation • Notifies the Province of any material technical problems • Seeks approval from the Province if there is a potential requirement to implement the emergency payment program • Provides the same or similar level of functionality as the current processing system • Seeks approval from the Province if system changes or modification materially alters the functionality of the processing system

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 19 and 22 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 8 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on % claims processed through automated rules • Reports on number and type of change requests from Province for payment schedule amendments or business rule changes, and system improvement requests • Reports quarterly on QA reviews • Reports annual availability on contract year basis • Reports monthly on restoration after fail over • Reports monthly on restoration after service interruption • Reports on a complaint basis on processing of paper claims • Reports monthly on processing of remaining documents

General Description: The claims processing system employs thousands of automated business rules resulting in approximately 98.5% of claims being automatically processed. These business rules represent legislative requirements, conditions set out in negotiated agreements, Payment Schedule policies and precedent established.

The budgets for medical and health care provider claims are capped and operations is responsible to ensure claims are accurately submitted and paid.

Medical providers and when required, software vendors, are provided "advanced notice" when business rules are modified resulting in a change to how a claim is paid or when claim submission requirements change.

Responsibilities:

Province	Service Provider
• Sets the payment policies • Approves all additions and changes to the automated business rules within 10 Business Days of receipt from Service Provider • Provides policy interpretation/ clarification as required • Approves all communications related to business rules changes or claims submission requirements within 3 Business Days of receipt or earlier if urgent • Reviews performance reports • Develops communication material to providers on rule changes which is usually sent by HIBC via broadcast message • Initiates most changes to the automated business rules • Approves test results • Prioritizes the implementation of the automated business rules • Initiates or approves new or changed explanatory codes	• Routinely analyzes claims requiring manual adjudication for automated rule development and existing rules for efficiency and accuracy • Recommends new automated business rules or modifications to existing rules to the Province and provides a development and implementation plan • Codes, user tests for desired outcome and implements new or modified business rules approved by the Province • May initiate/request/develop communication material to providers on rule changes – subject to MOH approval • Notifies the Province when material complaints are received about the accuracy of the automated rules • Provides MOH with an updated copy of the claims business rules when changes have been made.

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 12 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 9 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports on business rule implementation at time of completion; updates on status provided twice monthly. • Reports per payment cycle on number of exceptions/rejects from rules by type of claim and reject reason as a percentage of total claims processed. To be combined with reports required for manual adjudication • Reports per payment cycle on total number and value of claims by type of specialty processed through automated system. To be combined with reports required for manual adjudication • Reports per payment cycle on payments aged greater than 60 days from date of receipt and number and value of claims pending processing

2.5 MSP Provider Manual In-province claims adjudication – including reciprocal and third party claims

General Description: The adjudication program is comprised of several subprograms containing thousands of automated business rules processing approximately 98.5% of all claims. Claims failing those business rules require manual intervention by trained adjudication staff.

Rejections can occur because of the complexity of the claim, discrepancies in practitioner claims, input errors, changes in the Payment Schedule, misunderstanding by practitioner of billing processes, conflict with another insurer claim etc. Independent judgment in decision-making may be required. Requires significant training and expertise.

Disputed payments are entitled to administrative review. Claims can be re-submitted electronically with additional supporting information or a written appeal may be sent.

Payment disputes, issues that are unclear or where no policy interpretation exits are referred to formal advisory committees such as the Medical Advisory Committee (MAC) and the Medical Payment Issues Committee (MPIC). If payment decision is upheld, the physician can appeal to the BCMA Reference Committee. For policy disputes, cases are referred to either the BCMA Tariff Committee or the Medical Services Commission. Interest is payable after 60 days on all correctly submitted claims.

In some cases, the adjudicator may be required to request various reports such as operative and consultation reports from physicians to properly adjudicate a claim.

Responsibilities:

Province	Service Provider
• Sets the Payment Schedules and associated payment rules • Governance responsibility for the relationship with the various Practitioner Associations such as the British Columbia Medical Association (BCMA) with respect to Payment Schedule policy and administration • Chairs the formal advisory committees with appropriate Service Provider representation. The purpose of such committees is to provide policy direction and clarification/interpretation on existing business rules • Adjudicates claims referred by the Service Provider where no policy exists, billed under miscellaneous fees where no Payment Schedule listing exists or disputes to outcomes of the administrative review process. Develops a mechanism to transfer knowledge of decisions by medical advisors to adjudicators when	• Adjudicates claims in accordance with established policy or precedent • Prepares case files and refers complex claims requiring a clinical assessment to a Province's medical advisor for adjudication • Tracks and monitors the appropriateness of claims referred by adjudicators to a medical advisor • Makes requests for supporting documentation from practitioners such as operative reports when required to properly adjudicate a complex claim • Implements new or amended policies as directed by the Province • Implements an administrative review process • Prepares necessary documentation and refers all claims where policies or precedent is weak or non-existent including miscellaneous fees to the appropriate advisory committee.

Province	Service Provider
appropriate • Approves the content of the adjudication-training program • Approves all communications related to Payment Schedule changes, new or amended policies and educational material • Conducts reviews on decisions on an "as and when required basis" to validate and test the training and quality assurance programs • Reviews performance reports	Participates on all such committees • Conducts regular analysis of claims failing the automated business rules in order to determine opportunities for further automation and/or opportunities to educate practitioners on proper billing practices • Develops and administers an adjudication training program which includes medical terminology, and quality assurance program to ensure claims adjudicators' decisions are complying with Province Policies and procedures • Prepares background material to support the Province in adjudicating referred claims or disputed payments. Implements Province decisions. • Notifies the Province on emerging trends or suspicious billing practices

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See item 26 set out in the table in Paragraph 4 of the Service Levels Schedule. See item 13 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 10 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports every payment period on % of manual claims processed by claim type and processing outcome. Report to also include number and type of claims in the backlog and interest payments by payment period • Reports monthly on the number and type of recommendations for automated rule development, cases referred to the Province • Reports monthly on number of cases pending and average processing time • Reports monthly on the QA reviews

2.6 MSP Provider Manual Out of Country travel claims adjudication

General Description: The Province through the MSP reimburses beneficiaries for insured medical services obtained while temporarily traveling outside of Canada. Reimbursement is made up to the rate that would be payable if services were provided in BC. Hospital per diem is reimbursed at

a fixed daily rate set by the Province. Often reimbursement is less than 10% of the total bill. Peak time for claim submission currently is March, April and May of each year.
Although MSP is the primary insurer for medical required physician services, there currently are 21 agreements with extended health insurers. The agreements permit the extend health carrier to reimburse the patient directly and then seek reimbursement from the Province for its portion of the claim. Claims are adjudicated against BC Physician Payment Schedule and subject to the same payment rules as in province claims.
There is no official appeal process; however, there is an administrative review process.
Repeated/frequent/unusual requests for reimbursement from individuals or families are monitored for patterns that may flag a residency issue or a fraudulent claim pattern.

Responsibilities:

Province	Service Provider
• Sets the policy and payment schedules • Reviews performance reports • Provides policy interpretation/clarification as required • Approves changes to the claim form and brochure	• Processes all claims received directly from beneficiaries or indirectly through extended health insurers • Enters claim details into an online system to create payment and update patient claims history record • Provides beneficiary with a written notice of payment • Implements an administrative review process • Responds to general inquiries regarding benefits and claim status • Maintains a quality assurance program to ensure claims adjudicators' decisions are complying with Province policies and procedures and to ensure the quality of written responses. Participates, on an as required basis, at external information workshops • Prints and makes available the necessary claim forms and brochures • Recommends changes to claims forms or brochures • Implement mechanism to identify potential fraud cases, prepares case files and notifies Province of suspected fraud • Monitors patterns of claims to identify any potential residency issues and notifies Province of suspected cases

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement:	• Reports monthly on number of claims and amounts reimbursed by medical and hospital claim type and location of service

See items 14(a) and 26 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 11 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly results within quarterly QA reviews

2.7 MSP Provider Out of Province/Country Pre-authorizations

General Description: Out of Country medical treatment may be a benefit only when appropriate and acceptable services are not available in Canada. Each case is adjudicated on its own merits. Applications are submitted by the specialist involved in the patient's care and provincial coverage is adjudicated by the Province's Medical Consultant. Approved requests are paid at the usual and customary rate.
In addition to the usual provision of an administrative review process, applicants of denied requests are provided with an opportunity for their case to be heard before a panel of the Medical Services Commission (MSC).

Responsibilities:

Province	Service Provider
• Sets the policy and adjudicates all applications • Provides direction when additional information is required to make decision • Provides policy interpretation/clarification as required • Prepares briefing file and presents file to the panel of the MSC • Approves any changes to out-of-country application form. • Reviews performance reports • Adjudicates and advises the Service Provider of decision within 5 Business Days unless the case urgent then decision made within 2 Business Days	• Reviews the request to ensure all required information has been submitted • Requests additional information on incomplete applications which may include requesting an expert opinion from one of the Province's Centres of Excellence, e.g. Cancer Agency • Prepares case file for referral to the Province • Enters details of request on tracking system and monitors cases • Drafts and mails response letter on behalf of the Province • Enters decision outcome on tracking system • Responds to enquiries on benefit coverage and case status • Negotiates a reduced fee on approved cases • Processes payments in Canadian funds when claims received and drafts associated letter • Prepares all background required for the Province's Medical Consultant to prepare briefing file for hearing or to respond to

Province	Service Provider
	inquiries from media, politicians etc • Attends hearing to provide technical support, if required • Providing ad hoc reports as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 12 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of applications received, number approved and denied and number of cases pending

2.8 MSP Provider Pre-authorizations (In Province)

General Description: Cosmetic procedures are not benefits under the Medical Services Plan. Occasionally, a cosmetic type procedure is used to remedy a medical condition. This service would be a benefit but requires pre-approval.

Adjudication rules are defined for the majority of procedures. However, due to the complexity of some requests, adjudication may be required by a medical advisor. Individual decisions can set precedent. Infrequently, obtaining pre-approval is not possible. Retroactive approval may be granted under limited circumstances.

There is no formal appeal process but an administrative review process is available on denied applications.

Responsibilities:

Province	Service Provider
• Determines the policy and provides, as required, policy clarification/interpretation • Adjudicates appeals referred by the Service Provider within 15 Business Days of receipt • Reviews performance reports	• Processes routine requests where there are policies or established precedent and advises applicant of decision. Updates the online system with adjudication outcome to enable automated processing • Refers complex requests to a Province medical advisor for adjudication • Provides an administrative review process for appeals on denied claims. Refers appeals on a negative administrative review to the

Province	Service Provider
	Province • Implements Province decisions on appeals and notifies the applicant • Notifies the Province of repeated suspected inappropriate requests

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 26 set out in the table in Paragraph 4 of the Service Levels Schedule	• Reports monthly results within quarterly QA reviews

2.9 MSP Provider Retroactive Payment Adjustments

General Description: Retroactive payment adjustments are occasionally required when changes to payment rates are negotiated or approved with a retroactive effective date.

Practitioners and when applicable, software vendors, are provided with an advance electronic notice as to when the retroactive adjustment will be issued.

Requires the capability and capacity to extract millions of paid records and calculate and apply a single or variety % increases to specified paid claims.

Responsibilities:

Province	Service Provider
• Provides direction on the payment rate changes and effective dates • Consults with the Service Provider on the implementation strategy and approves the timelines for issuing the payment adjustment • Approves the communication regarding the adjustment within 2 Business Days	• Analyzes the effort required to implement the adjustment and advises on the implementation strategy • Processes the retroactive payment including updating the payment schedule database and all impacted paid claim records with the retroactive amount • Validates with the Province the total value of the retroactive adjustment before implementation

Province	Service Provider
• Drafts the electronic communication to providers and software vendors as required	

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 14 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports promptly on the final total adjustment amount of the retroactive payment

2.10 MSP Provider Online Payment Schedule Amendments

General Description: Operations is required to implement amendments to the various online practitioner payment schedules used in the processing of claims.

Amendments can range for a payment rate change to a single item, modification of a fee item attribute, implementation of a new fee item to implementing a new payment schedule for a specialty or across the board payment rate changes.

Practitioners and when applicable, software vendors, are provided with an advance electronic notice of amendments.

Responsibilities:

Province	Service Provider
• Advises of amendments in writing • Consults with the Service Provider on medium to large volume and medium to high impact changes to determine implementation strategy and timelines • Provides clarification/interpretation as required • Drafts/approves communications to practitioners/vendors/ other stakeholders	• Updates the online Payment Schedule with amendment(s) • On medium to large volume and medium to high impact changes analyzes the effort required to implement and advises the Province on the implementation strategy and timelines

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 15 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly all amendments

2.11 MSP Provider Payment Advances

General Description: The Province is contractual obligated, under limited circumstances such material software failures, to provide fee-for-service physicians with an interest free advance payment on future claims. Advances are recovered from future remittances.

Responsibilities:

Province	Service Provider
• Determines the criteria for advances	• Processes requests for advances in accordance with established criteria • Issues advance payments and establishes re-payment plans in accordance with guidelines provided by the Province

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
None.	None

2.12 MSP Provider Overage Claims Requests

General Description: Claims must be submitted within 90 days of service rendered. Exceptions may be granted under limited circumstances.

Responsibilities:

Province	Service Provider
• Determines the exception criteria • Reviews performance reports	• Processes requests for overaged claims and advises client of decision • Provides an administrative review process for appeals on denied claims • Tracks and monitors requests

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 17 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volume of requests, number granted and denied

2.13 MSP Provider Inquiry Management – Coverage

General Description: Provider Services provides a variety of information related to beneficiary coverage services to health care provider offices.

Responsibilities:

Province	Service Provider
• Approves scripts • Reviews performance reports	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday, except statutory holidays, to respond to all calls from providers seeking to verify patient coverage for MSP • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled • Administers the automated IVR service • Routinely evaluates the effectiveness of scripts and utilization of services available and makes necessary enhancements • Implements new IVR replacement technology (see Schedule J of this Agreement)

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 10 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 45 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes of inquiries by service type

SCHEDULE 5 SECTION 2 – MSP PROVIDER SERVICES

2.14 MSP Teleplan Support Centre

General Description: Provides electronic billing registration services and a variety of related client services to over 4,000 medical sites in British Columbia.

Responds to questions/problems regarding:

- Electronic billing;
- Electronic remittance statements/refusal;
- Hardware/software requirements;
- Access issues, passwords/userid, etc.; and
- Network problems.

Teleplan Support Centre staff often liaise between the medical site and the software vendor. Coordinates vendor software testing. Provides first level support for Primary Care sites. Provides quality assurance testing on changes to the electronic billing software.

Responsibilities:

Province	Service Provider
• Province sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Staffs a contact/call centre providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday except statutory holidays, with client service representatives that have the appropriate level of knowledge to provide technical and business support for electronic claims submission including hardware and software problem resolution • Maintains a tracking system including escalation management for all calls handled • Processes applications for electronic claims submission • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Immediately alerts the Province of a major failure of the electronic billing system when downtime is expected to exceed 24 hours

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 10 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports monthly results within quarterly QA reviews

2.15 MSP Provider Claims Billing Support

General Description: Provides claims billing assistance to health care practitioner offices; first level of administrative review for payment disputes; information on benefits and Payment Schedule policies; researches and responds to enquiries and complaints from physicians and supplementary benefits practitioners; provides information, and advice on payments of fee-for-service claims as well as interpretation of the *Medicare Protection Act* (British Columbia), *Freedom of Information and Protection of Privacy Act (*British Columbia) and Medical Services Commission Payment Schedule.
Position acts as a first level of appeal for adjudication disputes.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday except statutory holidays, with appropriate client service representatives able to respond to all calls from physicians, health care practitioners and their office staff related to claims billing, claims adjudication policies, legislation, etc. • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled • Notifies Province on emerging trends • Immediately alerts the Province on any caller seriously threatening to go to the media or senior government officials

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 10, 10(a) and 11 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports monthly results within quarterly QA reviews

2.16 MSP Benefit Inquiry Services - General Public

General Description: Provides telephone access to the general public on wide variety of topics ranging for inquiries on benefits, information and status on Out of Province and Out of Country claims, requests for information on claims paid on their behalf, policy interpretation, and FOI requests.

Responsibilities:

Province	Service Provider
• Province sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports • Participates in script review and approval	• Staffs a contact/call center providing minimum availability: 8:00 am – 4:30 pm, Monday to Friday except statutory holidays, to respond to a wide variety of calls from the general public on MSP benefits, request for Personal Information, complaints etc. • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a tracking system for all calls handled • Provide and refreshes technology to support beneficiary services as described in Schedule J attached hereto

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirement: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objective:** See item 43 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports monthly results within quarterly QA reviews • Reports quarterly on the number of FOI requests and the number of requests for claims history listings

2.17 MSP Provider General Correspondence

General Description: Provider Services receives a wide variety of general correspondence from benefit inquiries, Freedom of Information (FOI) requests, requests for listings of services paid by MSP, complaints or tips on potential fraud, requests for reimbursement, etc.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Responds to or acknowledges receipt of all correspondence • Where appropriate, standard responses are developed and used • Notifies Province of emerging trends and of tips on potential fraud • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 22 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Report monthly on volumes of correspondence received, number processed, average processing time and inventory of letters including average number of days outstanding • Reports quarterly on the number of FOI requests and the number of requests for claims history listings • Reports monthly results within quarterly QA reviews

SECTION 3 – PHARMACARE SERVICES

3.1 PharmaCare Automated Claims Submission

General Description: All prescriptions dispensed at community pharmacies are entered on PharmaNet. Claims for dispenses and clinical services are submitted electronically, adjudicated in real time and outcome is automatically returned to transmitting pharmacy. Payment of claims is made weekly. Some designated medical supplies are also processed through PharmaNet.

Responsibilities:

Province	Service Provider
• Determines drug benefits and reimbursement policy for each benefit plan • Determines the claim detail to be submitted • Determines clinical services eligibility criteria and reimbursement policy	• Maintains the 24/7 operational requirements of PharmaNet • Processes updates to data tables • Creates and provides the weekly data file to be used by the Ministry of Finance (or any successor thereto) to issue payments to pharmacies weekly

Province	Service Provider
• Determines and approves all new or modified business rules • Ensures the necessary spending authority for processing payments is in place • Determines and revises data access requirements and provides same to the Service Provider within 5 Business Days of completion. The initial data access requirements are attached as Appendix 1 to this Schedule, as amended from time to time • Reviews performance reports • Notification to executive, GCPE, Colleges, BCPhA, vendors, etc as needed	• Resolves all service interruptions • Issues immediate 'fan out' alerts on service interruptions to all Pharmanet users when severity level is 2 or 3 or a planned outage (Note: Severity Level 1 issues are addressed separately, as documented in Severity Application Matrix document. • Implement enhancements as per the Provinces requirements

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 19 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 23 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes and expenditures • Reports monthly on number of data table updates • Reports monthly on PharmaNet performance including outages/any service interruptions • Reports annual availability on contract year basis • Reports monthly on claims transaction response time

3.2 PharmaCare Manual Claims Processing (offline)

General Description: A small group of providers do not submit claims via PharmaNet. Prescription/Supplies claims are submitted manually by patient or supplier for reimbursement.

Responsibilities:

Province	Service Provider
• Determines benefits and payment policies • Reviews performance reports	• Processes claims according to payment policies • Maintains a quality assurance program to ensure compliance with

Province	Service Provider
	Province policies and procedures and accuracy of processing

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 24 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes and expenditures by claim type • Reports on inventory of aged claims • Reports monthly results within quarterly QA reviews

3.3 PharmaNet Tables Administration

General Description: Database tables used for system access, adjudication, changes in benefits, deductibles and payments. This includes the production of PharmaNet, Training PharmaNet, and Excel spreadsheets.

Responsibilities:

Province	Service Provider
• Provides required updates to data tables. • Initiates and approves all adjudication rules changes • Provides policy interpretations/clarifications • Reviews performance reports	• Processes required updates submitted by Province

- **Service Level and Reporting Requirements:**

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 25 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of updates by type

3.4 PharmaNet External Software Compliance Testing

General Description: Point of Service (POS) software must be compliant with standards for connecting to PharmaNet. The standards are published and available from the Province web site. Testing is initiated at the request of the Province and re-testing is required if the original test finds deficiencies. Random testing may be required to ensure continued compliance.

Responsibilities:

Province	Service Provider
• Determines and approves changes to the PharmaNet compliance rules • Initiates random testing if required • Reviews performance reports	• Performs tests at request of the Province • Conducts spot audits according to established guidelines • Prepares report on test results and provides to the Province

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
	• Reports semi annually on number of compliance tests completed

3.5 PharmaCare Pre-authorizations

General Description: Pre-authorization for Prosthetics and Orthotics over limits set by the Province and Special Authorities is required. Out of province prescription, under limited situation, can receive pre-approval for coverage (i.e. transplant patients going to out of province for their surgery).

Responsibilities:

Province	Service Provider
• Sets policy • Processes pre-authorization and Special Authorities applications • Approves out of province coverage for transplant patients • Advises the Service Provider of decision on pre-authorizations and out of country transplant cases within 2 Business Days • Reviews performance reports	• Prepares and mails pre-authorization decision letters • Processes out of province coverage payments • Processes payments for pre-authorized prosthetic and orthotics claims

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 27 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes pre-authorization letters • Reports monthly on volumes and expenditures for out of country transplant claims

3.6 PharmaCare Payments

General Description: PharmaCare payments include automated claims received via PharmaNet, manual claims and payments to pharmacies for the following programs including but not limited to:

- Methadone Maintenance Payment Program;
- Plan B (Permanent Residents of Licensed Residential Care Facilities) Capitation Payments;
- Rural Incentive Program;
- Service Claims for vaccinations, adaptations and medication reviews; and
- Smoking Cessation

Responsibilities:

Province	Service Provider
• Provides payment authority to release funds for distribution • Provides report on Rural Incentive Program payments • Reviews performance reports	• Processes automated and manual adjustments • Notifies the Province immediately of any payment process failures • Maintains a quality assurance program to ensure compliance with Province policies and procedures and accuracy of manual processing

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See item 19 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports weekly on volumes and expenditure by automated and manual claims • Reports monthly results within quarterly QA reviews

3.7 PharmaCare Plan Registration Services

General Description: PharmaCare administers 10 Drug Benefit Plans. Operations is responsible for the automated and manual beneficiary registration to the appropriate PharmaCare Plan(s) and pharmacy, supplier, emergency department and physician registration/access to PharmaNet.

Pharmacy registration is also required for Plan B and the Methadone Maintenance Payment Program. PharmaCare plans currently include:

Plan B - "Permanent Residents of Licensed Residendial Care Facilities", providing coverage to eligible residents of residential community care facilities licensed under the *Community Care and Assisted Living Act,* and patients of hospitals licensed under Part 2 of the *Hospital Act*

Plan C - "Recipients of Income Assistance", providing coverage to residents, or persons holding refugee status in Canada, who receive health care benefits under the *Employment and Assistance Act* or *Persons with Disabilities Act*. .

"Cystic Fibrosis", providing coverage to eligible residents with cystic fibrosis for the provision of digestive enzymes.

Plan F - "Children in the At Home Program", providing coverage to children who are the subject of payments made through the program known as the "At Home Program" administered by the ministry of the minister responsible for the *Child, Family and Community Service Act*.

Plan G - "No-Charge Psychiatric Medication", providing coverage to eligible residents for the provision of psychiatric medications.

Plan I - "Fair PharmaCare", providing coverage to eligible residents based on net family income.

Plan M - "Medication Management", providing coverage to eligible residents for medication management services provided by pharmacists

"Palliative Care", providing coverage to eligible residents who receive palliative care at home.

Plan S - "Smoking Cessation Program", providing coverage to eligible residents for the provision of nicotine replacement therapies.

Plan X - "British Columbia Centre for Excellence in HIV/AIDS", providing to residents who are HIV-positive and enrolled with the British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, for the provision of antiretroviral drugs.

Responsibilities:

Province	Service Provider
• Determines eligibility criteria and associated policies • Reviews performance reports	• Provides a multi-channel registration process for Fair PharmaCare (FP) including web, phone and paper • Processes all FP paper applications and telephone registration requests • Issues, processes and stores all FP consent forms • Provides real-time registrations interfaces and manual back up process for Plans C, F and G

Province	Service Provider
	• Processes manual registrations for the Palliative Care Drug Plan • Provides multi-language services in Mandarin, Punjabi and Cantonese Monday through Friday except statutory holidays, from 9:00 am to 3:30 pm and any calls received outside of those hours will have call back service within 1 business day (including Saturdays) • Maintains a quality assurance program to ensure compliance with Province policies and procedures and document processing accuracy

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 1(a) and 5 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 28 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volume by type and average processing time of registrations • Reports monthly on inventory of registrations • Reports monthly results within quarterly QA reviews • Reports monthly on document processing for imaged documents. Otherwise, measures document processing on a complaint basis and retains records for audit. • Measures multilanguage services including wait time for call back on a complaint basis and retains records for audit.

3.8 Fair PharmaCare (FP) Administrative Review Processes

General Description: Provides support to the registration process of families and individuals, resolve eligibility issues, handle specific requests for income review, revocation of CRA consent, retroactive payments, and handle general FP correspondence.

Responsibilities:

Province	Service Provider
• Determines policies • Provides policy interpretation/clarification • Adjudicates formal appeals on administrative review decisions	• Processes incomplete and non-standard Fair PharmaCare (FP) registrations and consent forms • Processes errors and exceptions resulting from automated

Province	Service Provider
and advises the Service Provider of decision within 10 Business Days • Approves system generated letters • Manages Memorandum of Understanding (MOU) with Canada Revenue Agency (CRA) • Reviews performance reports	processes such as the automated MSP Beneficiary Services matching process • Actions eligibility problems resulting from family changes, failure of family to return consent form, or file with CRA • Processes CRA consent revocations • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA • Process manual reimbursements for Appeals, Current Year Income Reviews • Provides support for monthly deductable payment option (MDPO) program • Processes requests for income reviews where family income has changed or for new residents • Process requests for early retroactive payments • Processes informal appeals (i.e. complaints) of earlier administrative review decisions • Prepares case files for formal appeal requests and forwards to the Province • Responds to general FP correspondence and telephone inquiries

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 29 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number and types of reviews, aged inventory, and number of first time appeals and number of second time appeals forwarded to the Province • Reports monthly results within quarterly QA reviews • Measures urgent requests on a complaint basis and retains records for audit. • Reports monthly on routine requests • Reports monthly on processing of correspondence

3.9 Fair PharmaCare Income Verification Process

General Description: The Fair PharmaCare Plan is based on an individual's or family's net income. Net income is self-reported during the initial registration process and verified with the Canada Revenue Agency (CRA) at the time of registration and annually thereafter. In order for CRA to provide an individual's or family's net income PharmaCare must obtain a signed consent. The automated verification process is weekly via FTP. The electronic response from CRA updates the system and generates correspondence.

Exceptions are manually processed according to established policy.

Responsibilities:

Province	Service Provider
• Determines criteria for income verification and appropriate supporting documentation (e.g. consent form) • Provides policy interpretation/clarification • Manages the MOU with the Canada Revenue Agency and reports to CRA outcome of audits • Approves any required changes issued by CRA • Approves system-generated letters	• Administers the income verification process with CRA and makes any necessary adjustments resulting from the verification process. Maintains a contact with the local CRA office for verification as required (for prior tax years) • Conducts audits on the income verification process as prescribed in the CRA MOU and reports outcome to the Province • Refers any required changes by CRA to the Province • Maintains and updates system generated letters • Complies with CRA security standards in accordance with memorandum of understanding in respect of security standards between the Service Provider and CRA

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 30 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes, number of adjustments and letters generated

3.10 PharmaCare Restricted Claimant Program

General Description: Program assists in reducing misuse of PharmaCare benefits by limiting coverage for certain patients to medications prescribed or pharmacies which prescriptions drugs may be obtained.

Responsibilities:

Province	Service Provider
• Determines the program policies and approves restrictions • Manages all appeals • Reviews patient profiles and approves restriction or removal of restrictions within 5 days of request from the Service Provider • Provides pharmacist support during business hours to review urgent requests	• Processes approved restrictions and advises patient • Provides business hour program coverage for routine processes • Provide 24x7 coverage for emergency changes to restriction • Alerts Province of potential misuse by patient • Provide routine pharmacy and physician changes during business hours – 9:00 a.m. – 4:00 p.m., Mon through Fri, except statutory holidays,

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 31 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number and type of restrictions • Measures processing of temporary restriction changes (phone calls) on a complaint basis • Measures processing of approved restrictions and notification letters and changes to approved restrictions on a complaint basis and retains records for audit. • Reports monthly on processing of correspondence.

3.11 [Intentionally Deleted]

3.12 PharmaCare General Correspondence

General Description: PharmaCare receives a wide variety of general correspondence from benefit inquiries, confirmation of Special Authority by third party insurers, blood glucose strip certificates, requests for listing of drugs paid on their behalf, complaints or tips on potential fraud, requests for reimbursement, etc.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Responds to inquiries in most appropriate manner • Manages a quality assurance program to ensure high quality client service and the accuracy of the responses

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 33 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on volumes, type and inventory of written inquiries • Reports monthly results within quarterly QA reviews • Measures processing of blood glucose strips certificates, 3rd party insurer requests and out-of-province requests on a complaint basis and retains records for 18 months for audit. • Reports monthly on processing of general correspondence

3.13 PharmaCare Help Desk – Pharmacists and other Service Providers

General Description: The PharmaCare Help Desk is available 24 hours, 7 days per week (with reduced hours December 24th and 25th). The Help Desk responds to a wide variety of calls from Pharmacies and other Service Providers regarding patient benefit eligibility, questions about adjudication results, status of Special Authorities requests, restricted claimants, general inquiries on benefit plans, etc. The Help Desk also provides troubleshooting for system problems such as pharmacy network connection problems, slow response times, gateways down, and resetting passwords.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports Note: Fair PharmaCare Self Registration IVR was retired in July 2006	• Staffs a contact/call centre providing 24/7 availability, except Dec 24th 10:15pm to Dec 25th 10:15pm, with client service representatives that have the appropriate level of knowledge to provide technical and business support for PharmaNet system including network interfaces (such as HIAL and EMPI), and software problem resolution and the PharmaCare Program • Manages network incidents and response times and escalates problems • Maintains a call tracking system including escalation management for all systems trouble shooting • Maintains a quality assurance program to ensure high quality

Province	Service Provider
	client service and the accuracy of the responses • Immediately alerts the Province of a major failure of the PharmaNet system when downtime is expected to exceed 4 hours

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 10, 11 and 20 set out in the table in Paragraph 4 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Reports monthly results within quarterly QA reviews

3.14 PharmaCare General Public Inquiry Services

General Description: Handles inquiries about eligibility, drugs, benefits, special authorities, etc., provides telephone Fair PharmaCare registration, and specific inquiries around income reviews, retroactive payments, changes to Personal Information, requests for claim information, etc.

Responsibilities:

Province	Service Provider
• Reviews performance reports	• Staffs a contact/call center 8:00 am – 8:00 pm, Monday to Friday, except statutory holidays, and 8:00 am – 4:00 pm Saturdays to respond to all calls from the general public related to PharmaCare including providing phone registration service • Manages a quality assurance program to ensure high quality client service and the accuracy of the responses • Maintains a call tracking system (2012 currently using Call Centre Anywhere (CCA))

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 9 and 11 set out in the table in Paragraph 4 of the Service Levels Schedule. **Service Level Objectives:** See item 46 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, average speed to answer and types of calls including Fair PharmaCare phones registration • Reports monthly results within quarterly QA reviews

SECTION 4 – COMMON PROCESSES

4.1 Province initiated registrations and payments

General Description: Periodically the Province may initiate a registration, an amendment to a registration such as waiving the wait period, a provider or beneficiary payment, an adjustment to a payment, a recovery or approve a service as a benefit as a result of an appeal, functions remaining the responsibility of the Province, medical provider or beneficiary audit/investigation or non-precedent setting circumstances.

Responsibilities:

Province	Service Provider
• Provides sufficient written instruction to enable the Service Provider to accurately complete the necessary transactions • Where appropriate, provides reasonable timelines for the completion of the request • Completes the necessary written correspondence to the Province Customer or provides the Service Provider with the approved content to for any written correspondence • Responds to all requests for clarification, as necessary • Responds to referred inquiries related to the decision	• Processes the request according to the instructions and timelines provided • Records the appropriate details of the request • Retains and stores all requests for future retrieval by the Province • Completes and mails any written correspondence as approved by the Province • Confirms any discrepancies with the Province before processing the request • Where appropriate, handles any general inquiries on a Province initiated request and refers inquirer to Province on queries related to the decision

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
None.	None

4.2 Province Customers and Stakeholders Communications

General Description: MSP and PharmaCare Operations communicate to beneficiaries and medical providers through multiple channels including: Premium bill messages, Group Administrators, brochures, forms, Province website, bulletins, newsletters, fan-out notices, email, electronic broadcast messages, and resource manuals. See Schedule K of this Agreement for the Communication Plan and Communication Process.

Responsibilities:

Province	Service Provider
• Responsible for organized public communications regarding the outsourcing agreement and any changes to business. • Consults with the Service Provider in advance of any public communications that could impact business operations. • Responds to all media calls • Approves mechanisms and processes for communications • Approves all materials published and posted to web prior to issuance/launch	• Drafts and/or proposes content, prints, distributes, tracks and reports. • Responds to written inquiries, as per agreed upon protocols, refers to the Province issues requiring escalation, tracks and reports. • Responds in real time to verbal inquiries, refers to Province per agreed upon protocols. • Drafts scripted messages where appropriate. • Refers all media calls to the designated Province contact.

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
None.	• Reports quarterly on communication activities by channel • Reports on any complaints or issues

4.3 Document Inventory

General Description: Maintains a Document Inventory (including applications, address changes, inquiries, etc.)

Responsibilities:

Province	Service Provider
• Reviews monthly performance reports	• Digitizes all incoming documents requiring processing • Stores and destructs all images in accordance with the Province's Operational Records Classification system (ORCS) and policies • Archives all applicable paper documents in accordance with ORCS

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 38 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on number of incoming documents processed by type and number unsuitable for digitizing • Reports monthly on processing of documents/correspondence • Archiving of documents reported through audit

4.4 Document Pre-processing/Mail Room Activities (including registration and scanning)

General Description: Pre-processing/mail room activities (including registration and scanning) of all relevant MSP and PharmaCare incoming documents

Responsibilities:

Province	Service Provider
• Review performance reports	• Sorts, preps scans, registers and stores all documents requiring processing • Returns originals to submitter, where required or requested

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objective: See item 39 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Report monthly on number of document scanned by type – consolidate with report provided pursuant to Section 4.3 of this Schedule

4.5 Province Access and Reports

General Description: Provision of access to required systems/applications and all operational data to enable the Province to carry out functions remaining with the Province. Provision and support of a reporting tool to enable the Province to 'pull' reports and query the data. Periodically, the production of ad hoc reports related operational data is required to respond to potential policy changes, analysis on existing policies, Minister inquiries, etc. These reports are varied. Examples are: information on the % of BC residents covered by MSP, number of individuals/families whose premiums are paid through group administrators, number of Fair PharmaCare beneficiaries within certain income bands, number of claims outstanding for a particular provider or reason, number of claims and dollars paid for Out of Country/Province services, etc.

Responsibilities:

Province	Service Provider
• Defines systems and data access requirements, acting reasonably. The initial data access requirements are attached as Appendix 1 to this Schedule, as amended from time to time • Approves requests for individual access and advises when access to be terminated • Defines standard and ad hoc reports required, acting reasonably	• Provides access to Province staff to required operational systems/applications • Provides access to all operational data/information through a reporting tool or operational data repository • Assists the Province with interpretation of the data • Produces standard reports as required by the Province • Provides access to subject matter experts, as required

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 40 set out in the table in Paragraph 5 of the Service Levels Schedule.	

4.6 Information Requests: Personal claims history, information requests from third parties, Freedom of Information Requests, Court Orders

General Description: These include requests from patients for their own MSP claim and PharmaNet claims history and/or other documents relating to them, requests for claims history from the Ministry of Children and Families on their client/family, court order requesting claim history and documents on individuals or medical providers, information requests from third parties such as ICBC or WCB, Ombudsman, Coroner's office, Office

of the Public Trustee, information requests under the *Freedom of Information and Privacy Act*, information requests from other Province programs, etc.

Responsibilities:

Province	Service Provider
• Approves and manages all Information Sharing agreements with Third Parties • Approves and manages all information requests submitted under the *Freedom of Information and Privacy Act* or by the Ombudsman • Approves and manages all information requests submitted by the RCMP, Canadian Security and Investigations Service, court orders, other provincial jurisdictions, etc. • Provides the Service Provider with written instructions, supporting documentation and timelines for the release information to individuals, government Ministries, external agencies and organizations or other provincial or federal jurisdictions • Approves any charges to applicants proposed by the Service Provider for preparing information requests • Approves the data elements maintained in the tracking system	• Processes individual's requests for their own MSP claim and PharmaNet claims history and/or other documents relating to them subject to confirmation of the identity of the individual • Processes requests from ICBC for patient history listings subject to receipt of patient consent and where no revocation exists • Processes requests approved by the Province for release • Maintains a tracking system for all requests and monitors for repeat requests • Retains all individual consents and Province requests and supporting documentation in accordance with ORCS • Promptly notifies the Province if any request appears suspicious

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 41 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports monthly on the volumes and types of requests processed and the number outstanding

4.7 Policy and Procedures (Operational) Manuals

Manuals describe the policies, procedures and practices undertaken to deliver the business functions described in this Schedule. The Manuals also describe the methods of operations and procedures use to perform the Services such as, network topologies, security administration, system configurations, call

centre processes, human resource functions, business processes and associated documentation. The manuals serve as training and reference tools for both Operations and Province staff.

Province	Service Provider
• Provides copies of all Medical Services Commission minutes, policy updates and interpretations to the Service Provider to ensure procedures/practices align with current requirements • Approves all changes to manuals within 10 Business Days of receiving amendments	• Maintains current and comprehensive operational manuals which are available to designated MoH employees through the HIBC Sharepoint Site. • Updates manuals when advised of policy, legislative or procedural changes • Provide draft changes to the Province for approval prior to publishing any material changes to manuals • Tracks all changes to ensure there is an historical record (Note that these obligations are in addition to the documentation requirements in the Agreement).

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Objectives: See item 42 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports annually on manuals' most current version date

4.8 Third-Party Processing Agent

General Description: The Province has agreements with ICBC and WCB whereby MSP acts as a processing agent for these agencies. Services provided include: claims processing for physician, certain health care provides and hospital services, Province Customer services and communications related to claims processing and developing adjudication business rules and explanatory codes specific to ICBC and WCB claims. Physician claims designated as the responsibility of ICBC are processed without charge.

The Service Provider on behalf of WCB and ICBC may perform additional processing activities unrelated to the core services. The Service Provider will consult with and obtain the Province's approval/support before agreeing to take on additional services.

The Province is a party to a processing services agreement with WCB. In addition, to ICBC, the Province has a Memorandum of Understanding with the Ministry of Human Resources to process physician form fees on their behalf.

Responsibilities:

Province	Service Provider
• Liaise with WCB and ICBC to determine governance requirements • Manages the Agreements with WCB and ICBC respectively • Recovers funds from WCB for administration of claims processing	• Acts as sub-contracted processing agent for the Province for physician and certain other health care provider WSBC and ICBC claims • Provides client services to physicians, certain other health care provider, labs, hospitals, etc., related to the submission and payment of ICBC and WSBC claims • Makes any necessary claims adjustments to reflect the correct insurer designation • Develops/modifies and implements new routine non-complex adjudication business rules that can be easily accommodated • Adds, amends or deletes fee item listings specific to ICBC or WSBC • Amends WSBC premium payment as required • Provides bi-weekly electronic files on Payment Schedule fee item information, explanatory code information, specialty code information, demographic information on practitioner and payee numbers • Provides various reports as requested by WSBC including (aged invoices/forms; available payee (account/billing) codes; • Provides electronic communications to physicians on behalf of ICBC and WSBC • Works with WSBC and ICBC to identify business and system requirements • Seeks the Province's Approval on any changes initiated by ICBC or WSBC

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: See items 10, 11, 12, 13, 19, 22 and 26 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Reports every payment cycle on number of claims and dollar value and number of claims requiring manual adjudication by insurer type • Reports on number and value of adjustments to correct insurer designation

Service Level Objectives: See items 8, 9, 10, 14, 15, 17, and 22 set out in the table in Paragraph 5 of the Service Levels Schedule.	• Identifies potential improvements for WCB and ICBC

4.9 Technical Services Support Desk (TSSD) –

General Description: The Technical Services Support Desk is a single point of contact for all incoming internal and external end user support. The service is available 24 hours, 7 days per week, responding to incoming incidents/requests as they arrive, triaging incoming/requests at a tier one level, and providing first call resolution when applicable.

Responsibilities:

Province	Service Provider
• Sets policy and provides, as required, policy clarification/interpretation • Reviews performance reports	• Staffs a technical support centre providing 24/7 availability, except Dec 24th 10:15pm to Dec 25th 10:15pm, with technical support advisors that have the appropriate level of knowledge to provide technical and business support for all applications The Service Provider manages for the Ministry • Manages network incidents and response times and escalates problems • Maintains a call tracking system including escalation management for all systems trouble shooting • Maintains a quality assurance program to ensure high quality client service and the accuracy of the responses • Alerts the Province within 2 hours of any major interruption of service • Manages Ministry business requests and access applications (Security Management)

Service Level and Reporting Requirements:

Service Levels and Outcomes	Reporting
Service Level Requirements: Currently there are no SLR's and SLO's	• Reports monthly on call volumes, wait times, abandonment rates, busy rate, and average speed to answer • Number of Incidences/Request, opened and closed, first call

	resolution • Reports monthly on QA reviews

SCHEDULE F
SERVICE LEVELS

[See Attached]

SCHEDULE F

SERVICE LEVELS

1. General Principles

The Parties agree as follows:

(a) This Schedule defines and describes the Service Levels, being comprised of Service Level Requirements and Service Level Objectives, which have been mutually developed and agreed to by the Province and the Service Provider.

(b) Service Level Requirements have been established between the Service Provider and the Province with respect to the certain Services set out in Paragraph 4 below.

(c) Service Level Objectives have been established between the Service Provider and the Province with respect to all other Services for which Service Level Requirements have not been established.

(d) Subject to Paragraph 1(e) below, commencing on the Hand-Over Date and during the Term, the Service Provider will meet or exceed the Service Level Requirements and the Service Level Objectives.

(e) Each Service Level Requirement is to be measured as described in Paragraph 4 below. Certain Service Level Requirements will only be in effect during certain periods of the Term specified in Paragraph 4. The Service Provider will not be required to meet or exceed a Service Level Requirement which is designated as a Phased SLR until the Phase-In Date for such Service Level Requirement. From the Hand-Over Date until the applicable Phase-In Date, the Service Provider will perform each Service having a Phase SLR at or above the Service Level Requirement expressly specified for such period or where no Service Level Requirement is specified then at the standard and level which was actually achieved by the Province in the performance of such Service to the applicable Province Customers or Stakeholders immediately prior to the Hand-Over Date with such level being deemed to be a Service Level Requirement. The Service Provider agrees that such performance standard and level shall be determined by the Province to the extent reasonably reliable data is available with respect thereto including, without limitation, Province Customer and Stakeholder feedback received by the Province, complaint logs, or similar information.

(f) Each Service Level Objective is to be measured as described in Paragraph 5 below. During the Term, the Service Provider will perform each Service in accordance with and will meet or exceed the measures, time frames, and specifications set out in Paragraph 5.

(g) Measurements of Service Levels will take effect on the Hand-Over Date and continue for the duration of the Term.

(h) The Service Provider will provide Service Level Credits against Fees payable by the Province if the Service Provider fails to meet or exceed Service Level Requirements. Commencing on the Hand-Over Date and subject to the At Risk Amount limit and Paragraph 1(e) above, the Service Provider will credit the Province with Service Level Credits for SLR Failures in accordance with Paragraph 8 below and Articles 8 and 12 of the Agreement.

(i) Subject to Paragraph 1(j), the At Risk Amount will be adjusted within 30 days of the end of each Contract Year such that the At Risk Amount for the then current Contract Year equals 17.5% of the Average Annual Fee as of the end of the prior Contract Year, divided by 12.

(j) The At Risk Amount will only be adjusted pursuant to Paragraph 1(i) where the Average Annual Fee increases or decreases by at least 10% in aggregate as compared to the Average Annual Fee last used to calculate the At Risk Amount (or, if it has not yet been adjusted, as compared against the Fee initially calculated to be payable in the first Contract Year).

(k) The total Service Level Credits set out in the far right column of the table in Paragraph 4 shall not exceed three times the At Risk Amount. Each time the At Risk Amount is adjusted pursuant to Paragraph 1(i) above, such Service Level Credits shall be automatically adjusted on a pro rata basis in order that the ratio of such Service Level Credits to the At Risk Amount is not changed by such adjustment.

(l) The Uninterruptible Services shall consist of the Services designated as either an IT Uninterruptible Service or Other Uninterruptible Service in the far left column of the table in Paragraph 4.

2. Definitions

Capitalized terms used in this Schedule will have the meanings set forth in this Paragraph 2. Capitalized terms not defined in this Schedule shall have the meanings set forth in Schedule A or otherwise in this Agreement.

(a) "**Average Annual Fee**" means the average aggregate annual Fees payable under this Agreement, calculated at the end of each Contract Year based upon the Fees payable during such Contract Year, including Inflation, taking into account any and all adjustment to the Fees as follows:

(i) any adjustment to Fees in accordance with Schedule I;

(ii) any adjustments made pursuant to Change Orders or Service Requests;

(iii) excluding any fees for work that has express risk control mechanisms included within the payment terms and conditions for such work, including for example a holdback amount; and

(iv) excluding any credits granted by the Service Provider to the Province during such Contract Year.

(b) "**At Risk Amount**" means $552,979, as adjusted pursuant to Paragraph 1(i) above.

(c) "**Calls**" means, with respect to Service Level Requirement 9, 10 and 10(a), all calls directly answered by an agent, including escalations and transfer queues, with the exception of abandoned calls or calls resolved through voicemail or callback.

(d) "**Critical Items**" mean any incident or situation that could lead to service level failure, be harmful to the Province's or the Service Provider's reputation or have material importance to any of the Province Customers or Stakeholders.

(e) "**Full Service State**" means that the system is capable of and achieving all Service Level Requirements in respect of it.

(f) "**Health Authorities**" mean the governing bodies with responsibilities for the planning, coordination and delivery of regional health services, including hospital, long term care and community services.

(g) "**Inbound Documents**" means, with respect to Service Level Requirement 3, 4 and 6, all document types with a Maximage status measure of "Done" with the exception of multi-year MSP Premium Assistance documents.

(h) "**IVR**" means interactive voice response.

(i) "**MSP Payment Cycle**" means the scheduled monthly payment cycle used in connection with the Services whereby a payment is deposited with the payee on the 15th or closest proceeding Business Day and the last Business Day of each month.

(j) "**Payment Period**" means, in respect of the Medical Services Plan, a MSP Payment Cycle period, or, in respect of pharmacies, the weekly payment cycle period used in connection with PharmaCare services.

(k) "**PharmaNet Professional and Software Compliance Standards Library**" means the reference material for all connections to the PharmaNet system, which is housed on the Province's website.

(l) "**Primary Care**" means the alternative payment program for general practitioners as described in Section 2.2 of the Services Schedule.

(m) "**Quality Adjudication**" refers to the level of accuracy in manual claims adjudication and pre-authorizations processing. The results are measured through the Service Provider's quality assurance testing methodology.

(n) **"SLR Failure"** means any failure of the Service Provider to meet or exceed a Service Level Requirement.

(o) **"Service Level Objective Description"** has the meaning given to it in Section 5(a).

(p) "**Service Level Report**" means the reports to be provided by the Service Provider to the Province in accordance with Schedule H which:

(i) communicates the results of each Achieved Service Level and any and all failures of the Service Provider to meet or exceed Service Levels (including, for greater certainty, SLR Failures) during the past six months;

(ii) provides a detailed explanation for each such failure, if any; and

(iii) allows the Province to verify the Service Provider's performance and compliance with the Service Levels and to identify trends.

The Service Level Report shall be in the form as the Province may reasonably require from time to time.

(q) "**Service Level Requirement Description**" has the meaning given to it in Section 4(a).

(r) "**Services Schedule**" means the schedule describing the Services attached to the Agreement as Schedule E.

3. Interpretation

References to Paragraphs in this Schedule shall refer to the paragraphs of this Schedule. All times and dates set out in this Schedule shall be determined in accordance with Pacific Standard Time or Pacific Daylight Savings Time, as applicable.

4. Service Level Requirements

The Parties agree that the following shall apply in respect of Service Level Requirements:

(a) The measures for each service function set out in the table below will be calculated and determined in accordance with the description and calculation method, including source data, reports, inclusions and exclusions, for each such service function (each a "**Service Level Requirement Description**") attached as Appendix A to this Schedule.

(b) Only completed, submitted documents will be measured when determining Achieved Service Levels;

(c) The Service Level Requirements for processes, namely the service functions numbered 1(a), 3, 4, 5, and 6 in the table below, shall only be amended by mutual agreement of the Parties as a result of Transformation or as otherwise contemplated in respect of Service Level amendments in the Agreement;

(d) The Service Level Requirement for service function number 19 in the table below excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure;

(e) The Service Level Requirements for systems, namely the service functions numbered SLR 20(a) and SLR 23(a) in the table below, exclude downtime due to scheduled maintenance (i.e. maintenance windows) as mutually agreed by the Parties and outages due to a Force Majeure;

(f) The Service Level Requirements for each of service functions for systems, namely the service functions numbered SLR 20(a) and SLR 23(a) in the table below, are to be measured on a Contract Year basis and a SLR Failure will occur each time a system outage exceeds four hours or eight hours, as applicable, during the Contract Year provided that:

(i) for service function 20 the Service Provider must first incur a SLR Failure for exceeding the 8.76 hours (in aggregate) of permitted system downtime during the Contract Year; and

(ii) for service functions 23, 24 and 25 the Service Provider must first incur a SLR Failure for exceeding the 43.8 hours (in aggregate) of permitted system downtime during the Contract Year; and

(g) Any Phase-In Date set out for a service function in the table below will apply to each Service Level Requirement in respect of such service function which makes reference to a Phase-In Date.

The following table sets out the Service Level Requirements and their corresponding Service Level Credits for certain Services:

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
Registration:				
1. [Intentionally deleted]				
1(a) Providers	Section 2.1 Section 3.7	99% within 2 Business Days	N/A	$27,649

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
2. [Intentionally deleted]				
3. MSP Enrolment – OTHER UNINTERRUPTIBLE SERVICE	Section 1.1	80% within 10 Business Days* 99% within 20 Business Days* * In the event that more than 81,005 Inbound Documents are to be processed in the aggregate for Service Level Requirements 3, 4 and 6 in a month: (a) this Service Level Requirement will not apply to the Inbound Documents processed under this service function that are in excess of the aggregate 81,005 Inbound Documents; and (b) the Parties will mutually agree to determine the joint corrective action in respect of such Inbound Documents..	N/A	$82,947 $55,298
4. MSP Premium Assistance	Section 1.1	80% within 10 Business Days* 99% within 20 Business Days* * In the event that more than 81,005 Inbound Documents are to be processed in the aggregate for Service Level Requirements 3, 4 and 6 in a month: (a) this Service Level Requirement will not apply to the Inbound Documents processed under this service function that are in excess of the aggregate 81,005 Inbound Documents; and (b) the Parties will mutually agree to determine the joint corrective action in respect of such Inbound Documents.	N/A	$82,947 $55,298
5. Fair PharmaCare Paper Registration	Section 3.7	99% within 3 Business Days	N/A	$55,298

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
6. Beneficiary Account Maintenance	Section 1.1	40% within 40 Business Days 80% within 10 Business Days* 75% within 180 Business Days 99% within 20 Business Days* * In the event that more than 81,005 Inbound Documents are to be processed in the aggregate for Service Level Requirements 3, 4 and 6 in a month: (a) this Service Level Requirement will not apply to the Inbound Documents processed under this service function that are in excess of the aggregate 81,005 Inbound Documents; and (b) the Parties will mutually agree to determine the joint corrective action in respect of such Inbound Documents.	N/A	$82,947 $55,298
7. [Intentionally deleted]				
8. Provider Account Maintenance	Section 2.1	99% within 5 Business Days	N/A	$55,298
Telephone Inquiry Services (average queue time to a Customer Service Representative (CSR))				
9. Beneficiaries	Sections 1.2, 1.5, 2.16 and 3.14	Less than 3 minutes (during 8:00 am – 4:30 pm, averaged monthly)* *In the event that more than 157,088 Calls are to be answered in the aggregate for Service Level Requirements 9, 10 and 10a in a month: (a) this Service Level Requirement will not apply to the Calls under this service	N/A	$82,947

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
		function in excess of the aggregate 157,088 Calls; and (b) the Parties will mutually agree to determine the joint corrective action.		
10. Provider	Section 2.13, 2.14, 3.13 and 4.8	Less than 1 minute (during 8:00 am – 4:30 pm), averaged monthly * *In the event that more than 157,088 Calls are to be answered in the aggregate for Service Level Requirements 9, 10 and 10a in a month: (a) this Service Level Requirement will not apply to the Calls under this service function in excess of the aggregate 157,088 Calls; and (b) the Parties will mutually agree to determine the joint corrective action.	N/A	$82,947
10(a). Billing support	Section 2.15	Less than 3 minutes (during 8:00 am – 4:30 pm), averaged monthly* *In the event that more than 157,088 Calls are to be answered in the aggregate for Service Level Requirements 9, 10 and 10a in a month: (a) this Service Level Requirement will not apply to the Calls under this service function in excess of the aggregate 157,088 Calls; and (b) the Parties will mutually agree to determine the joint corrective action.	N/A	$82,947
11. Busy rate	Sections 1.2, 1.5, 2.14, 2.15, 2.16, 3.13, 3.14 and 4.8	Less than or equal to 2% (during 8:00 a.m. – 4:30 p.m. averaged monthly)	N/A	$27,649
12. In-province auto adjudicated claims	Sections 2.4 and 4.8	96.5% processed within the next MSP Payment Cycle 98.5% processed within 2nd	N/A	$82,947 $55,298

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
		MSP Payment Cycle (percentage to increase up to 99% as stakeholders implement measures to increase automation or reduce processing time)		
13. In-province manually	Sections 2.5 and 4.8	100% of claims processed within 85 days* * In the event that more manually adjudicated claims than the agreed annual volume (in accordance with agreed growth rate) of manually adjudicated claims are to be processed in a year: (i) this Service Level Requirement will not apply to the manually adjudicated claims in excess of the agreed volume; and (ii) the Parties will mutually agree to determine the joint corrective action.	N/A	$82,947
14. [Intentionally deleted]				
14(a). Out of country claims (peak and non peak)	Section 2.6	80% processed within 4 Payment Cycles* 95% processed within 6 Payment Cycles* *Effective April 1, 2013, this Service Level Requirement will include the processing of out of country claims by payees, and after such date, in the event that more out of country claims by payees than the agreed annual volume (in accordance with agreed growth rate) of out of country payee claims are to be processed in a year, this Service Level Requirement will not apply to the out of country payee claims in excess of such agreed volume.	N/A	$82,947 $55,298

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
15. [Intentionally deleted]				
MSP Provider Pre-authorizations including notification:				
16. [Intentionally deleted]				
16(a). Routine & complicated	Section 2.8	100% processed within 7 Business Days	N/A	$55,298
17. [Intentionally deleted]				
18. New Care Card issuance	Section 1.1	99% sent prior to eligibility of benefits	N/A	Nil
19. Health Care Practitioner and Pharmacy payments – Data files transmitted by the Service Provider to the Province to approve and distribute payments (excluding specific situations where Office of the Controller General (British Columbia) is not available to receive the transmission of the file)	Sections 2.3, 3.1, 3.6 and 4.8	MSP claims payments: mid and end of month – 100% on time issued. Pharmacy: weekly - 100% issued on time.	N/A	$82,947]
20. [Intentionally deleted]				
Systems availability:		**These measures are per Contract Year:**		
20(a). PharmaNet Help Desk (OTHER UNINTERRUPTIBLE SERVICE), PharmaNet Application (IT UNINTERRUPTIBLE SERVICE), Teleplan Application accepting claims (IT UNINTERRUPTIBLE SERVICE)	Sections 3.1, 3.13, 2.3, and 4.8	24/7 99.9% of the Contract Year (i.e. 8.76 hours per application for a total of 26.28 hours of downtime cumulatively permitted per Contract Year) with no single outage > 4 hours after total downtime > .1% during the Contract Year	N/A	$55,298 $55,298
21. [Intentionally deleted]				
22. [Intentionally deleted]				
23. [Intentionally deleted]				

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES	PHASE-IN DATE	SERVICE LEVEL CREDITS
23(a). Fair PharmaCare IVR and Web Application (IT UNINTERRUPTIBLE SERVICE), IVR Travel Assistance Application (IT UNINTERRUPTIBLE SERVICE), Self Service Options and IVR Applications	Section 3.7, 1.4, 1.1, Item #13 in General Responsibilities and Principles	24/7 99.8% of the Contract Year (i.e. 17.52 hours per application for a total of 52.56 hours of downtime cumulatively permitted per Contract Year) with no single outage > 4 hours after total downtime > .2% during the Contract Year	N/A	$55,298 $55,298
24. [Intentionally deleted]				
25. [Intentionally deleted]				
26. Quality Adjudication	Sections 2.2, 2.5, 2.6, 2.8 and 4.8	Minimum of 98% accuracy	N/A	$55,298
27. Notification of Critical Items (i.e. information breaches)	Item #9 in General Responsibilities and Principles	2 hours (for initial unconfirmed notice)	N/A	$55,298

5. Service Level Objectives

The Parties agree that the following shall apply in respect of Service Level Objectives:

(a) The measures for each service function set out in the table below will be calculated and determined in accordance with the description and calculation method for each such service function measure (each a "**Service Level Objective Description**") attached as Appendix B to this Schedule.

(b) Only completed, submitted documents will be measured when determining Achieved Service Levels;

(c) All references to abandonment rate and the average speed of answer will be based on a monthly average; and

(d) All Service Level Objectives in respect of documents will be measured from the date of receipt by the Service Provider.

The following table sets out the Service Level Objectives for certain Services:

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
Registration:		
1. MSP Beneficiary Registration and Account Maintenance Services	Section 1.1	95% of replacement CareCards will be mailed within 10 Business Days from the date of the telephone request or from the date a written request is processed.
2. [Intentionally deleted]		
3. [Intentionally deleted]		
4. [Intentionally deleted]		
5. MSP Beneficiary Travel Assistance Program – CSR support	Section 1.5	Average speed of answer – < 3 minutes 100% of all travel assistance correspondence to be processed within 30 Business Days
6. [Intentionally deleted]		
7. MSP Non-Fee for Service Payments	Section 2.2	Payment requests from the Province to Health Authorities and Primary Care sites are processed within one Payment Cycle from date of receipt of correct and complete invoice. Medical Advisor Sessional and travel expenses are paid within one Payment Cycle from date of receipt of correct and complete invoice. 100% of rural health correspondence is processed within 30 Business Days.
8. MSP Provider Electronic Claims Submission and Payment System	Sections 2.3 and 4.8	Annual availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure). Accountability will be assigned in accordance with the jointly approved Roles and Responsibilities Matrix. If the primary data centre for the claims system requires a fail over to the DRP site, the system files and data must be restored to a point that processing can resume within 12 hours of SSBC provisioning of the DRP site and to Full Service State within 48 hours. Accountability will be assigned in accordance with the jointly approved Roles

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		and Responsibilities Matrix. Service interruption must be restored within one Business Day when only Service Provider Group infrastructure is involved, or within one day of restoration of Province Shared Infrastructure. 95% of paper claims are processed through data entry within the following Payment Cycle from receipt and 100% within the second Payment Cycle following receipt 100% of the following types of documents are processed within 30 Business Days: • Cheques from other provinces for non-BC patient • Physicians who do not bill by Teleplan
9. MSP Automated claims business rules	Sections 2.4 and 4.8	Continuous development and implementation of appropriate automated rules
10. MSP Provider Manual In-province claims adjudication – including reciprocal and third party claims	Sections 2.5 and 4.8	Decisions on disputed claims referred to Medical Advisor Committee (MAC), Medical Payment Issues Committee (MPIC) or BCMA Reference Committee are processed within 10 Business Days of receipt from the Province
11. MSP Provider Manual Out of Country travel claims adjudication This SLO is eliminated as of April 1, 2013 the requirement has been combined into SLR 14a, as effective April 1, 2013.	Section 2.6	Reimbursement to Extended Health Insurers – processed within 4 Payment Cycles
12. MSP Provider Out of Province/Country Pre-authorizations	Section 2.7	80% of requests requiring referral to the Province are prepared and transferred within 10 Business Days and 99% within 20 Business Days of receipt of completed application. 100% of all OOC/OOP pre-authorization requests/documents are processed within 30 Business Days.
13. [Intentionally deleted]		
14. MSP Provider Retroactive Payment Adjustments	Sections 2.9 and 4.8	Retroactive payment adjustments processed within 6 weeks of notice from Province to proceed when no implementation date is provided by the Province

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
15. MSP Provider Online Payment Schedule Amendments	Sections 2.10 and 4.8	Low volume/low impact – one Business Day from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) Medium volume/medium impact - 5 Business Days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) Large volume/high impact – 20 Business Days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required)
16. [intentionally deleted]		
17. MSP Provider Overage Claims Requests	Sections 2.12 and 4.8	90% of complete requests are processed within 20 Business Days from date scanned 100% of requests for permission to re-bill will be processed within 30 Business Days
18. [Intentionally deleted]		
19. [Intentionally deleted]		
20. [Intentionally deleted]		
21. [Intentionally deleted]		
22. MSP Provider General Correspondence	Sections 2.17 and 4.8	90% of all general correspondence is processed within 20 Business Days from receipt 99% of all general correspondence is processed within 40 Business Days from receipt General correspondence consists of: • Beneficiary general correspondence • Correspondence with providers • Critical care coverage • Dental claim adjudication correspondence

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		• Orthodontics and dental correspondence • Patient paid, request reimbursement • Physician requesting clarification • Provider adjudication correspondence • Reciprocal billing – BC physician/OOP patient
23. PharmaCare Automated Claims Submission	Section 3.1	Annual availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeure) Claims transaction response time including TAC TDU (measured from the time the transaction enters PharmaNet to the time the completed transaction is returned to the Network) less than 2.5 seconds 97% of the time.
24. PharmaCare Manual Claims Processing (offline)	Section 3.2	Adjudication – 90% within 10 Business Days 99% within 20 Business Days 100% of PharmaCare Helpdesk correspondence processed within 30 Business Days.
25. PharmaNet Tables Administration	Section 3.3	Drug prices, Low Cost Alternatives shortages – real time Incorrect prices in Production tables updated within 1 Business Day Other updates including drug price listing changes processed within 10 Business Days Urgent price change requests will be handled on an exception basis based on a mutually agreed to basis.
26. [Intentionally deleted]		
27. PharmaCare Pre-authorizations	Section 3.5	Pre-authorization letters prepared and mailed within 7 Business Days of receiving approval by the Prosthetics and Orthotics Committee 100% of orthotics and prosthetics documents/correspondence processed within 30 Business Days

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
28. PharmaCare Plan Registration Services	Section 3.7	Palliative Care registrations processed within 1 Business Day Consent forms processed within 2 Business Days Process Emergency Department, Hospital and Medical Practice access to PharmaNet within 2 Business Days of receiving the request Process Pharmacy Access request received from the College of Pharmacist within 1 Business Day to initiate work orders for connection site Multi-language services in Mandarin, Punjabi and Cantonese during the hours of 9:00 a.m. to 3:30 p.m. and any calls received outside of those hours will have call back service within 1 Business Day (including Saturdays) of receipt of call with IVR enabling the multi-lingual message to be left with commitment to return call within the same time period
29. Fair PharmaCare (FP) Administrative Review Process	Section 3.8	Urgent FP administrative review cases, when the patient is in immediate need of a prescription, are handled in real time as long as all required information is available Routine FP administrative review cases not associated with an urgent need to fill a prescription (such as income reviews, consent revocations, exceptions to automated processes, appeals, requests for retroactive payments) – 95% handled within 20 Business Days 100% of the following correspondence associated with FP Administrative Review will be processed within 30 Business Days: • address changes including PO cards • administrative review tickets • affidavits and income documents • applications for income review • correspondence to FP Administrative Review • Correction of information forms

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		• Canada Revenue Agency letters • FP forms • Income tax filed forms • Monthly deductible payment option • FP appeals • Retro Payment of PharmaCare
30. Fair PharmaCare Income Verification Process	Section 3.9	Automated income verification process is scheduled weekly. Prior to annual renewal the process is scheduled more frequently
31. PharmaCare Restricted Claimant Program	Section 3.10	Approved restriction and notification letter processed within 5 Business Days Temporary restriction change processed in real time Changes to approved restriction processed in real time
32. [Intentionally deleted]		
33. PharmaCare General Correspondence	Section 3.12	Blood glucose strip certificates processed within 1 Business Day Third Party Insurer requests processed within 5 Business Days Out of Province requests processed with 5 Business Days unless required sooner 90% of all general correspondence is processed within 20 Business Days from receipt 99% of all general correspondence is processed within 40 Business Days from receipt General correspondence consists of the following types of documents: • Drug receipts • PharmaCare General Correspondence • PharmaCare WorkSafe BC cheques • Pharmacy and program maintenance • Pharmacy processing

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
		• Plan B correspondence and payment adjustments
34. [Intentionally deleted]		
35. [Intentionally deleted]		
36. [Intentionally deleted]		
37. [Intentionally deleted]		
38. Document Inventory	Section 4.3	All applicable documents are archived on schedule per ORCS 100% of all documents/correspondence covered by a Service Level Requirement processed within 30 Business Days 100% of the document type 'Research Review' processed within 30 Business Days
39. Document Pre-processing/Mail Room Activities (including registration and scanning)	Section 4.4	Document pre-processing/mail room activities completed within 3 Business Days of receipt
40. Province Access	Section 4.5	Provides access to required systems/applications within 2 Business Days of request Withdraws access within 1 Business Day of request
41. Information Requests	Section 4.6	95% of correctly submitted Personal Information requests are processed within 20 Business Days from date scanned 95% of correctly submitted ICBC requested listings are processed within 20 Business Days from date scanned 100% of the following documents will be processed within 30 Business Days: • Beneficiary/MSP FOI requests • History printout to settle claims • PharmaCare FOI requests • Provider FOI requests

SERVICE FUNCTION	SERVICE SCHEDULE REFERENCE	MEASURES
42. Policy and Procedures (Operations) Manuals	Section 4.7	Procedures manuals are comprehensive and in a current state Updates as a result of policy changes are made within 5 Business Days of receiving approval
43. MSP Enrolment Specialist Secondary Queue (average queue time to a CSR)	Sections 1.2 and 2.16	Less than 10 minutes (during 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly)
44. Group Administrator and Government Agent Call Queue (average queue time to a CSR)	Section 1.2	Less than 5 minutes (during 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly) for level 1 calls Less than 5 minutes (during 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly for level 2 calls
45. Practitioner Checking Patient Coverage for MSP – Call In (average queue time to a CSR)	Section 2.13	Less than 5 minutes (during 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly)
46. PharmaCare General Public Secondary Call Queue (average queue time to a CSR)	Section 3.14	Less than 5 minutes (during 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly)

For greater certainty, other Service Level Objectives may exist from time to time pursuant to the Agreement including, without limitation, pursuant to Section 8.5 of the Agreement.

6. Monitoring and Reporting

Unless otherwise specified in this Agreement, each Service Level will be measured by the Service Provider on a monthly basis. Without limiting more immediate reporting requirements, the Service Provider will provide to the Province, as part of the Service Provider's monthly deliverables in accordance with Schedule H, a Service Level Report. The Service Provider will provide the Province with direct data access to all Service Level Reports produced by the Service Provider and all of the raw data and detailed supporting information for each Service Level Report. For greater certainty, the Service Provider shall provide sufficient access and system resources to the Province to allow the Province to generate its own reports from such data.

No less frequently than once in each Contract Year nor more frequently than twice in each Contract Year, the Province and the Service Provider will review the Service Levels to ensure they continue to remain appropriate. Such review shall be conducted by the Joint Steering Committee and shall be approved by the Joint Executive Committee upon completion.

7. Service Level Failures

If the Service Provider fails to meet a Service Level in respect of the performance of a Service, the Province shall be entitled to exercise all its rights and remedies provided to it in this Agreement, including, without limitation, the particular remedies set out in this Schedule and in Articles 8 and 21 of this Agreement.

8. Service Level Credits

The Service Provider will issue a Service Level Credit to the Province for every SLR Failure that occurs in a particular month of the Term on the basis set forth below.

(a) For each SLR Failure occurring in a particular month, the Service Provider will credit the Province the corresponding Service Level Credit for the Service Level Requirement in respect of which the SLR Failure occurred set out in the table in Paragraph 4.

(b) The Service Level Credits will be aggregated for all missed Service Levels Requirements in the applicable month and credited to Province, provided such Service Level Credits shall not exceed the At Risk Amount in such month.

(c) If a SLR Failure in respect of a particular Service Level Requirement occurs in consecutive months, the Service Level Credit for such Service Level Requirement will be multiplied by one and half (1.5) times, on a cumulative basis, when calculating the Service Level Credit resulting from such SLR Failure for each consecutive month.

(d) On the occurrence of three or more SLR Failures in respect of a particular Service Level Requirement within a six month period of the Term, the Service Level Credit for such Service Level Requirement will be multiplied by one and half (1.5) times, on a non-cumulative basis, when calculating the Service Level Credit that results from each such SLR Failure that occurs after the second SLR Failure within such six month period.

(e) In no event will the amount of Service Level Credits credited to the Province with respect to all SLR Failures occurring in a single month of the Term exceed, in total, the At Risk Amount.

(f) If one event causes SLR Failures in respect of multiple Service Level Requirements in a particular month of the Term, only the largest Service Level Credit among the Service Level Credits for the Service Level Requirements in respect of which the SLR Failures occurred will be credited to the Province in such month.

(g) In event that 25% of the total possible Service Level Credits for a month are calculated for three months out of any six month period during the Term, such failure shall be deemed to be a Material Breach for the purposes of this Agreement.

(h) The Province will have the right, on 90 days notice, but no more than twice each Contract Year to adjust the Service Level Credits amounts set out in the far right column of the table in Paragraph 4 as long as the aggregate monthly Service Level Credits to which Province is eligible hereunder do not exceed three times the At Risk Amount. For greater certainty, any such adjustment will not be subject to the Change Request Process in Article 7 of this Agreement.

(i) The total amount of Service Level Credits that the Service Provider will be obligated to credit against Fees payable by the Province to the Service Provider, with respect to SLR Failures occurring each month shall be reflected on monthly invoices issued by the Service Provider to the Province. Each Service Level Credit will be reflected on the invoice for the second subsequent month after the month in which the SLR Failure giving rise to such Service Level Credit occurred unless such SLR Failure becomes subject to the review process set out in Paragraph 10(b), in which case, the Service Level Credit will be reflected on the next monthly invoice issued by the Service Provider after the Province makes its decision whether or not to waive any of its rights based on the recommendations of the Joint Steering Committee.

9. Service Level Adjustments

The Province may issue a Change Request to:

(a) add to, delete or change the Services to be measured and/or the corresponding Service Levels for such Services, as the case may be, to reflect changes in Service delivery operations; and

(b) increase the existing Service Levels, where warranted, to reflect operational or technical improvement in delivery of the Services;

in accordance with the Change process set out in Article 7 of this Agreement. The Service Provider will use reasonable commercial efforts to implement any changes to the Services to be measured or the Service Levels which result from such process, in a diligent and expeditious manner in accordance with Article 7 of this Agreement.

10. Excused Performance

(a) The Service Provider shall not be responsible for a failure to meet one or more Service Levels, and shall not be required to pay Service Level Credits or be subject to any remedy by the Province under this Agreement including any right to terminate this Agreement, to the extent and only to the extent such failure is directly attributable to any of the following and not due to a failure of the Service Provider to perform its obligations under this Agreement:

(i) the actions or acquiescence of the Province;

(ii) the actions or acquiescence of the Service Provider, where such actions or acquiescence were expressly directed by the Province and the Service

Provider had provided prior notice in writing to the Province that such actions or acquiescence could result in such failure; or

(iii) an event of Force Majeure provided that the Service Provider complies with its obligations in Article 24 of this Agreement.

(b) If a Service Level Report shows an unusual circumstance occurred in connection with a SLR Failure, the Service Provider may require that the Joint Steering Committee consider the unusual circumstance and recommend whether or not the Service Provider should be relieved of its obligations arising from the SLR Failure because of the unusual circumstance. Based on the review of the unusual circumstance conducted by the Joint Steering Committee and its recommendations in respect thereof, the Province may, in its sole discretion, waive the Service Provider's obligation to provide Service Level Credits in respect of such SLR Failure or any other of the Province's rights pursuant to this Agreement.

(c) If a failure to meet one or more Service Levels is directly attributable to the termination of this Agreement where such termination is a result of termination by the Province for convenience or results from no fault of the Service Provider, the Service Provider may require that the Joint Steering Committee consider such failure and recommend whether the Service Provider should be relieved of its obligations arising from the SLR Failure. Based on the review of the failure conducted by the Joint Steering Committee and its recommendations in respect thereof, the Province may, in its sole discretion, waive the Service Provider's obligation to provide Service Level Credits in respect of such failure or any other of the Province's rights pursuant to this Agreement.

11. Cooperation

The achievement of the Service Levels by the Service Provider may require the coordinated, collaborative effort of the Service Provider with its Subcontractors and Suppliers. The Service Provider will provide a single point of contact for the prompt resolution of all Service Level failures and all failures to provide high quality Services to the Province, regardless of whether the reason for such Service Level failures, or failure to provide high quality Services to Province, was caused by a Subcontractor or Supplier.

APPENDIX A
SERVICE LEVEL REQUIREMENT DESCRIPTIONS

[SEE ATTACHED]

SLR 1(a) [Previous SLR 1 and 2 Combined]

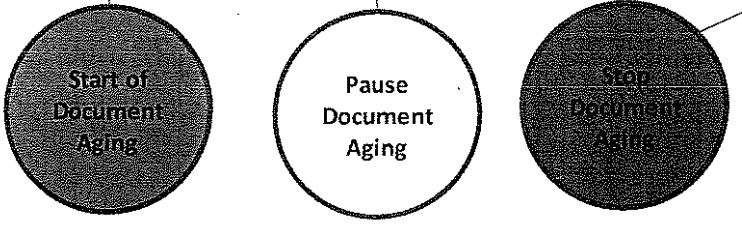
Service Function:	Provider Registration
Schedule E Reference:	Section 2.1 and 3.7
Service Level Requirements:	99% processed within 2 Business Days from registration

Definition:

HIBC receives correspondence for MSP Provider (via fax and mail) and Pharmacy registrations (initiated via email from the College of Pharmacists) on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed it is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date. These documents often require additional communication with/from the Provider, or other 3rd parties and can be placed on hold until ready for further action by HIBC staff.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-2	3+
99% within 2 Business Days	Within Target	Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd party	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month
- Volumes and % completed within target can be reported separately for each document

type as desired by the respective program areas

Measurement of % processed within 2 Business Days:

- Documents aged 2 days or less at completion are within target
- Documents aged 3 days or more at completion are outside of target
- Therefore the % processed within 2 Business Days is the number of documents completed within 2 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Provider Registration Documents completed within the calendar month
- Provider Registration Document Types
  - Medical Providers Registration
  - Pharmacy Registrations

Exclusions:

- Incomplete Provider Registration. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non-Provider Registration Document Types

Example:

A total of 120 Provider Registration documents were completed in a given month, and the completions are broken up into the following groups:

- 119 aged 2 days or less
- 1 aged 3 days or more

Then the SLR performance is measured as follows:

- 99.17% within 2 Business days (119/120)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 3

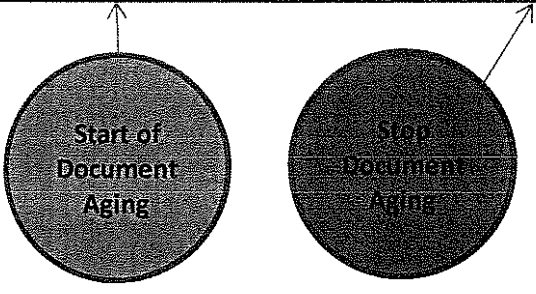
Service Function:	MSP Enrolments
Schedule E Reference:	Section 1.1
Service Level Requirements:	80% processed within 10 Business Days 99% processed within 20 Business Days

Definition:

HIBC receives MSP Enrolment documents on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date.

Age of Document (Age from Registration to Completion in Business Days)			
	0-10	11-20	21+
80% within 10 Business Days	Within Target	Outside Target	
99% Within 20 Business Days	Within Target		Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR
Document Status	Received	Registered	Registered	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 10 Business Days:

- Documents aged 10 days or less at completion are within target
- Documents aged 11 days or more at completion are outside of target
- Therefore the % processed within 10 Business Days is the number of documents completed within 10 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- MSP Enrolment Documents completed within the calendar month
- MSP Enrolment Document Types
  - Adoptions
  - Baby Registrations (including automated Baby Registrations)
  - Immigration Renewal
  - Immigration Renewal - Other
  - New Resident Apps
  - Temporary Doc App
  - Temporary Doc App - Other

Exclusions:

- Incomplete MSP Enrolment Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non-MSP Enrolment Document Types

Example:

Supposing that a total of 12000 MSP Enrolment documents were completed in a given month, and the completions are broken up into the following groups:

- 10500 aged 10 days or less
- 1450 aged between 11 and 20 days
- 50 aged 21 days or more

Then the SLR performance is measured as follows:

- 87.5% within 10 Business days (10,500/12,000)
- 99.58% within 20 Business days ((10,500+1,450)/12,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 4

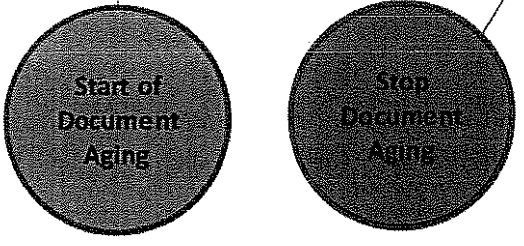
Service Function:	MSP Premium Assistance
Schedule E Reference:	Section 1.1
Service Level Requirements:	80% of the PA forms are processed within 10 business days from registration 99% of the PA forms are processed within 20 business days from registration

Definition:

HIBC receives MSP Premium Assistance documents on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-10	11-20	20+
80% within 10 Business Days	Within Target	Outside Target	
99% within 20 Business Days	Within Target		Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR
Document Status	Received	Registered	Registered	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 10 Business Days:

- Documents aged 10 days or less at completion are within target
- Documents aged 11 days or more at completion are outside of target
- Therefore the % processed within 10 Business Days is the number of documents completed within 10 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- MSP Premium Assistance Documents completed within the calendar month
- MSP Premium Assistance Document Types
  - PA Current Year
  - PA Received with Enrollment
  - PA Previous Two years
  - PA Multi-Year

Exclusions:

- Incomplete MSP Premium Assistance Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non- MSP Premium Assistance Document Types

Example:

Supposing that a total of 12000 MSP Premium Assistance documents were completed in a given month, and the completions are broken up into the following groups:

- 10500 aged 10 days or less
- 1450 aged between 11 and 20 days
- 50 aged 21 days or more

Then the SLR performance is measured as follows:

- 87.5% within 10 Business days (10,500/12,000)
- 99.58% within 20 Business days ((10,500+1,450)/12,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 5

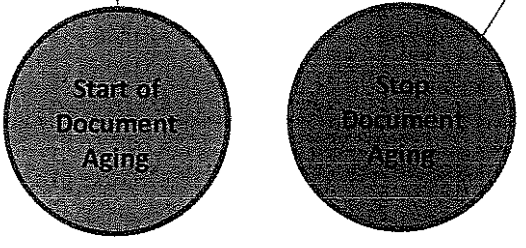
Service Function:	Fair PharmaCare Paper Registration
Schedule E Reference:	Section 3.7
Service Level Requirements:	99% processed within 3 Business Days from registration

Definition:

HIBC receives Fair PharmaCare paper registrations on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. After the document has been processed it is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-3	4+
99% within 3 Business Days	Within Target	Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR
Document Status	Received	Registered	Registered	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 3 Business Days:

- Documents aged 3 days or less at completion are within target
- Documents aged 4 days or more at completion are outside of target
- Therefore the % processed within 3 Business Days is the number of documents completed within 3 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Fair PharmaCare Paper Registration Documents completed within the calendar month
- Fair PharmaCare Paper Registration Document Types
    - Fair PharmaCare Paper Registrations

Exclusions:

- Incomplete Fair PharmaCare Paper Registration. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non- Fair PharmaCare Paper Registration Document Types

Example:

A total of 120 Fair PharmaCare Paper Registration documents were completed in a given month, and the completions are broken up into the following groups:

- 119 aged 3 days or less
- 1 aged 4 days or more

Then the SLR performance is measured as follows:

- 99.17% within 3 Business days (119/120)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 6

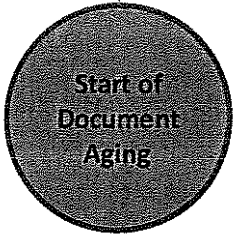
Service Function:	Beneficiary Account Maintenance
Schedule E Reference:	Section 1.1
Service Level Requirements:	80% processed within 10 Business Days 99% processed within 20 Business Days

Definition:

HIBC receives Beneficiary Account Maintenance documents on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date.

Age of Document (Age from Registration to Completion in Business Days)			
	0-10	11-20	21+
80% within 10 Business Days	Within Target	Outside Target	
80% within 20 Business Days	Within Target		Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR
Document Status	Received	Registered	Registered	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 10 Business Days:

- Documents aged 10 days or less at completion are within target

- Documents aged 11 days or more at completion are outside of target
- Therefore the % processed within 10 Business Days is the number of documents completed within 10 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Beneficiary Account Maintenance Documents completed within the calendar month
- Beneficiary Account Maintenance Document Types
  - 3rd Party Registration
  - Address Changes
  - Cancel Coverage Group
  - Cancel Coverage Pay Direct
  - CareCard Requests
  - Changes In Province
  - Changes OOP
  - Company Changes
  - Complex Correspondence
  - Convention Refugee Claimants
  - Direct Pay APP with PA
  - Direct Pay Apps
  - Employee Dept# Changes
  - Employee Record Card - OOP
  - Group Applications
  - Health Canada (Native)
  - MHR
  - Multi-Lists
  - Opt Out
  - Overage - In Canada
  - Overage - Outside Canada
  - Permanent Moves
  - Personal Status Chg
  - Power of Attorney
  - Recert Verification
  - Refugee Claimants
  - Temporary Absences

Exclusions:

- Incomplete Beneficiary Account Maintenance Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For

purposes of SLR calculation they will be included in the month in which they are completed.

- Non-Beneficiary Account Maintenance Document Types

Example:

Supposing that a total of 12000 Beneficiary Account Maintenance documents were completed in a given month, and the completions are broken up into the following groups:

- 10500 aged 10 days or less
- 1450 aged between 11 and 20 days
- 50 aged 21 days or more

Then the SLR performance is measured as follows:

- 87.5% within 10 Business days (10,500/12,000)
- 99.58% within 20 Business days ((10,500+1,450)/12,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 8

Service Function:	Maintaining Account Information of Providers
Schedule E Reference:	Section 2.1
Service Level Requirements:	99% processed within 5 Business Days from registration

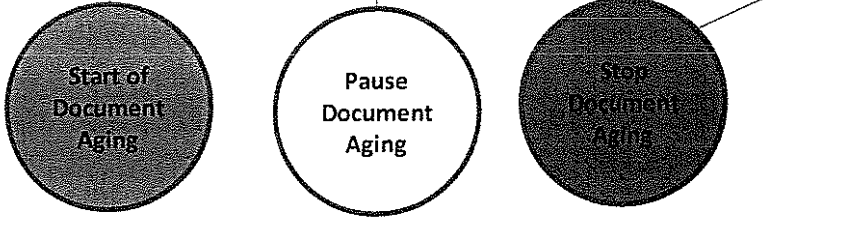
Definition:

HIBC receives Provider Account Maintenance documents on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed it is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-5	6+
99% within 5 Business Days	Within Target	Outside Target

Occasionally, these documents are placed on Hold, pending review or update by an external (non-HIBC) agent or body. Once the documentation is complete, the document is completed by HIBC staff.

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd party	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 5 Business Days:

- Documents aged 5 days or less at completion are within target
- Documents aged 6 days or more at completion are outside of target
- Therefore the % processed within 5 Business Days is the number of documents completed within 5 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Provider Account Maintenance Documents completed within the calendar month
- Provider Account Maintenance Document Types
    - Provider Account Maintenance

Exclusions:

- Incomplete Provider Account Maintenance Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.

- Non-Provider Account Maintenance Document Types

Example:

A total of 120 Provider Account Maintenance documents were completed in a given month, and the completions are broken up into the following groups:

- 119 aged 5 days or less
- 1 aged 6 days or more

Then the SLR performance is measured as follows:

- 99.17% within 2 Business days (119/120)

Service Level Agreement:

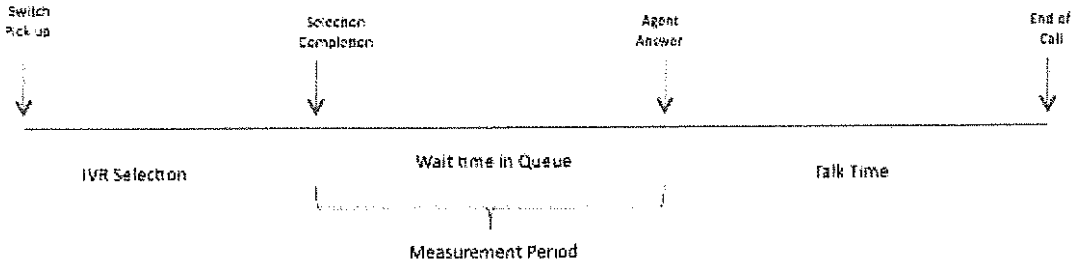
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 9

Service Function:	Beneficiaries Telephone Inquiries
Schedule E Reference:	Sections 1.2, 1.5, 2.15, 2.16 and 3.14
Service Level Requirements:	ASA < 3 minutes 8:00am - 4:30pm on public business days, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for Beneficiary Services before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53)



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the Enrolment & Registration, Fair PharmaCare Registrations and Benefit Specialist queues

Exclusions:

Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up. Any calls that are handled by Voicemail or Callback.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

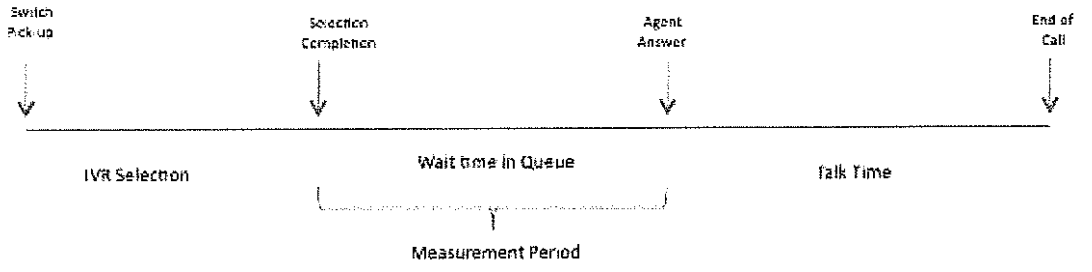
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 10

Service Function:	Provider Telephone Inquiries
Schedule E Reference:	Sections 2.13, 2.14, 3.13 and 4.8
Service Level Requirements:	ASA < 1 minute 8:00am - 4:30pm on public business days, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for Provider Services before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 0:53)



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the Practitioner Account Services, Teleplan HelpDesk, Out of Country Claims Specialists, Pharmacy Enquiries, Pharmacy Enquiries - System Problems and, Emergency Room queues

Exclusions:

Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up. Any calls that are handled by Voicemail or Callback.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=1,325,000 seconds, W = 2500

1,325,000 / (30,000 – 2500 - 2500) = 53

53 = 0 minutes 53 seconds

Average Speed to answer = 0:53

Service Level Agreement:

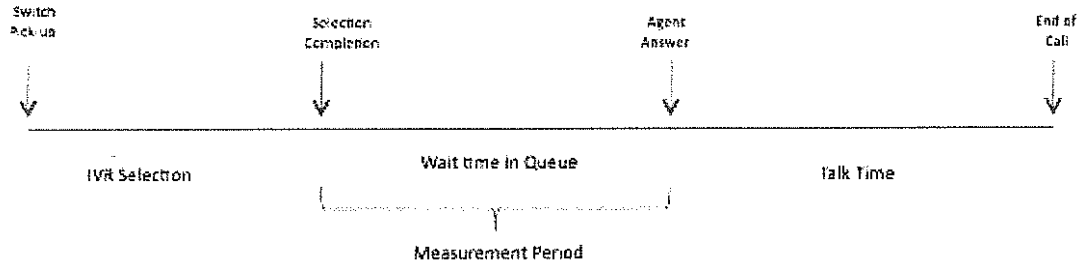
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 10(a)

Service Function:	Billing Support Telephone Inquiries
Schedule E Reference:	Sections 2.13, 2.14, 3.13 and 4.8
Service Level Requirements:	ASA < 3 minutes 8:00am - 4:30pm on public business days, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for Billing Support before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53)



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the Practitioner Billing Support queue

Exclusions:

Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up. Any calls that are handled by Voicemail or Callback.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

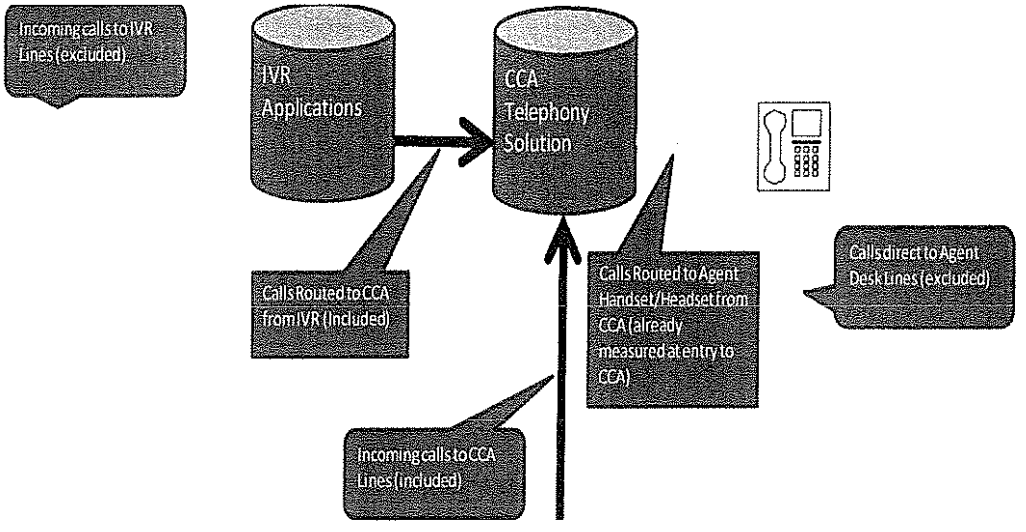
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 11

Service Function:	Busy Rate
Schedule E Reference:	Sections 1.2, 1.5, 2.14, 2.15, 2.16, 3.13, 3.14 and 4.8
Service Level Requirements:	Less than or equal to 2% (during 8:00 a.m. – 4:30 p.m. averaged monthly)

Definition:

Busy Rate is defined as the number of calls receiving a 'busy signal' divided by the total number attempts made to contact a service.



Calculation Method:

Measurement of Busy Rate less than or equal to 2% (during 8:00 a.m. – 4:30 p.m. averaged monthly):

- Telus provides a monthly report detailing peak volumes, and peak utilization by day for the past month

Inclusions:

All incoming phone lines/numbers to CCA

Exclusions:

Calls to physical phone lines (i.e. direct, personal, desk lines)
Calls resolved by the IVR
Calls received outside of 8:00 a.m. -4:30 p.m.

Example:

See attached report (Page 3).

Percent utilization during the monthly peak was 75%, indicating that capacity was such that all callers were routed appropriately and no one would have received a busy signal.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

APPENDIX

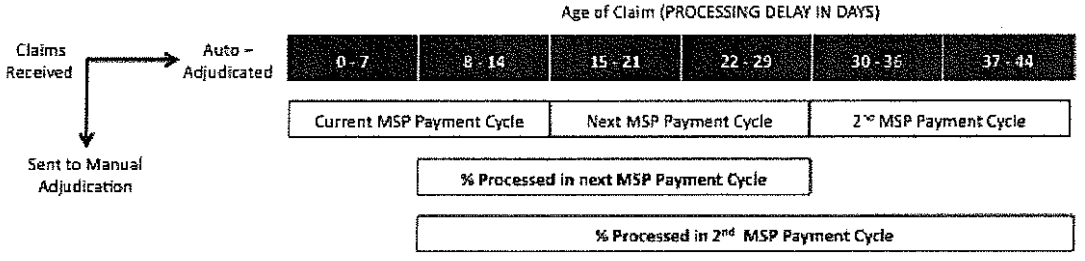
Date	Peak Hour	Incoming Calls	Outgoing Calls	Total Calls	Hold Time (s)	Minutes of Use	Channels Working	Channels Required	Percent Utilization
2012-09-01	10:30	135	36	171	187	532	552	18	3%
2012-09-02	11:30	73	28	101	143	240	552	11	2%
2012-09-03	13:30	64	21	85	140	198	552	9	2%
2012-09-04	10:00	958	320	1278	746	15895	552	306	55%
2012-09-05	11:30	875	293	1168	676	13167	552	255	46%
2012-09-06	9:30	835	258	1093	749	13653	552	266	48%
2012-09-07	12:00	731	232	963	718	11530	552	226	41%
2012-09-08	10:00	129	33	162	251	677	552	20	4%
2012-09-09	15:00	45	19	64	208	222	552	11	2%
2012-09-10	11:00	1049	283	1332	758	16832	552	323	59%
2012-09-11	10:30	911	261	1172	785	15338	552	295	53%
2012-09-12	13:30	888	301	1189	852	16883	552	323	59%
2012-09-13	10:30	1029	331	1360	880	19945	552	377	68%
2012-09-14	11:00	1043	326	1369	802	18288	552	350	63%
2012-09-15	10:30	143	32	175	207	603	552	19	3%
2012-09-16	14:30	58	30	88	155	227	552	11	2%
2012-09-17	12:30	1112	325	1437	919	22002	552	415	75%
2012-09-18	10:00	1075	345	1420	738	17467	552	334	61%
2012-09-19	10:30	1022	340	1362	669	15175	552	292	53%
2012-09-20	10:00	906	324	1230	672	13775	552	268	49%
2012-09-21	13:30	750	246	996	683	11330	552	223	40%
2012-09-22	12:00	130	29	159	279	738	552	21	4%
2012-09-23	11:30	56	12	68	374	423	552	15	3%
2012-09-24	10:00	981	297	1278	743	15835	552	305	55%
2012-09-25	14:30	753	268	1021	701	11932	552	234	42%
2012-09-26	11:00	783	228	1011	675	11367	552	223	40%
2012-09-27	10:00	787	331	1118	607	11302	552	222	40%
2012-09-28	13:30	733	200	933	950	14772	552	285	52%
2012-09-29	12:00	130	32	162	320	863	552	24	4%
2012-09-30	14:30	53	17	70	199	232	552	11	2%

SLR 12

Service Function:	In-province auto-adjudicated claims
Schedule E Reference:	Sections 2.4 and 4.8
Service Level Requirements:	96.5% processed within the next MSP Payment Cycle 98.5% processed within 2nd MSP Payment Cycle

Definition:

MSP claims received by HIBC are either auto-adjudicated by the claims system or referred to the manual adjudication process (see SLR 13). SLR 12 measures the % of auto-adjudicated claims that are processed within the next MSP payment cycle and the 2nd MSP payment cycle.



Calculation Method:

- Attainment of the SLRs is measured based on the Processing Delay Analysis report generated during each payment run, approximately 7 days before the payment date
- The report provides counts of claims that will be paid on the payment date, grouped by age range (PROCESSING DELAY IN DAYS) in 7-day intervals.

Measurement of % processed within the next MSP Payment Cycle:

- As the payment run occurs 7 days before the payment date, there are no claims aged 0 – 7 days old that will be paid on the payment date.
- All claims aged 8 – 14 days will be paid within the CURRENT MSP Payment Cycle.
- All claims aged 15 – 29 days will be paid within the NEXT MSP Payment Cycle.
- Therefore the % processed within the next MSP Payment Cycle measures the CUMULATIVE PERCENTAGE of claims aged 0 – 29 days that will be paid on the payment date.
- As there are two payment cycles per month, the monthly report for SLR 12 reports the weighted average (by volume) of these figures.

Measurement of % processed within the 2ND MSP Payment Cycle:

- All claims aged 30 – 44 days will be paid within the 2ND MSP payment cycle.

- Therefore the % processed within the next MSP Payment Cycle measures the CUMULATIVE PERCENTAGE of claims aged 0 – 44 days that will be paid on the payment date.

- As above, the monthly report for SLR 12 reports the weighted average (by volume) of these figures over the two payment cycles in the month.

Inclusions:

All auto-adjudicated MSP claims

Exclusions:

Manually adjudicated MSP claims
Non-MSP claims

Example:

See attached report (Page 3).

% processed within the next MSP Payment Cycle is the CUMULATIVE PERCENTAGE of claims with PROCESSING DELAY IN DAYS of 22 – 29 days (i.e., 97.77%).

% processed within the 2nd MSP Payment Cycle is the CUMULATIVE PERCENTAGE of claims with PROCESSING DELAY IN DAYS of 37 – 44 days (i.e., 99.65%).

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

APPENDIX

CP152PDLYL02 M S P - CLAIMS DIVISION PAGE 1

RUN AT 2012-09-21 22:21 PROCESSING DELAY ANALYSIS PAYMENT RUN: 1059 2012-09-28

FOR IN-PROVINCE SERVICES - ALL AUTOMATED CLAIMS PROCESSING

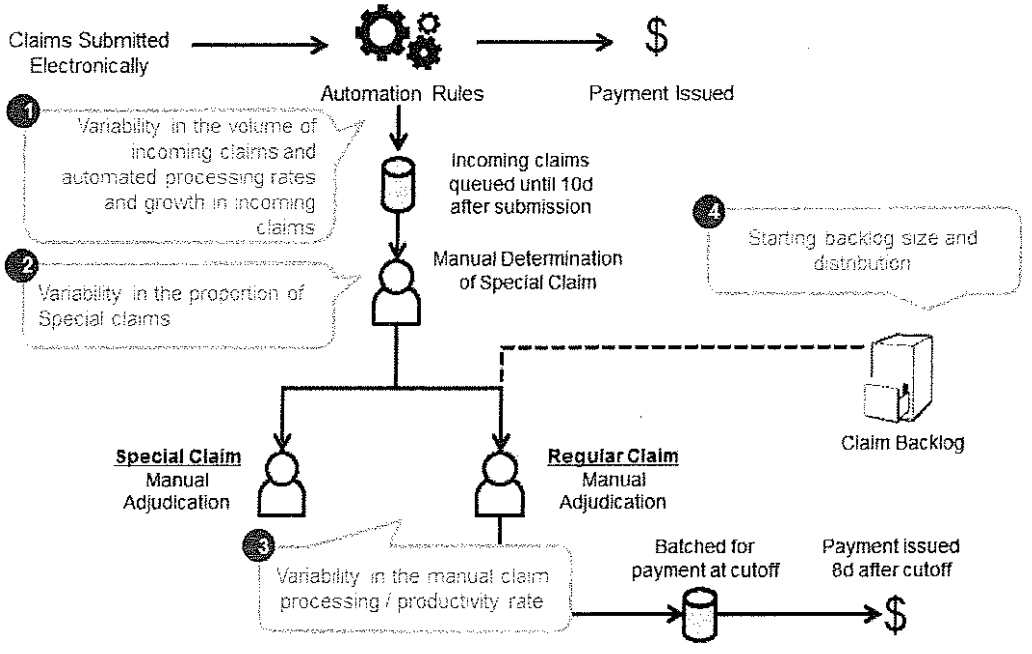
PROCESSING DELAY IN DAYS	NUMBER OF DETAILS	PERCENTAGE OF TOTAL NUMBER	CUMULATIVE PERCENTAGE	PAID AMOUNT ($000'S)	PERCENTAGE OF TOTAL AMOUNT	CUMULATIVE PERCENTAGE
000 - 007	0	0.00	0.00	0	0.00	0.00
008 - 014	1,427,340	35.86	35.86	46,870	40.27	40.27
015 - 021	1,793,228	45.05	80.90	49,230	42.29	82.56
022 - 029	671,524	16.87	97.77	16,954	14.57	97.13
030 - 036	56,763	1.43	99.20	2,234	1.92	99.04
037 - 044	18,172	0.46	99.65	611	0.53	99.57
045 - 059	7,228	0.18	99.84	282	0.24	99.81
060 - 074	4,391	0.11	99.95	170	0.15	99.96
075 - 089	601	0.02	99.96	27	0.02	99.98
090 - 119	758	0.02	99.98	12	0.01	99.99
120 - 149	316	0.01	99.99	3	0.00	99.99
150 - 179	195	0.00	99.99	5	0.00	100.00
180 - 209	262	0.01	100.00	2	0.00	100.00
210 - 239	14	0.00	100.00	0	0.00	100.00
240 - 269	7	0.00	100.00	0	0.00	100.00
OVER 269	0	0.00	100.00	0	0.00	100.00
TOTAL	3,980,799	100.00	100.00	116,401	100.00	100.00

SLR 13

Service Function:	In-province manually Adjudicated Claims
Schedule E Reference:	Section 4.8, 2.5
Service Level Requirements:	100% processed within 85 days from date of receipt

Definition:

HIBC receives claims submitted by physicians and other medical services providers on an ongoing basis. The majority of these claims are auto-adjudicated; however a significant number are rejected to manual processing. SLR 13 measures the % of claims adjudicated within 85 days of receipt.



Calculation Method:

- Attainment of the SLRs is measured based on the Processing Delay Analysis report generated during each payment run, approximately 7 days before the payment date.
- The report provides counts of claims that will be paid on the payment date, grouped by age.

Measurement of % processed within 85 days:

- As the payment run occurs 7 days before the payment date, there are no claims aged 0 – 7 days old that will be paid on the payment date.

- Claims aged 0-85 days are completed within target.
- Claims aged 86+ days are completed outside of target.
- Therefore the % processed within 85 days will be defined as the # of claims processed within 85 days, divided by the total # of claims processed in the month (both inside and outside of target).
- As there are two payment cycles per month, the monthly report for SLR 13 will report the weighted average (by volume) of these figures.

Inclusions:

- Manually adjudicated claims completed within the calendar month.

Exclusions:

- Incomplete claims. Incomplete claims are claims that are in inventory at month end, but that have not yet been adjudicated. For purposes of SLR calculation they will be included in the month in which they are adjudicated. After adjudication they may be included as automated or manual claims, as a future rule change could lead to the claim being automated, despite being rejected for manual processing in a past run.
- Claims held for clinical review.
- Non-MSP claims (WorkSafeBC, ICBC). These claims will continue to be worked on a priority basis.
- Growth in the number of manually adjudicated claims that exceeds the agreed-to growth rate included in the new SLR that will be excluded.

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Actual Volume	1,000,622	1,134,416	1,090,839	1,140,056	1,011,331	1,034,762									
Forecast Volume (3% growth)							1,065,805	1,097,779	1,130,712	1,164,634	1,199,573	1,235,560	1,272,627	1,310,806	1,350,130

- Claims that have aged over 85 days due to circumstances beyond MAXIMUS' control.

Example:

Supposing that a total of 12000 Manual In-Province Claims were completed in a given payment run, and the completions are broken up into the following groups:

- 11550 aged 85 days or less
- 50 aged 86 days or more

Then the SLR performance is measured as follows:

- 99.58% within 85 days ((10,500+1,450)/12,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 14(a) [Previous SLR 14 and 15 Combined]

Service Function:	Out of Country Claims (OOC)
Schedule E Reference:	Section 2.6
Service Level Requirements:	80% of all incoming claims are processed within 42 business days 95% of all incoming claims are processed within 63 business days

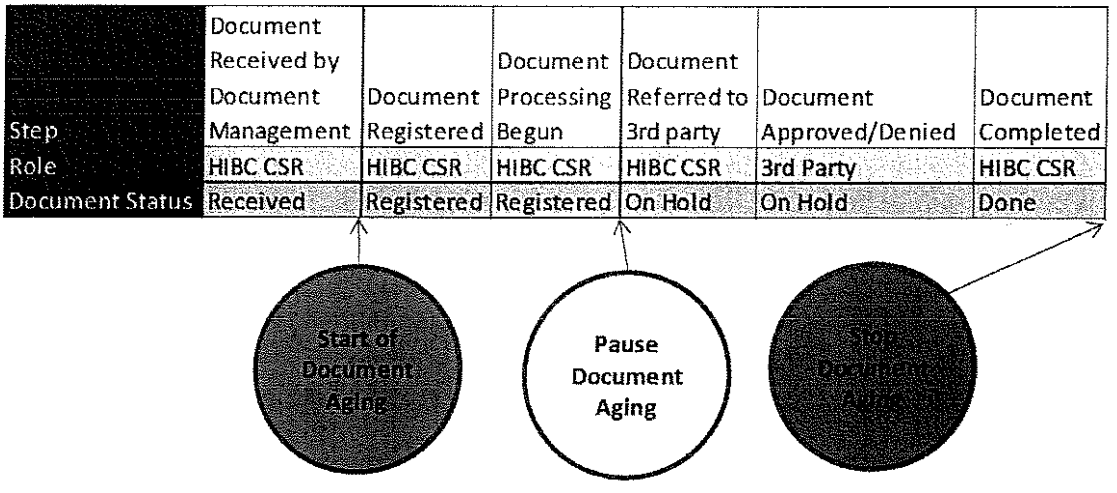
Definition:

HIBC receives Out of Country Claims on an ongoing basis. These claims are submitted by beneficiaries or 3rd party insurers for expenses that occurred for emergency medical procedures while out of country or provided in Quebec. These claims are adjudicated by HIBC Staff based on the MSP Payment Schedule.

Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date, excluding Hold time.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-42	43-63	64+
80% within 42 Business Days	Within Target	Outside Target	
95% within 63 Business Days	Within Target		Outside Target

Occasionally these documents require additional communication with/from the Provider, or other 3rd parties and can be placed on hold until ready for further action by HIBC staff.



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 42 Business Days:

- Documents aged 42 days or less at completion are within target.

- Documents aged 43 days or more at completion are outside of target.

- Therefore the % processed within 42 Business Days is the number of documents completed within 42 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Measurement of % processed within 63 Business Days:

- Documents aged 63 days or less at completion are within target.

- Documents aged 64 days or more at completion are outside of target.

- Therefore the % processed within 63 Business Days is the number of documents completed within 63 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

- Out of Country Claims Documents completed within the calendar month
- Out of Country Claims Document Types
    - Claims for Uninsured Services
    - Claims with No ID or PHN
    - Priority OOC Corr
    - Svcs Provided OOP/OOC
    - Claims Submitted by Travel Insurer

Exclusions:

- Incomplete Out of Country Claims Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non- Out of Country Claims Document Types
- Growth in the number of 3rd party OOC claims that exceeds the agreed-to volume cap will be excluded. For the years 2013-2020 the volume cap is 30,859. The volume caps are associated to OOC 3rd Party claims only.

Example:

Supposing that a total of 12000 Out of Country Claims documents were completed in a given

month, and the completions are broken up into the following groups:

- 10500 aged 42 days or less
- 1450 aged between 43 and 63 days
- 50 aged 63 days or more

Then the SLR performance is measured as follows:

- 87.5% within 42 Business days (10,500/12,000)
- 99.58% within 63 Business days ((10,500+1,450)/12,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 16(a) [Previous SLR 16 and 17 Combined]

Service Function:	MSP Provider Pre-Authorizations
Schedule E Reference:	Section 2.8
Service Level Requirements:	100% within 7 Business Days

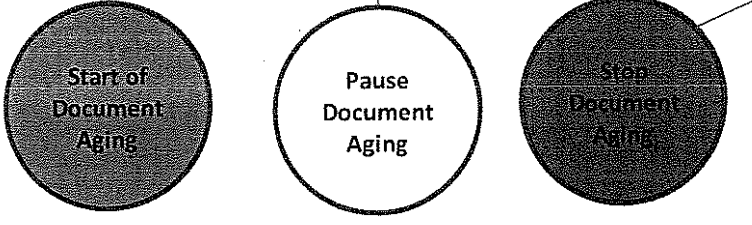
Definition:

HIBC receives MSP Provider Pre-Authorization documents on an ongoing basis. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. The Document age is the elapsed time, in Business Days, from Registration Date to Completion Date, excluding Hold time.

Age of Document (Age from Registration to Completion in Business Days)		
	0-7	8+
100% within 7 Business Days	Within Target	Outside Target

Occasionally, these documents are placed on Hold, pending review by an external (non-HIBC) medical consultant. Once the medical consult approves or denies the Pre-Authorization, the document is completed by HIBC staff.

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Referred to Medical Consultant	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	Medical Consultant	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 7 Business Days:

- Documents aged 7 days or less at completion are within target
- Documents aged 8 days or more at completion are outside of target
- Therefore the % processed within 7 Business Days is the number of documents completed within 7 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- MSP Provider Pre-Authorization Documents completed within the calendar month
- MSP Provider Pre-Authorization Document Type
    - Authorization In Province (previously *Authorization - Cosmetic Requests*)

Exclusions:

- Incomplete MSP Provider Pre-Authorization Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non- MSP Provider Pre-Authorization Document Types

Example:
A total of 1000 MSP Provider Pre-Authorization documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 7 days or less
- 1 aged 8 days or more

Then the SLR performance is measured as follows:

- 99.9% within 7 Business days (999/1,000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 19

Service Function:	Health Care Practitioner and Pharmacy payments – Data files transmitted by the Service Provider to the Province to approve and distribute payments (excluding specific situations where Office of the Controller General (British Columbia) is not available to receive the transmission of the file)
Schedule E Reference:	Sections 2.3, 3.1, 3.6 and 4.8
Service Level Requirements:	**Requirement 1** - MSP claims payments: mid and end of month – 100% on time issued. **Requirement 2** - Pharmacy: weekly - 100% issued on time

Definition:

Data files are transmitted by HIBC to the Province to approve and distribute payments. Excluding specific situations where the Office of the Controller General (British Columbia) is not available to receive the transmission of the file, HIBC has an obligation to transmit these files in accordance with the agreed schedule.

Calculation Method:

- Attainment of the SLRs is measured based on whether the respective MSP Claims and PharmaCare jobs run successfully before the transmission deadline.

Measurement of % payments issued on time:

- System Incident logs are consulted to determine whether there were any incidents that would impact generation or transmission of these files.
- MSP Claims Production Control and PharmaCare HelpDesk are responsible for monitoring these file transmission; supervisors in these areas are then contacted to ascertain whether jobs ran successfully.
- System Incident Log and communications with the above groups are retained to verify SLR results as needed.

Inclusions:

- MSP Claims Payments (twice a month).
- Pharmacy Payments (weekly).

Exclusions:

- Downtime due to scheduled maintenance.
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS such as CGI and SSBC.

Example:

System incident log is checked; no incidents reported. MSP Claims Production Control and PharmaCare HelpDesk supervisors are emailed asking them to confirm that payments ran on time.

Supervisors confirm that respective jobs were successfully completed as scheduled.

Payments were issued 100% on time.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 20 (a) [Previous SLRs 20, 21 and 22 Combined]

Service Function:	PharmaNet Help Desk PharmaNet Application Teleplan Application accepting claims
Schedule E Reference:	Sections 3.13, 3.1, 2.3, 4.8
Service Level Requirements:	24/7 99.9% of the Contract Year (i.e. 8.76 hours per application for a total of 26.28 hours of downtime cumulatively permitted per Contract Year) with no single outage > 4 hours after total downtime > .1% during the Contract Year

Definition:

The services identified support Pharmacists, Physicians and other providers who use the PharmaNet and Claims systems. In case of a service outage or disruption MAXIMUS has established a business continuity plan, (including a back-up facility and phone lines), which allows the HelpDesk to continue handling calls and providing support with minimal service disruption, and for PharmaNet and Claims systems to recover with minimal impact to service levels.

Calculation Method:

- To be out of compliance with this SLR, the listed services must first exceed the 26.28 hours (in aggregate) of permitted downtime during the Contract Year (24 hours * 365 days *3 applications = 26280 hours/year).

- If more than 26.28 hours of downtime for the year have been accrued, attainment of the SLR is measured based on the duration of any outages throughout the month. There is a penalty associated with missing the availability target, regardless of the duration of subsequent outages.

Measurement of % availability (Contract Year):

- System Incident logs are consulted to determine whether there were any outages that impacted the listed services.

- Application owners are contacted to confirm whether there were any outages, and to provide the duration of outage if necessary.

- System Incident Log and communications with the above groups are retained to verify SLR results as needed.

- If multiple outages occur during the Contract Year, the hours are accrued to determine whether HIBC has exceeded the 26.28 hours of permitted downtime.

Measurement of outage duration:

- System Incident logs are consulted to determine whether there were any outages that impacted the listed services.
- Application owners are contacted to confirm whether there were any outages, and to provide the duration of outage if necessary.
- System Incident Log and communications with the above groups are retained to verify SLR results as needed.

Inclusions:

- Outages to the listed services.

Exclusions:

- Downtime due to scheduled maintenance
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS such as CGI and SSBC.

Example:

System incident log is checked; a single severity 1 incident preventing access to PharmaNet occurred during the last month, 4.1 hours in duration, no further outages are reported during the Contract Year. Business and application owners confirm the outage and duration.
As there were no other incidents reported in the Contract Year, HIBC has not exceeded the 26.28 hours of permitted downtime, and the SLR has been attained.
However MAXIMUS has now accrued 4.1 hours of downtime this year towards the permitted amount of 26.28 hours. Further outages beyond that threshold could result in SLR failure.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 23(a) [Previous SLRs 23, 24 and 25 Combined]

Service Function:	Fair PharmaCare IVR and Web Application IVR Travel Assistance Application Self Service Options and IVR Applications
Schedule E Reference:	Section 3.7, 1.4, 1.1, Item #13 in General Responsibilities and Principles
Service Level Requirements:	24/7 99.8% of the Contract Year (i.e. 17.52 hours per application for a total of 52.56 hours of downtime cumulatively permitted per Contract Year) with no single outage > 4 hours after total downtime > .2% during the Contract Year

Definition:

The services identified provide IVR and other self-service options for Fair PharmaCare and Travel Assistance programs. In case of a service outage or disruption MAXIMUS has established a business continuity plan, (including a back-up facility and phone lines), which allows the systems continue handling calls and providing support with minimal service disruption, and for systems to recover with minimal impact to service levels.

Calculation Method:

- To be out of compliance with this SLR, the listed services must first exceed the 52.56 hours (in aggregate) of permitted downtime during the Contract Year (24 hours * 365 days *3 applications = 26280 hours/year).

- If more than 52.56 hours of downtime for the year have been accrued, attainment of the SLR is measured based on the duration of any outages throughout the month. There is a penalty associated with missing the availability target, regardless of the duration of subsequent outages.

Measurement of % availability (Contract Year):

- System Incident logs are consulted to determine whether there were any outages that impacted the listed services.

- Business and application owners are contacted to confirm whether there were any outages, and to provide the duration of outage if necessary.

- System Incident Log and communications with the above groups are retained to verify SLR results as needed.

- If multiple outages occur during the Contract Year, the hours are aggregated to determine whether HIBC has exceeded the 52.56 hours of permitted downtime.

Measurement of outage duration:

- System Incident logs are consulted to determine whether there were any outages that impacted the listed services.
- Business and application owners are contacted to confirm whether there were any outages, and to provide the duration of outage if necessary.
- System Incident Log and communications with the above groups are retained to verify SLR results as needed.

Inclusions:

- Outages to the listed services.

Exclusions:

- Downtime due to scheduled maintenance.
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS such as CGI and SSBC.

Example:

System incident log is checked; a single severity 1 incident preventing access to the TAP IVR occurred during the last month, 4.1 hours in duration, no further outages are reported during the Contract Year. Business and application owners confirm the outage and duration.
As there were no other incidents reported in the Contract Year, HIBC has not exceeded the 52.56 hours of permitted downtime, and the SLR has been attained.
However MAXIMUS has now accrued 4.1 hours of downtime this year towards the permitted amount of 52.56 hours. Further outages beyond that threshold could result in SLR failure.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 26

Service Function:	Quality Adjudication
Schedule E Reference:	Sections 2.2, 2.5, 2.6, 2.8 and 4.8
Service Level Requirements:	Minimum of 98% accuracy

Definition:

Provider claims are randomly checked for adjudication accuracy. Claims are checked for errors such as incorrect payment amount, breach of privacy protocol, incorrect fee item paid, incorrectly addressed letters, or providing inaccurate information in a call or letter. A minimum of 10 claims are checked per full time FTE and the accuracy is reported as an overall % for all claims checked within the reporting month. These individual audits are referred to as quality monitors. An error as listed above would result in that particular claim being scored as 0% accurate. An individual who has 10 claims checked, and makes an error on one of them would have a score of 90%.

Calculation Method:

- Attainment of the SLR is measured based on the average score of all monitors completed.

Measurement of % accuracy:

- The % scores for all individual quality monitors are averaged, resulting in the final, overall % score achieved.
- All quality monitors are either 100% accurate, or inaccurate (0% accurate).
- The % accurate is summed for all in-scope quality monitors, and divided by the total number of quality monitors performed.

Inclusions:

- All quality monitors completed within the calendar month for the work types described below:
    - In Province Claims (includes WCB, ICBC)
    - Out of Country Claims (includes OOP Payees)
    - Cosmetic Surgery
    - Northern Isolation Outreach Program
    - Rural Locum Program

Exclusions:

- Quality checks for work types not defined above.

Example:

Supposing that a total of 320 claims were checked in a given month, and 300 are determined to be 100% accurate. The remaining 20 monitors were scored 0%:

- 300 quality monitors at 100%

- 20 quality monitors at 0%

Then the SLR performance is determined as follows:

- 300 / 320 = 93.75%

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLR 27

Service Function:	Notification of Critical Items (i.e. information breaches)
Schedule E Reference:	Item #9 in General Responsibilities and Principles
Service Level Requirements:	2 hours (from supervisor's/CPO's notification to the Potential Incident's Group)

Definition:

Maximus employees may have access to citizens of BC personal information. Maximus has the highest standards of systems, procedures and processes to ensure that information is accessed only when there is a business need to do so, however there are occasions when an administrative or significant privacy breach occurs

When a suspected breach occurs there is a requirement to provide notification to the Ministry of Health. The initial action that may cause reason to believe a breach has happened may occur upon receiving mail, handling a call, or through Maximus' ongoing operational employee audit. If it is realized or suspected that personal information has been disclosed inappropriately, employees are required to report the incident to their supervisor or a designated supervisor as soon as they become aware of it. If the supervisor (or designate) agrees or suspects that a privacy breach has occurred, they immediately report the incident to the Potential Incident mailbox via email. This mailbox is monitored throughout the business day (8:00am – 4:30pm, Monday-Friday; except Statutory Holidays) by the Potential Incidents Group who assign incident numbers and report the potential privacy incidents to the Ministry of Health and the Maximus Chief Privacy Officer. This report will also contain the timestamp from the initial email sent by the Supervisor to the Potential Incidents Group. Potential Incidents staff may also consult with the Privacy Auditor or Chief Privacy Officer in order to further confirm that a privacy breach has occurred, clarify potential errors, or to determine if a 3rd Party was the cause of the incident. After the initial report to the Ministry, further investigation is done by MAXIMUS/HIBC staff to ascertain the cause and responsibility for the breach as well as confirm whether the incident was in fact a Privacy Incident.

Breaches discovered through HIBC operations

Role	HIBC Employee	HIBC Analyst	Potential Incidents Group	Ministry Staff
Action	Discovers potential breach and informs Supervisor.	Receives Breach and provides summary via email to 'Potential Incident' distribution list.	Assigns incident number and relays to Ministry Staff via email to 'MoH Privacy Incident Report' distribution list.	Receives breach notification, advises OCIO accordingly, escalates as needed and follow-up with HIBC CPO and Privacy Analyst.

Breaches discovered through privacy audit

Role	HIBC Privacy Auditor	HIBC Privacy Officer (CPO)	Ministry Staff
Action	Discovers potential breach and informs Chief Privacy Officer (CPO).	Assigns incident number and relays to Ministry Staff via email. Informs Potential Incidents group that they need to use next available incident number.	Receives breach notification, advises OCIO accordingly, escalates as needed and follow-up with HIBC CPO and Privacy Analyst.

Calculation Method:

- Attainment that the SLR is measured based on whether the Ministry of Health is notified within 2 hours of the suspected breach being initially reported to the Potential Incidents Group.

Measurement of delay to provide initial unconfirmed notice:

- At month end, the incoming timestamps for emails to the Potential Incident mailbox are compared to the outgoing timestamps for emails from the Potential Incident mailbox to provide confirmation that all incidents were reported to Ministry staff within 2 hours of discovery.

Inclusions:

- Suspected Privacy Incidents.
- Suspected 3rd Party Privacy Incidents (incorrectly delivered mail, etc.).

Exclusions:

- Time elapsed from the point where the front-line employee suspects a breach, to the time their supervisor deems it a potential breach and reports it to the OSS desk.
- Time elapsed from the point where the auditor suspects a breach, to the time that the Chief Privacy Officer deems it a breach and reports it to the OSS desk.

Inclusion of such time, or to include all breaches suspected by front line employees or Auditor, would be administratively burdensome due to a large volume of unconfirmed incidents that were not ultimately determined to be privacy incidents.

Example:

The Potential Incident mailbox contains an incoming and outgoing mail for every suspected incident. The timestamp on the incoming mail is compared against the timestamp on the outgoing mail; it is determined that no incident was reported more than 2 hours from discovery.

SLR is met.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

APPENDIX B
SERVICE LEVEL OBJECTIVE DESCRIPTIONS

[SEE ATTACHED]

SLO 1

Service Function:	MSP Beneficiary Registration and Account Maintenance Services
Schedule E Reference:	Section 1.1
Service Level Objectives:	95% of "no charge" replacement CareCards will be mailed within 10 Business Days from the date of the telephone or from the date a written request in processed.

Definition:

CareCard requests are submitted as paper forms, or communicated during a call with a beneficiary. Call requests are processed in real-time, and paper claims are processed under guidelines laid out in SLR 6 (MSP Maintenance).

Processing of CareCard requests leads to updates on the R&PB system for approved requests. These requests are batched and transmitted to the CareCard provider (Giesecke & Devrient) twice weekly on Monday and Wednesday evenings. Included in the same files are requests for CareCards for new enrollees in MSP.

G&D service level requirements are such that all CareCards are processed within timeframes needed for Maximus to meet SLO 1. Typically, CareCards are generated by G&D within two to four business days of receipt.

Calculation Method:

- Attainment of the SLO is measured based on whether the CareCard transmission ran successfully.
- System Incident logs are consulted to determine whether there were any incidents that would impact generation or transmission of these files.
- Production Control staff review the balancing logs on Tuesday and Thursday mornings following the file transmission to check for errors; providing additional assurance that process ran correctly.

Inclusions:

- Gold & Regular CareCard requests
- New and Replacement CareCard requests

Exclusions:

- None.

Example:

System incident log is checked; no incidents reported.

CareCards were issued 100% on time.

Service Level Agreement:

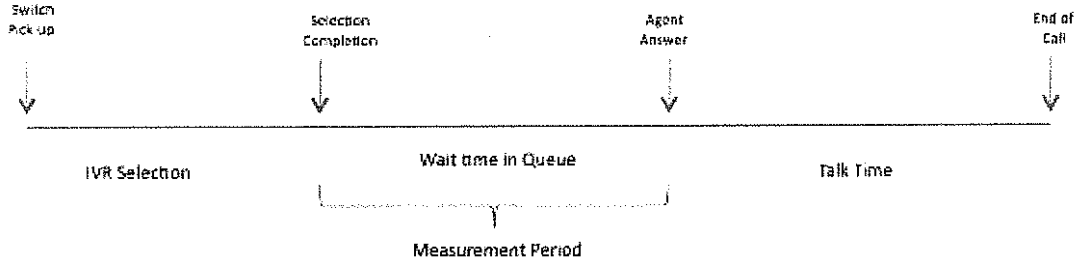
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 5

Service Function:	MSP Beneficiary Travel Assistance Program – CSR support
Schedule E Reference:	Section 1.5
Service Level Objectives:	**Objective 1 -** ASA < 3 minute 8:00am - 4:30pm on public business days Monday through Friday except statutory holidays, averaged monthly **Objective 2 -** 100% of all Travel Assistance correspondence to be processed within 30 business days

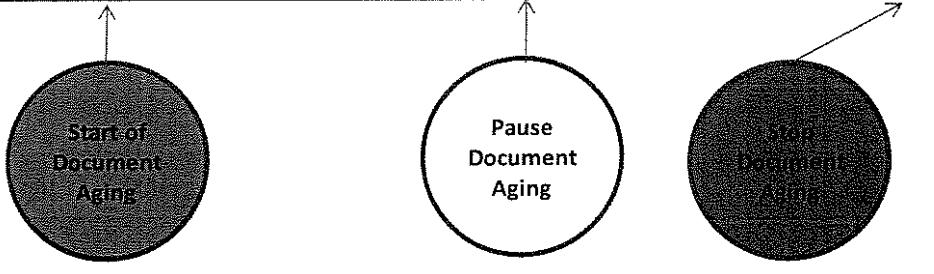
Definition:

Average Speed to Answer is the wait time in the queue for a Travel Assistance CSR before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 0:53). HIBC receives a low volume of Travel Assistance correspondence documents. These



documents were previously measured under SLO 38. This measure is now grouped with Objective 1 in order to align all TAP related measures for CSR support in once place.

Age of Document (Age from Aging Start to Completion in Business Days)						
		0-30		31+		
100% within 30 Business Days		Within Target		Outside Target		
Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objective 1 - ASA

- Total number of seconds callers were waiting in the queue
  Divided by
  (Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback).

- Expressed in minutes and seconds.

Objective 2 – Processing Delay

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Inclusions:

Objective 1 - ASA

- All agent answered calls received in the Travel Assistance queues.

Objective 2 – Processing Delay

- Travel Assistance Documents completed within the calendar month.

- Travel Assistance Document Types
  - Travel Assistance Program

Exclusions:

Objective 1 - ASA

- Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up. Any calls that are handled by Voicemail or Callback.

Objective 2 – Processing Delay

- None.

Example:

Objective 1 - ASA

- X= number of calls accepted

- Y = number of calls abandoned
- Z = Total number of seconds caller are waiting in the queue
- W = number of calls handled by Voicemail or Callback

- Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=1,325,000 seconds, W = 2500

- 1,325,000 / (30,000 – 2500 - 2500) = 53

- 53 = 0 minutes 53 seconds

- Average Speed to answer = 0:53

Objective 2 – Processing Delay

A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 30 days or less from Received Date to Completion
- 1 aged 31 days or more from Received Date to Completion

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (999/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 7

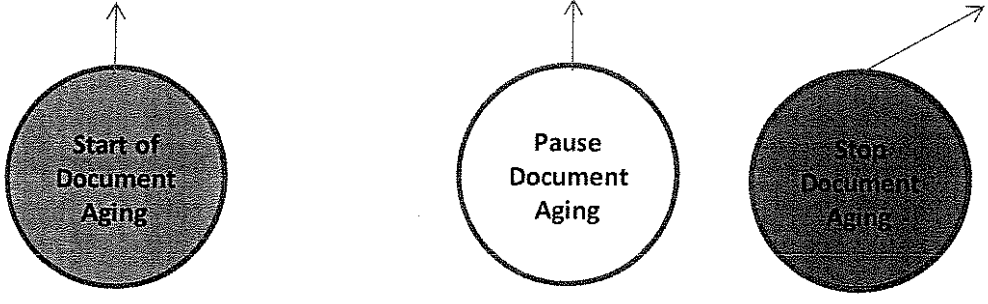
Service Function:	MSP Non-Fee for Service Payments
Schedule E Reference:	Section 2.2
Service Level Objectives:	**Objective 1** - Payment requests from the Ministry to Health Authorities and Primary Care sites are processed within one Payment Cycle from date of receipt of correct and complete invoice. **Objective 2** - Medical Advisor Sessional and travel expenses are paid within one Payment Cycle from date of receipt of correct and complete invoice. **Objective 3** - 100% of Rural Health correspondence is processed within 30 business days.

Definition:

HIBC receives a low volume of Rural Health correspondence documents. These documents were previously measured under SLO 38. This measure is now grouped with Objectives 1 and 2 in order to align all related measures for CSR support in one place.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-30	31+
100% within 30 Business Days	Within Target	Outside Target

Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objective 1 and 2

- Attainment of the SLO is measured on a complaint basis.

- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.

- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.

- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution..

- HIBC reports the number of complaints logged that are related to SLO 7 functions in the monthly SLO report.

Objective 3

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target.

- Documents aged 31 days or more at completion are outside of target.

- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objective 1 and 2

- All complaints received through the complaints escalation process related to SLO 7 for the current month.

Objective 3

- Rural Health correspondence Documents completed within the calendar month.

- Rural Health correspondence Document Types:
  - Rural Health Correspondence

SLO 7

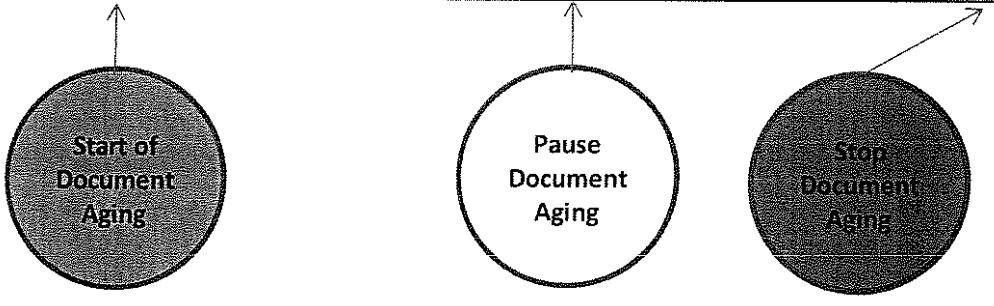
Service Function:	MSP Non-Fee for Service Payments
Schedule E Reference:	Section 2.2
Service Level Objectives:	**Objective 1** - Payment requests from the Ministry to Health Authorities and Primary Care sites are processed within one Payment Cycle from date of receipt of correct and complete invoice. **Objective 2** - Medical Advisor Sessional and travel expenses are paid within one Payment Cycle from date of receipt of correct and complete invoice. **Objective 3** - 100% of Rural Health correspondence is processed within 30 business days.

Definition:

HIBC receives a low volume of Rural Health correspondence documents. These documents were previously measured under SLO 38. This measure is now grouped with Objectives 1 and 2 in order to align all related measures for CSR support in one place.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-30	31+
100% within 30 Business Days	Within Target	Outside Target

Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objective 1 and 2

- Attainment of the SLO is measured on a complaint basis.

- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.

- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.

- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution..

- HIBC reports the number of complaints logged that are related to SLO 7 functions in the monthly SLO report.

Objective 3

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target.

- Documents aged 31 days or more at completion are outside of target.

- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objective 1 and 2

- All complaints received through the complaints escalation process related to SLO 7 for the current month.

Objective 3

- Rural Health correspondence Documents completed within the calendar month.

- Rural Health correspondence Document Types:
  - Rural Health Correspondence

Exclusions:

Objective 1 and 2

- Out of scope issues (MoH Policy complaints, or complaints for other services).

Objective 3

- None

Example:

Objective 1 and 2
A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would not be included in complaint based reporting, notwithstanding resolution at this stage.

Objective 3
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 30 days or less
- 1 aged 31 days or more

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (999/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 8

Service Function:	MSP Provider Electronic Claims Submission and Payment System
Schedule E Reference:	Sections 2.3 and 4.8
Service Level Objectives:	**Objective 1 -** Annual Availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force Majeur). Accountability will be assigned in accordance with the jointly approved Roles and Responsibilities Matrix. **Objective 2 -** If the primary data centre for the claims system requires a fail over to the DRP site, the system files and data must be restored to a point that processing can resume within 12 hours of WTS provisioning of the DRP site and to Full Service State within 48 hours. Accountability will be assigned in accordance with the jointly approved Roles and Responsibilities Matrix. **Objective 3 -** Service interruption must be restored within one Business Day when only MAXIMUS infrastructure is involved, or within one day of restoration of shared infrastructure. **Objective 4 -** 95% of paper claims are processed through data entry within the following payment cycle from receipt and 100% within the second payment cycle following receipt. **Objective 5 –** 100% of the following types of documents are processed within 30 Business Days: • Cheques from other provinces for non-BC patient • Physicians who do not bill by Teleplan

Definition:

Teleplan is the electronic claims submission system that links BC's medical and health care practitioners to MSP. In case of a service outage or disruption HIBC has established business continuity and disaster recovery plans for this application. There are limited exceptions to electronic claims submission by enrolled health care practitioners requiring the printing, mailing and data entry of card claims.

Calculation Method:

Objective 1 - Measurement of % availability (Contract Year):

- System Incident logs are consulted to determine whether there were any outages that impacted availability of the Claims Submission and Payment System.

- Claims business and application owners are contacted to confirm whether there were

any outages, and to provide the duration of outage if necessary.

- System Incident Log and communications with the above groups are retained to verify SLO results as needed.

- If multiple outages occur during the Contract Year, the hours are aggregated to determine whether HIBC has exceeded the 8.76 hours of permitted downtime.

Objective 2 & 3 - Measurement of time to recover and restoration of service:

- Only applicable if there is a need to implement the Disaster Recovery Plan

- System Incident logs are consulted to determine whether there were any outages that required failover over to the DRP site.

- Claims business and application owners are contacted to confirm whether there were any outages, and to provide the duration of service interruption if necessary.

- System Incident Log and communications with the above groups are retained to verify SLO results as needed.

Objective 4 - Processing of paper claims

- Attainment of the SLO is measured on a complaint basis

- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.

- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services

- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.

- HIBC reports the number of complaints logged that are related to SLO 8 functions in the monthly SLO report

Objective 5 - Processing of paper claims

HIBC is eliminating these two MaxImage document types, with rationale below:

Physicians who do not bill by teleplan submit correspondence through the 'Physician's requesting clarification' document type (SLO 22), and submit their claims through the web, or paper claims for data entry as defined in objective 4.

Cheques from other provinces for non-BC patient are now received through other channels.

Inclusions:

Objective 1 - Measurement of % availability (Contract Year):

- Outages to the Claims system

Objective 2 & 3 - Measurement of time to recover and restoration of service:

- Major outages requiring fail over to Claims DRP site

Objective 4 - Processing of paper claims

- All complaints received through the complaints escalation process related to SLO 8 for the current month

Objective 5

- See above

Exclusions:

Objective 1 - Measurement of % availability (Contract Year):

- Outages to other systems
- Downtime due to scheduled maintenance as mutually agreed by the Parties.
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS.

Objective 2 & 3 - Measurement of time to recover and restoration of service:

- Outages that do not require fail over to DRP site
- Outages to other systems
- Downtime due to scheduled maintenance as mutually agreed by the Parties.
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS.

Objective 4 - Processing of paper claims

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Objective 5

- See above

Example:

Objective 1 - Measurement of % availability (Contract Year):

System incident log is checked; a single incident preventing the Claims users from submitting payments occurred during the current month, 4.1 hours in duration, no further outages are reported during the Contract Year. Business and application owners confirm the outage and duration.

As there were no other incidents reported in the Contract Year, HIBC has not exceeded the 8.76

hours of permitted downtime, and the SLO has been attained.

However HIBC has now accrued 4.1 hours of downtime this year towards the permitted amount of 8.76 hours. Further outages beyond that threshold could result in SLO failure.

Objective 2 & 3 - Measurement of time to recover and restoration of service:

System incident log is checked; a single major incident preventing the Claims users from submitting payments occurred during the past month, with a total service interruption of 11 hours in duration, including the time for WTS to provision DRP site. Full service is restored the next day, after 24 hours. Business and application owners confirm the outage and duration. Objectives 2 & 3 are met, as the system was able to process claims within 12 hours, and in a full service state after 24 hours.

Objective 4 - Processing of paper claims

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would be included in complaint based reporting, notwithstanding resolution at this stage.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 9

Service Function:	MSP Automated claims business rules
Schedule E Reference:	Sections 2.4 and 4.8
Service Level Objectives:	Continuous development and implementation of appropriate automated rules

Definition:

The claims processing system employs thousands of automated business rules resulting in approximately 98.5% of claims being automatically processed. These business rules represent legislative requirements, conditions set out in negotiated agreements, Payment Schedule policies and precedent established. HIBC has an interest in improving these business rules, as claims that are not automatically processed are rejected for manual adjudication. These rule change requests are submitted via the OSSDesk and tracked through HIBC's ITG ticketing system.

Calculation Method:

- Business rule changes are implemented on an ongoing basis following submission and approval by Ministry Staff.
- Business rule development and implementation is tracked through ITG Work Orders created.
- Requesting MOH staff will receive notification at creation, update and closure of ITG request.
- If there is activity to close or implement rules requests on a monthly basis, this measure would be considered met. HIBC is confirming that action was taken on new, incoming rule changes and that existing rule changes are actioned based on prioritization received from MOH.
- Reports are run out of ITG, demonstrating the # of relevant work orders created and closed during the past quarter, as well as any work orders outstanding at the end of the quarter. (sample attached).

Inclusions:

- Work Orders created or closed in the past rolling quarter and open Work Orders created prior to the start of the rolling quarter.
- Work Orders for the AION application.

Exclusions:

- Work Orders closed prior to the start of the most recent rolling quarter.
- Work Orders for other applications.

Example:

Rule change request email received by OSSDesk. OSSDesk operator creates work order in ITG and ticket is automatically assigned to the AION application owner. Based on prioritization provided by MSD staff, the rule change will be developed, tested and implemented. he ITG system will provide notification via e-mail to Business Rules advisor at MSD when the ticket is created, updated and completed, providing confirmation that the business rules are being continuously developed and implemented.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

APPENDIX

Call Request No.:	Subject:	Application Category Level 2:	Created Date:	Closed Date:	Call Request Status:	Payment Schedule Change	Portfolio Rank:	Requested Completion Date:	Request Action Phase:	Revised Requested Date:	Requested By:
531363	11-08-25 RB 30,40,50	AION Legacy (Level 2)	24-Aug-11	27-Sep-11	Closed	N	1	30-Sep-11	Completed		Val Johnson
531337	11-08-22 RB54	AION Level 1	24-Aug-11	23-Sep-11	Closed	N	2	30-Sep-11	Pending Implementation		Val Johnson
531341	11-08-21 RB24	AION Level 1	24-Aug-11	8-Sep-11	Closed	Y	1	15-Sep-11	Completed		Val Johnson
531356	11-08-23 RB33	AION Level 1	24-Aug-11	23-Sep-11	Closed	Y	4	30-Sep-11	Pending Implementation	30-Sep-11	Val Johnson
531357	11-08-24 RB29	AION Level 1	24-Aug-11	23-Sep-11	Closed	Y	5	30-Sep-11	Pending Implementation		Val Johnson
531363	11-08-25 RB 30,40,50	AION Legacy (Level 2)	24-Aug-11	27-Sep-11	Closed	N	1	30-Sep-11	Completed		Val Johnson
531443	11 08 26 RB 33	AION Level 1	26-Aug-11	23-Sep-11	Closed	N	1	1-Jan-99	Pending Implementation		Val Johnson
531443	11 08 26 RB 33	AION Level 1	26-Aug-11	23-Sep-11	Closed	N	1	1-Jan-99	Pending Implementation		Val Johnson
531682	11-08-28 RB39	AION Level 1	1-Sep-11	23-Sep-11	Closed	N	11	15-Oct-11	Pending Implementation	14-Oct-11	Val Johnson
531683	11-08-29 RB66	AION Level 1	1-Sep-11	23-Sep-11	Closed	N	3	30-Sep-11	Pending Implementation	30-Sep-11	Val Johnson

SLO 10

Service Function:	MSP Provider Manual In-province claims adjudication – including reciprocal and third party claims
Schedule E Reference:	Sections 2.5 and 4.8
Service Level Objective:	**Objective 1 -** Decisions on disputed claims, referred to Medical Advisor Committee (MAC), Medical Payment Issues (MPIC) and BCMA Reference Committee, are processed within 10 business days of receipt from MoH.

Definition:

HIBC employees manually adjudicate in-province claims, including reciprocal and third party claims. Occasionally these adjudication decisions are disputed. These cases are very low volume in comparison to total volume of claims billed per year. Changing the current workflow to accommodate automated reporting could jeopardize the turnaround times and redirect capacity from core productive work as this SLO uses the same resources as SLR 13.

Calculation Method:

- Attainment of the SLO is measured on a complaint basis.
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC. The complaint is logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 10 functions in the monthly SLO report.

Inclusions:

- All complaints received through the complaints escalation process related to SLO 10 for the current month

Exclusions:

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Example:

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would not be included in complaint based reporting, as it was not logged as a complaint.

However, if the issue was escalated to the MoH, and deemed to be a complaint for further investigation, and was logged in the SLO complaints database, it would be included in monthly SLO reporting.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

SLO 12

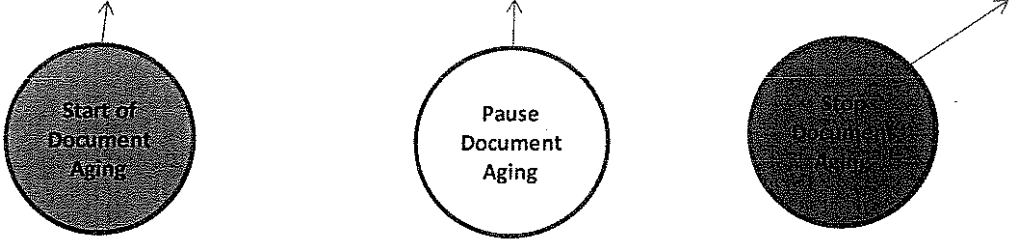
Service Function:	MSP Provider Out of Province/Country Pre-authorizations
Schedule E Reference:	Section 2.7
Service Level Objectives:	**Objective 1** - 80% of requests requiring referral to the Ministry are prepared and transferred within 10 business days of receipt of completed application. **Objective 2** - 99% of requests requiring referral to the Ministry are prepared and transferred within 20 business days of receipt of completed application. **Objective 3** - 100% of all documents/correspondence processed within 30 business days of receipt.

Definition:

HIBC receives requests for Out of Province/Country Pre-authorizations. Complex requests require referral to the external Medical Consultant. All requests referred to the Ministry are considered Complex, and Complex documents are placed on hold until reviewed by the Medical Consultant. Incomplete applications are identified by the completion state 'Missing Information'. When an incomplete application is received a letter goes out to the requestor and they are requested to submit a complete application. When they follow-up with a completed document, it is counted as a separate document in MaxImage. Documents that are Missing Information are still counted as completions under Objective 3.

Age of Document (Age from Registration to Completion in Business Days)				
	0-10	11-20	21-30	31+
80% within 10 Business Days	Within Target	Outside Target		
99% within 20 Business Days	Within Target		Outside Target	
100% within 30 Business Days	Within Target			Outside Target

Step	Document Received by Document	Document Registered	Document Processing Begun	Document Referred to Medical	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	Medical Consultant	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 10 Business Days:

- Documents aged 10 days or less at completion are within target
- Documents aged 11 days or more at completion are outside of target
- Therefore the % processed within 10 Business Days is the number of documents completed within 10 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target
- Documents aged 31 days or more at completion are outside of target
- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Out of Province/Country Pre-Authorization Documents completed within the calendar month
- Out of Province/Country Pre-Authorization Document Types
  - MSP Provider OOP Pre-auths
  - MSP Provider OOC Pre-auths

Exclusions:

- For Objectives 1 and 2, only completed applications are counted. Incomplete applications that are missing information are excluded.
- For Objectives 1 and 2, only complex applications are counted. Routine applications are excluded.
- For Objective 3, only Incomplete documents are excluded. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.

Example:

Objectives 1 and 2
A total of 1000 complex documents were completed in a given month, and the completions are broken up into the following groups:

- 900 aged 10 days or less
    - 800 of which were submitted as complete applications
- 95 aged between 11 and 20 days
    - 90 of which were submitted as complete applications
- 5 aged 21 days or more
    - 5 of which were submitted as complete applications

Then the SLO performance is measured as follows:

- 89.39% within 10 Business days (800/895)
- 99.44% within 20 Business days (890/895)

Objective 3
A total of 1500 documents were completed in a given month, (regardless of completion status and complexity), and the completions are broken up into the following groups:

- 1450 aged 30 days or less
- 50 aged 31 days or more

Then the SLO performance is measured as follows:

- 96.67% within 30 Business days (1450/1500)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 14

Service Function:	MSP Provider Retroactive Payment Adjustments
Schedule E Reference:	Sections 2.9 and 4.8
Service Level Objective:	Retroactive payment adjustments processed within 6 weeks of notice from Province to process when no implementation date provided by MoH.

Definition:

HIBC receives requests for Retroactive payment adjustments from the Province via email, service request or as electronic files. The SLO is not easily measurable without manual tracking of numerous start and hold times and requests are low volume.

Calculation Method:

- Attainment of the SLO is measured on a complaint basis
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 14 functions in the monthly SLO report

Inclusions:

- All complaints received through the complaints escalation process related to SLO 14 for the current month

Exclusions:

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Example:

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage. It would be included in complaint based reporting, notwithstanding resolution at this stage

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

SLO 15

Service Function:	MSP Provider Online Payment Schedule Adjustments
Schedule E Reference:	Sections 2.10 and 4.8
Service Level Objective:	**Objective 1** - Low volume/low impact - one business day from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) **Objective 2** - Medium volume/medium impact - 5 business days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required) **Objective 3** - Large volume/large impact - 20 business days from date all information is complete and correct (not including any effort to implement automated adjudication business rules if required).

Definition:

HIBC receives requests for MSP Provider Online Payment Schedule Adjustments from the BCMA via email, fax or as electronic files. The SLO is not easily measured and will be monitored on a complaint basis. Background information will be made available for audit purposes.

Calculation Method:

- Attainment of the SLO is measured on a complaint basis
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 15 functions in the monthly SLO report

Inclusions:

- All complaints received through the complaints escalation process related to SLO 15 for the current month

Exclusions:

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Example:

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would be included in complaint based reporting, notwithstanding resolution at this stage.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

SLO 17

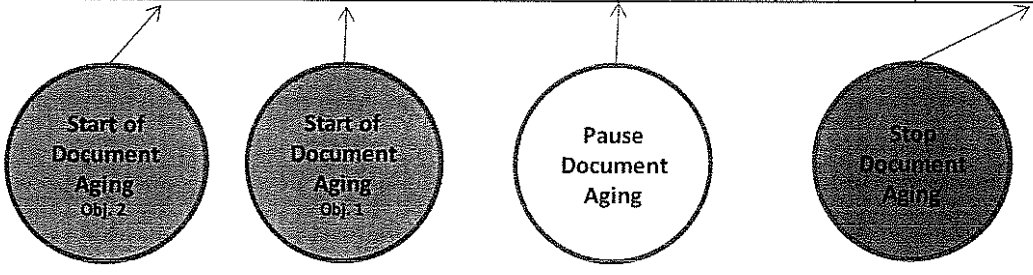
Service Function:	MSP Provider Overage Claims Requests
Schedule E Reference:	Sections 2.12 and 4.8
Service Level Objectives:	**Objective 1** - 90 % of complete requests are processed within 20 business days from date scanned. **Objective 2** - 100% of all documents/correspondence processed within 30 business days of receipt.

Definition:

HIBC receives Provider Overage Claims Requests. Some requests require referral to Ministry staff. All requests referred to the Ministry are considered Complex, and Complex documents are placed on hold until returned to HIBC for further action.

Age of Document (Age from Aging Start Status to Completion in Business Days)			
	0-20	21-30	31+
90% within 20 Business Days of Scanning	Within Target	Outside Target	
100% within 30 Business Days of Receipt	Within Target		Outside Target

Step	Document Received by Document Management	Document Scanned	Document Processing Begun	Document Referred to Medical Consultant	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	Medical Cons	HIBC CSR
Document Status	Received	Scanned	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target
- Documents aged 31 days or more at completion are outside of target
- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- MSP Provider Overage Claims Requests completed within the calendar month
- MSP Provider Overage Claims Requests Document Types
  - Request Permission to Re-bill

Exclusions:

- None

Example:

Objective 1 - 90 % of complete requests are processed within 20 business days from date scanned.

A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 920 aged 20 days or less from Scan Date to Completion
- 80 aged 21 days or more from Scan Date to Completion

Then the SLO performance is measured as follows:

- 92% within 20 Business days (920/1000)

Objective 2 - 100% of all documents/correspondence processed within 30 business days of receipt.

A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 30 days or less from Received Date to Completion
- 1 aged 31 days or more from Received Date to Completion

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (999/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 22

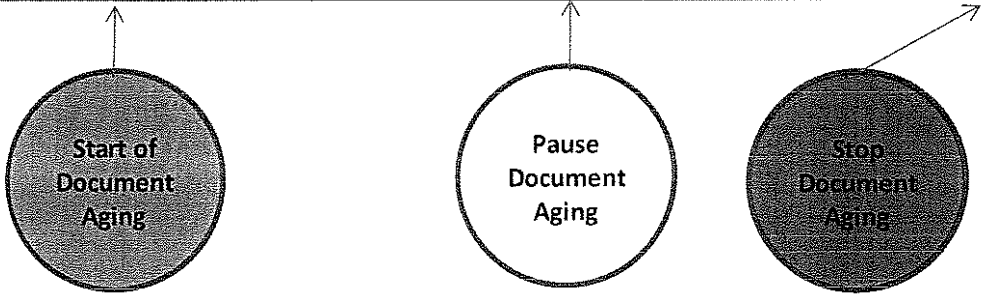
Service Function:	MSP Provider General Correspondence
Schedule E Reference:	Sections 2.17 and 4.8
Service Level Objectives:	**Objective 1** - 90% of all general correspondence is processed within 20 business days from receipt **Objective 2** - 99% of all general correspondence is processed within 40 business days from receipt

Definition:

HIBC receives general correspondence on an ongoing basis for MSP Provider services. Some correspondence requires referral to the Ministry and is placed on hold until returned to HIBC for further action.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-20	20-40	41+
90% within 20 Business Days of Receipt	Within Target	Outside Target	
99% within 40 Business Days of Receipt	Within Target		Outside Target

Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target

- Documents aged 21 days or more at completion are outside of target

- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 40 Business Days:

- Documents aged 40 days or less at completion are within target

- Documents aged 41 days or more at completion are outside of target

- Therefore the % processed within 40 Business Days is the number of documents completed within 40 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- Provider General Correspondence Documents completed within the calendar month
- Provider General Correspondence Document Types
  - Beneficiary General Correspondence
  - Correspondence with Providers
  - Critical Care Coverages
  - Dental Claim Adjudication Corr
  - Orthodontics and Dental Correspondence
  - Patient Paid, Request Reimb
  - Physician Requesting Clarification
  - Provider Adjudication Correspondence
  - Provider General Correspondence
  - Reciprocal Billing-BC Physician/OOP Pat

Exclusions:

- None

Example:

A total of 1000 complex documents were completed in a given month, and the completions are broken up into the following groups:

- 900 aged 20 days or less
- 95 aged between 20 and 40 days
- 5 aged 41 days or more

Then the SLO performance is measured as follows:

- 90.0% within 20 Business days (900/1000)
- 99.5% within 40 Business days (995/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 23

Service Function:	PharmaCare Automated Claims Submission
Schedule E Reference:	Section 3.1
Service Level Objectives:	**Objective 1** - Annual availability 99.9% (excludes downtime due to scheduled maintenance as mutually agreed by the Parties and outages due to a Force majeure). **Objective 2** - Claims transaction response time less than 2.5 seconds 97% of the time. To be measured from the time the transaction enters PharmaNet to the time the completed transaction is returned to the Network.

Definition:

PharmaNet Systems are a 24/7 service accessed by Pharmacists and other Service Providers. Prescriptions dispensed through community pharmacies are entered on PharmaNet, some other medical supplies are also processed through PharmaNet. Claims are submitted electronically, adjudicated in real time, and outcome is returned to the transmitting pharmacy.

Calculation Method:

Objective 1 - Measurement of % availability (Contract Year):

- System Incident logs are consulted to determine whether there were any outages that impacted availability of the Claims Submission and Payment System.
- Claims business and application owners are contacted to confirm whether there were any outages, and to provide the duration of outage if necessary.
- System Incident Log and communications with the above groups are retained to verify SLO results as needed.
- If multiple outages occur during the Contract Year, the hours are aggregated to determine whether HIBC has exceeded the 8.76 hours of permitted downtime.

Objective 2 – Measurement of Transaction response time

- Statistics are based on NetX logs and measure the incoming timestamp for a transaction, against the time stamp when the transaction has been processed and returns to the network.
- (Outgoing Timestamp – Incoming Timestamp) = Time to process transaction and update tables
- The report includes all TAC/TDU transactions (Claim adjudication transactions and associated updates to patient's medical history).

Inclusions:

Objective 1 - Measurement of % availability (Contract Year):

- Outages to the Claims system.

Objective 2 – Measurement of Transaction response time

- *TAC/TDU transactions for the past month.*

Exclusions:

Objective 1 - Measurement of % availability (Contract Year):

- Outages to other systems
- Downtime due to scheduled maintenance as mutually agreed by the Parties.
- Outages due to a Force Majeure.
- Outages due to action/in-action of a 3rd party that is not a sub-contractor or supplier to MAXIMUS.

Objective 2 – Measurement of Transaction response time

- *Other PharmaNet transaction types*

Example:

Objective 1 - Measurement of % availability (Contract Year):
System incident log is checked; a single incident preventing the Claims users from submitting payments occurred during the current month, 4.1 hours in duration, no further outages are reported during the Contract Year. Business and application owners confirm the outage and duration.

As there were no other incidents reported in the Contract Year, HIBC has not exceeded the 8.76 hours of permitted downtime, and the SLO has been attained.

However HIBC has now accrued 4.1 hours of downtime this year towards the permitted amount of 8.76 hours. Further outages beyond that threshold could result in SLO failure.

As there were no outages over 4 hours in duration, the SLO has been attained.

Objective 2 – Measurement of Transaction response time
4 million claim transactions are logged in the past month, of which 140,000 have a delay of over 2.5 seconds.

The SLO performance is determined to be:

(total # of transactions under 2.5 seconds)/(total # of transactions)

3,860,000/4,000,000 = 96.5%

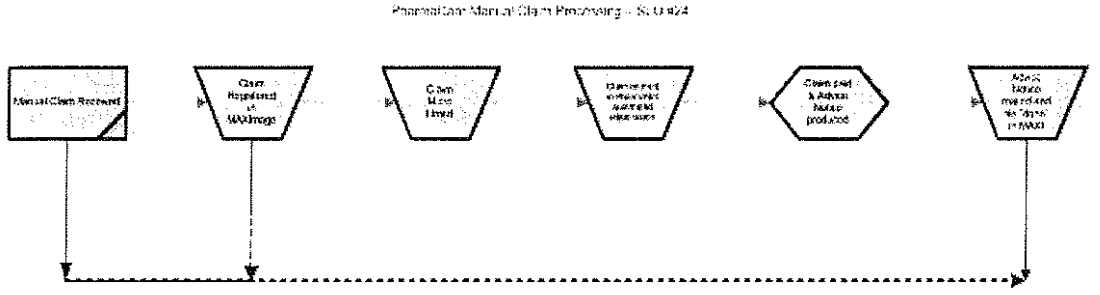
Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 24

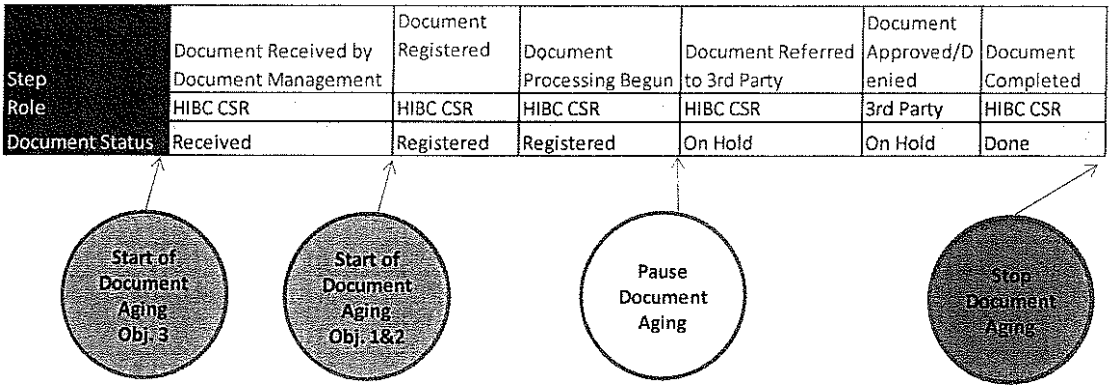
Service Function:	PharmaCare Manual Claims Processing (offline)
Schedule E Reference:	Section 3.2
Service Level Objectives:	**Objective 1** - 90% in 10 business days from date of registration. **Objective 2** - 99% in 20 business days from date of registration. **Objective 3** - 100% of all documents/correspondence processed within 30 business days of receipt.

Definition:



HIBC receives correspondence on an ongoing basis for PharmaCare Manual Claims Processing. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. After the document has been processed the document is updated by the completing agent with a Completion status. Claims are adjudicated in PharmaNet in real time once the agent keys them into the system. Some correspondence requires referral to a 3rd party and is placed on hold until returned to HIBC for further action.

Age of Document (Age from Aging Start to Completion in Business Days)				
	0-10	11-20	21-30	30+
80% within 10 Business Days	Within Target	Outside Target		
99% within 20 Business Days	Within Target		Outside Target	
100% within 30 Business Days	Within Target			Outside Target



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 10 Business Days:

- Documents aged 10 days or less at completion are within target
- Documents aged 11 days or more at completion are outside of target
- Therefore the % processed within 10 Business Days is the number of documents completed within 10 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target
- Documents aged 31 days or more at completion are outside of target
- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

- PharmaCare Manual Claims Processing Documents completed within the calendar month
- PharmaCare Manual Claims Processing Document Types
  - Orthotics and Prosthetics

Exclusions:

- None

Example:

Objectives 1 and 2
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 900 aged 10 days or less from registration date to completion
- 95 aged between 11 and 20 days from registration date to completion
- 5 aged 21 days or more from registration date to completion

Then the SLO performance is measured as follows:

- 90.0% within 10 Business days (900/1000)
- 99.5% within 20 Business days (995/1000)

Objective 3
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 995 aged 30 days or less from received date to completion
- 5 aged 31 days or more from received date to completion

Then the SLO performance is measured as follows:

- 99.5% within 30 Business days (995/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko

Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 25

Service Function:	PharmaNet Tables Administration
Schedule E Reference:	Section 3.3
Service Level Objective:	**Objective 1 -** Low Cost Alternatives Shortages - real time **Objective 2 -** Incorrect Prices in Production Tables updated within 1 business day **Objective 3 -** Other updates, including drug price listing changes, processed within 10 business days. Urgent price change requests will be handled on an exception basis based on a mutually agreed to process.

Definition:

HIBC receives requests for PharmaNet Tables Administration from the Province via email, service request or as electronic files. These services tend to be irregular and/or reactive. Direction and priorities are provided via emails and telephone calls and often multiple exchanges between Operations and the Program Area to achieve clarification and confirmation. There is no ability to measure performance beyond a complaint basis without considerable effort and cost for both parties.

Calculation Method:

- Attainment of the SLO is measured on a complaint basis
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 25 functions in the monthly SLO report.

Inclusions:

- All complaints received through the complaints escalation process related to SLO 25 for the current month

Exclusions:

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Example:

- A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage. It would be included in complaint based reporting, notwithstanding resolution.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

SLO 27

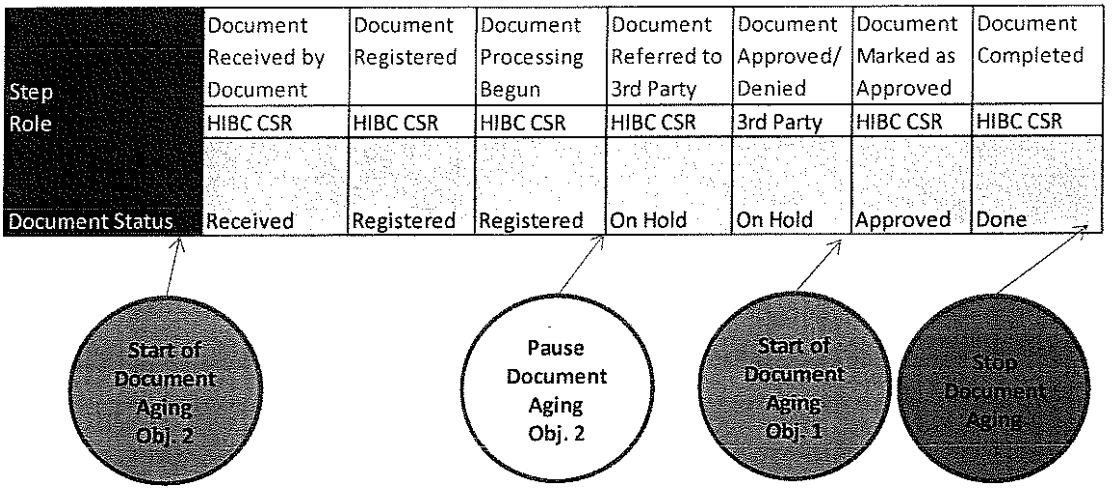
Service Function:	PharmaCare Pre-authorizations
Schedule E Reference:	Section 3.5
Service Level Objectives:	**Objective 1** - Pre-authorization letters prepared and mailed within 7 business days of receiving approval from the Prosthetics and Orthotics Committee. **Objective 2 -** 100% of orthotics and prosthetics documents/correspondence processed within 30 Business Days of receipt.

Definition:

Pre-authorization for Prosthetics and Orthotics over limits set by the Province and Special Authorities is required. Pre-authorization request are received by HIBC and held until they can be reviewed by the Orthotics and Prosthetics Committee in their weekly meeting. When approval is received from the Committee, the request is taken off hold, flagged as Approved, and processing completed. Not all requests are approved.

Objective 2 was previously reported under SLO 38. This measure is now grouped with Objective 1 in order to align all related measures for CSR support in once place.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-7	7-30	31+
100% within 7 Business Days	Within Target	Outside Target	
100% within 30 Business Days	Within Target		Outside Target



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 7 Business Days of receiving approval:

- Documents aged 7 days or less at completion are within target.
- Documents aged 8 days or more at completion are outside of target.
- Therefore the % processed within 7 Business Days is the number of documents completed within 7 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target.
- Documents aged 31 days or more at completion are outside of target.
- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objective 1 – 100% prepared and mailed within 7 business days of approval

- Approved PharmaCare Pre-Authorizations completed within the calendar month
- PharmaCare Pre-Authorizations Document Types
  - PharmaCare Pre-Authorizations

Objective 2 – 100% of correspondence processed within 30 business days of receipt

- PharmaCare Pre-Authorizations completed within the calendar month
- PharmaCare Pre-Authorizations Document Types
  - PharmaCare Pre-Authorizations

Exclusions:

Objective 1 – 100% prepared and mailed within 7 business days of approval

- Unapproved PharmaCare Pre-Authorizations
- Incomplete PharmaCare Pre-Authorizations
- Non- PharmaCare Pre-Authorizations Documents

Objective 2 – 100% of correspondence processed within 30 business days of receipt

- Incomplete PharmaCare Pre-Authorizations
- Non- PharmaCare Pre-Authorizations Documents

Example:

Objective 1 – 100% prepared and mailed within 7 business days of approval

A total of 1000 documents were completed in a given month, of which 400 were approved. The completions are broken up into the following groups:

- 399 aged 7 days or less from Approved Date to Completion
- 1 aged 8 days or more from Approved Date to Completion
- The 600 Pre-authorization requests that were not approved are discarded from this calculation.

Then the SLO performance is measured as follows:

- 99.9% within 20 Business days (399/400)

Objective 2 - 100% of all documents/correspondence processed within 30 business days of receipt.

A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 30 days or less from Received Date to Completion
- 1 aged 31 days or more from Received Date to Completion

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (999/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 28

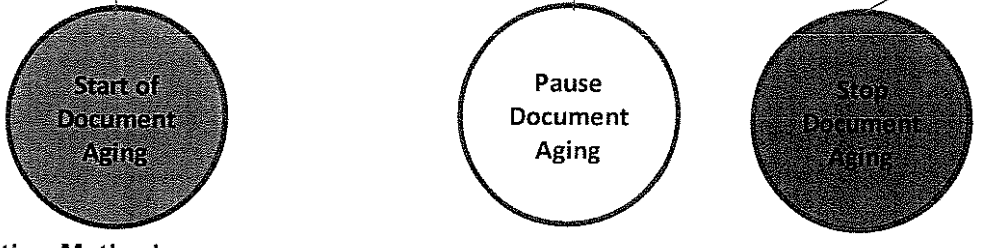
Service Function:	PharmaCare Plan Registration Services
Schedule E Reference:	Section 3.7
Service Level Objectives:	**Objective 1** - 100% of Palliative Care Registrations forms processed within 1 business day of receipt **Objective 2** - 100% of Consent forms processed within 2 business days of receipt **Objective 3** - 100% of Pharmanet access for hospitals & Practitioners processed within 2 business days **Objective 4** - 100% of work orders from College of Pharmacists to initiate site connection for Pharmanet access initiated within 1 business day **Objective 5** - Multi-languages calls provided Monday through Friday from 9:00 am to 3:30 pm and any calls received outside of those hours will have call back service within 1 business day (including Saturdays)

Definition:

PharmaCare administers a number of Drug Benefit Plans. Operations is responsible for the automated and manual beneficiary registration to the appropriate PharmaCare Plan(s) and pharmacy, supplier, emergency department and physician registration/access to PharmaNet.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-1	1-2	3+
100% within 1 Business Days	Within Target	Outside Target	
100% within 2 Business Days	Within Target		Outside Target

Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objective 1 and 2

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 1 Business Days:

- Documents aged 1 days or less at completion are within target

- Documents aged 2 days or more at completion are outside of target

- Therefore the % processed within 1 Business Day is the number of documents completed within 1 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 2 Business Days:

- Documents aged 2 days or less at completion are within target

- Documents aged 3 days or more at completion are outside of target

- Therefore the % processed within 2 Business Days is the number of documents completed within 2 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Objective 3 and 4

- Attainment of the SLO is measured on a complaint basis

- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.

- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.

- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.

- HIBC reports the number of complaints logged that are related to SLO 28 functions in the monthly SLO report.

Objective 5

- Multi-language queues have call back options enabled and CCA reports provide statistics on the longest wait to answer for callbacks (i.e., 12:22:05, in HH:MM:SS format).
- HIBC is able to determine at what time calls arrived, and attainment of the SLO is met if calls are returned within the next business day.

Inclusions:

Objective 1

- Palliative Care Registrations completed within the calendar month
- PharmaCare General Correspondence Document Types
  - Palliative Care Forms

Objective 2

- PharmaCare Consent forms completed within the calendar month
- PharmaCare Consent form Document Types
  - PharmaCare Consent Forms

Objective 3 and 4

- All complaints received through the complaints escalation process related to SLO 28 for the current month

Objective 5

- *Callbacks for the following queues:*
  - *Fair PharmaCare Registration – Mandarin*
  - *Fair PharmaCare Registration – Cantonese*
  - *Fair PharmaCare Registration – Punjabi*
  - *Fair PharmaCare Registration – French*

Exclusions:

Objective 1 and 2

- Incomplete documents
- Document Types not identified above

Objective 3 and 4

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Objective 5

- Calls for queues not identified above
- Calls that are not answered via callback

Example:

Objective 1
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 1 business day or less from receipt to completion
- 1 aged 2 business days or more from receipt to completion

Then the SLR performance is measured as follows:

- 99.9% within 1 Business days (999/1000)

Objective 2
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 2 business days or less from receipt to completion
- 1 aged 3 business days or more from receipt to completion

Then the SLR performance is measured as follows:

- 99.9% within 2 Business days (999/1000)

Objective 3 and 4
- A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage. It would be included in complaint based reporting, notwithstanding resolution.

Objective 5
At month end, the workgroup reports for Fair PharmaCare queues are run. The longest wait to answer is 12 hours and 22 minutes. The SLO is met, as all calls were returned within less than 1 business day.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

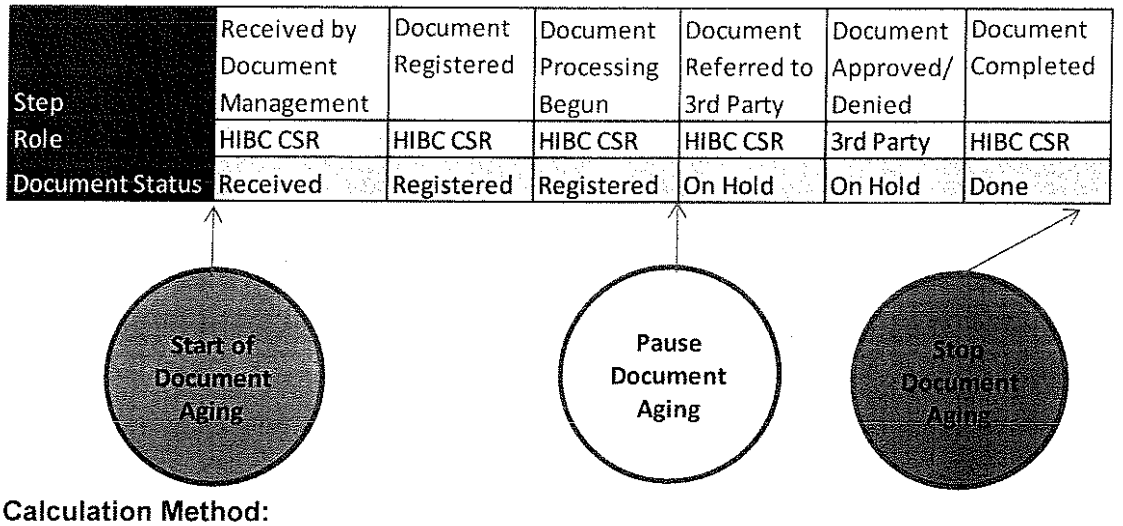
SLO 29

Service Function:	Fair PharmaCare (FP) Administrative Review Process
Schedule E Reference:	Section 3.8
Service Level Objectives:	**Objective 1** - Urgent Fair PharmaCare administrative review cases when the patient is in immediate need of a prescription are handled in real time as long as all required information is available. **Objective 2** - Routine Fair PharmaCare administrative review cases not associated with an urgent need to fill a prescription --95% within 20 business days. Such as: Income Reviews, Consent Revocations, Exceptions to automated processes, Appeals, Requests for retroactive payments **Objective 3** - 100% of Routine Fair PharmaCare administrative review cases processed within 30 business days.

Definition:

The Administrative Review group provides support to the registration process of families and individuals, resolve eligibility issues, handle specific requests for income review, revocation of CRA consent, retroactive payments, and handle general FP correspondence. Objective 1 is not easily measurable without manual tracking and such tracking would impede the turnaround time.

Objective 3 was previously measured under SLO 38. This measure is now grouped with Objectives 1&2 in order to align all related measures for CSR support in once place.



Calculation Method:

Objective 1

- Attainment of the SLO is measured on a complaint basis.

- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.

- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.

- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.

- HIBC reports the number of complaints logged that are related to SLO 29 functions in the monthly SLO report.

Objective 2 & 3

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 20 Business Days of Receipt:

- Documents aged 20 days or less at completion are within target.

- Documents aged 21 days or more at completion are outside of target.

- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Measurement of % processed within 30 Business Days of Receipt:

- Documents aged 30 days or less at completion are within target.

- Documents aged 31 days or more at completion are outside of target.

- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objective 1

- All complaints received through the complaints escalation process related to SLO 29 for the current month.

Objective 2 and 3

- Administrative Review Documents completed within the calendar month.

- Administrative Review Document Types:

- Address Changes Including PO Card
- Admin Review Tickets
- Affidavits and Income Documents
- Application for Income Reviews
- Corr to PharmaCare Admin Review
- Correction of Info Forms
- Fair PharmaCare Forms
- Income Tax Filed Forms
- Monthly Deductible Payment Option
- PharmaCare Appeals
- Retro-Payment of PharmaCare

Exclusions:

Objective 1

- Out of scope issues (MoH Policy complaints, or complaints for other services).

Objective 2 & 3

- Incomplete Administrative Review documents

- Non-Administrative Review documents

Example:

Objective 1
A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage. It would be included in complaint based reporting, notwithstanding resolution.

Objective 2&3
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 20 days or less
- 1 aged 21-30 days
- 0 aged 31 days or more

Then the SLO performance is measured as follows:

- 99.9% within 20 Business days (999/1000)
- 100% within 30 Business days (1000/1000)

Service Level Agreement:

Date:	Date:

Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 30

Service Function:	Fair PharmaCare Income Verification Process
Schedule E Reference:	Sections 3.9
Service Level Objectives:	Automated income verification process is scheduled at least weekly. Prior to annual renewal the process is scheduled more frequently.

Definition:

The Fair PharmaCare plan is based on an individual or family's net income. The income is self-reported during initial registration and then verified with the Canada Revenue Agency (CRA) at the time of registration, and then annually thereafter. This verification is an automated process and runs weekly via FTP. Electronic response from CRA updates the system for eligibility purposes and generates correspondence as applicable.

Calculation Method:

- Attainment of the SLO is measured based on whether the process is scheduled at least weekly, and more frequently during annual renewal. This job schedule is shared with PSD, and is attached. Barring a change in the schedule, this SLO will always be in compliance.
- PharmaCare Production Support group maintains spreadsheets with details of both verification run types. The job run dates from these spreadsheets will be used to determined compliance with the objective.

Inclusions:

- Automated income verification process.
- Regular and Annual Renewal runs.

Exclusions:

- None.

Example:

Regular Run was executed on October 3rd, 5th, 10th, 12th, 17th, 19th, 24th, 26th, 31st.
Annual Renewal Run was executed October 15th,18th,22nd,24th,29th.

The SLO is met, as a check of the above dates against a calendar confirms that the regular verification job was run twice weekly, and that since mid-October, the Annual Renewal job has also run twice weekly.

Period	Frequency and day of the week	Type of run	Approx number of records
Jan 01 to Dec 31	Twice a week	Regular run - for current benefit year	300-1500 PHNs per run
Mid Oct to Dec 31	Twice a week	Annual Renewal run - for the next benefit year	160,000 PHNs per run

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 31

Service Function:	PharmaCare Restricted Claimant Program
Schedule E Reference:	Section 3.10
Service Level Objectives:	**Objective 1 -** Approved restriction and notification letter processed within 5 business days. **Objective 2 -** Temporary restriction change processed in real time **Objective 3 -** Changes to approved restriction processed in real time **Objective 4 -** 100% of all Restricted claimant correspondence to be processed within 30 business days

Definition:

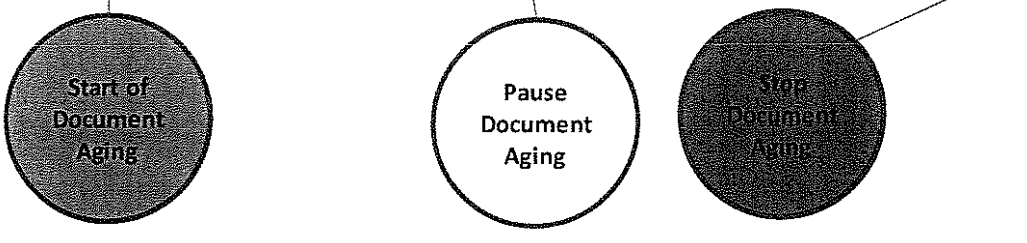
The Restricted Claimant Program assists in reducing misuse of PharmaCare benefits by limiting coverage for certain patients to medications prescribed or pharmacies from which prescriptions drugs may be obtained.

Objectives 1, 2 & 3 are not easily measurable without manual tracking and such tracking could impede the turnaround time.

HIBC receives a low volume of Restricted Claimant documents. These documents were previously included under SLO 38. This measure is reported with Objective 1, 2, 3 in order to align all related measures for CSR support in one place. It can take up to 3 days (as defined under SLO 39) from date of Receipt, for mail to be Registered. This time is included in Objective 4.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-30	31+
100% within 30 Business Days	Within Target	Outside Target

Step	Document Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd party	Document Approved/Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objectives1, 2 and 3

- Attainment of the SLO is measured on a complaint basis.
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 31 functions in the monthly SLO report.

Objective 4

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target.
- Documents aged 31 days or more at completion are outside of target.
- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objectives1, 2 and 3

- All complaints received through the complaints escalation process related to SLO 31 for the current month.

Objective 4

- Restricted Claimants Documents completed within the calendar month.
- Restricted Claimants Document Types:
  - Restricted Beneficiaries
  - Restricted Claimants Forms
  - Restricted Claimants Requests

Exclusions:

Objectives1, 2 and 3

- Out of scope issues (MoH Policy complaints, or complaints for other services).

Objective 4

- None
- Incomplete Restricted Claimants Documents. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non-Restricted Claimants Documents

Example:

Objectives1, 2 and 3
A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would be included in complaint based reporting, notwithstanding resolution at this stage.

Objective 4
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 999 aged 30 days or less
- 1 aged 31 days or more

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (999/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

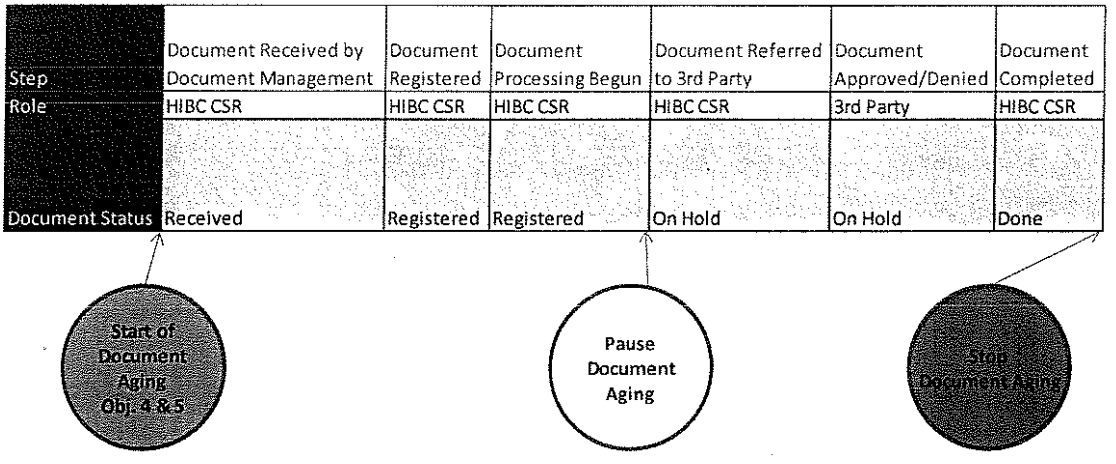
SLO 33

Service Function:	PharmaCare General Correspondence
Schedule E Reference:	Section 3.12
Service Level Objectives:	**Objective 1** - Blood glucose strip certificates processed within 1 Business Day **Objective 2** - 3rd Party Insurer requests processed within 5 Business Days **Objective 3** - Out of Province requests processed within 5 Business Days unless required sooner **Objective 4** - 90% of all general correspondence is processed within 20 business days from receipt **Objective 5** - 99% of all general correspondence is processed within 40 business days from receipt

Definition:

HIBC receives PharmaCare General Correspondence on an ongoing basis for PharmaCare services. This correspondence takes many forms and arrives via different media and routes. Objectives 1, 2, & 3 are not easily measurable without manual tracking of numerous start and hold times and requests are low volume. Some correspondence requires referral to the Ministry and is placed on hold until returned to HIBC for further action. For Objectives 4 & 5, incoming correspondence is registered in MaxImage and it can take up to 3 days (as defined under SLO 39) from date of Receipt, for mail to be Registered. This time is included in measurement of Objectives 4 & 5.

Age of Document (Age from Aging Start to Completion in Business Days)			
	0-20	21-40	41+
90% within 20 Business Days	Within Target	Outside Target	
99% within 40 Business Days	Within Target		Outside Target



Calculation Method:

Objective 1, 2 and 3

- Attainment of the SLO is measured on a complaint basis
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC or delegate. Complaints are logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 33 functions in the monthly SLO report

Objective 4 and 5

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month
- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target
- Documents aged 21 days or more at completion are outside of target
- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Measurement of % processed within 40 Business Days:

- Documents aged 40 days or less at completion are within target
- Documents aged 41 days or more at completion are outside of target
- Therefore the % processed within 40 Business Days is the number of documents completed within 40 or fewer Business Days, divided by the total number of documents completed (within or outside of target)

Inclusions:

Objective 1, 2 and 3

- All complaints received through the complaints escalation process related to SLO 33 for the current month

Objective 4 and 5

- PharmaCare General Correspondence Documents completed within the calendar month
- PharmaCare General Correspondence Document Types
  - Drug Receipt Documentation
  - Pharmacy Processing Correspondence
  - Correspondence to PCare HelpDesk
  - PharmaCare WCB Cheques
  - Pharmacy and Program Maintenance
  - PharmaCare General Correspondence
  - Plan B Correspondence and Pymt Adj

Exclusions:

Objective 1, 2 and 3

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Objective 4 and 5

- None

Example:

Objective 1, 2 and 3

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage, it would be included in complaint based reporting, notwithstanding resolution at this stage.

Objective 4 and 5

A total of 1000 complex documents were completed in a given month, and the completions are broken up into the following groups:

- 900 aged 20 days or less
- 95 aged between 21 and 40 days
- 5 aged 41 days or more

Then the SLR performance is measured as follows:

- 90.0% within 20 Business days (900/1000)
- 99.5% within 40 Business days (995/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 38

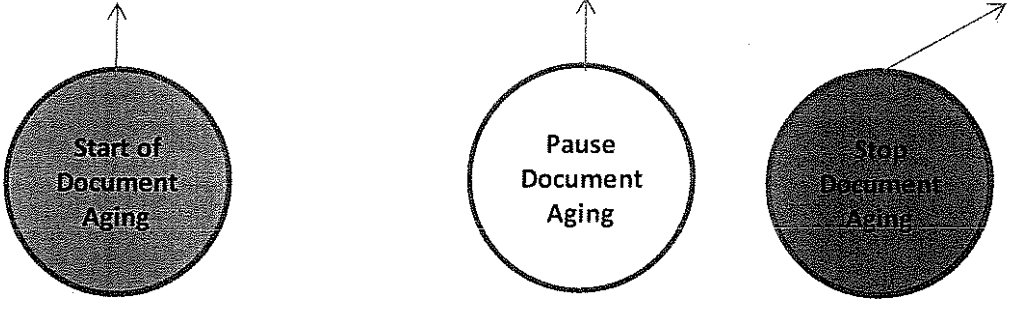
Service Function:	Document Inventory
Schedule E Reference:	Section 4.3
Service Level Objectives:	**Objective 1 -** 100% of all documents/correspondence covered by this SLO processed with 30 business days **Objective 2 -** All applicable documents are archived on schedule per ORCS

Definition:

SLO 38 provides assurance that there will be no unprocessed inventory older than 30 business days except for those documents that have another SLR or SLO processing requirements greater than 30 business days. Research Review (Manager MLA and Ministry Requests document type) work is included in this measurement. Once these documents are prepared and Registered in MaxImage they are ready for an agent to process the document. The Registration Date is system generated at the end of the pre-processing steps and is the start point for determining document age. It can take up to 3 days (as defined under SLO 39) for mail to be Registered. SLO 38 also covers records retention, storage and destruction.

Age of Document (Age from Aging Start to Completion in Business Days)		
	0-30	31+
100% within 30 Business Days	Within Target	Outside Target

Step	Received by Document Management	Document Registered	Document Processing Begun	Document Referred to 3rd Party	Document Approved/ Denied	Document Completed
Role	HIBC CSR	HIBC CSR	HIBC CSR	HIBC CSR	3rd Party	HIBC CSR
Document Status	Received	Registered	Registered	On Hold	On Hold	Done



Calculation Method:

Objective 1 - % Processed within 30 business days

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Objective 2 – Documents archived per ORCS schedule

- Compliance will be subject to audit, and documentation retained where available.

Inclusions:

Objective 1 - % Processed within 30 business days

- All documents of types identified below that are completed within the calendar month.

3rd Party Registration	MHR
Address Changes	Manager MLA and Ministry Requests
Adoptions	Medical Providers Registration
Authorization - Cosmetic Requests	Multi-Lists
Baby Registrations	New Resident Apps
Cancel Coverage Group	Opt Out
Cancel Coverage Pay Direct	Overage - In Canada
CareCard Requests	Overage - Outside Canada
Changes In Province	PA Current Year
Changes OOP	PA Previous Two Years
Company Changes	PA Received with Enrollment
Complex Correspondence	Permanent Moves
Consent form for Online PA application	Personal Status Chg
Convention Refugee Claimants	Pharmacy OOP Request
Direct Pay APP with PA	Pharmacy Registrations
Direct Pay Apps	Power of Attorney
Employee Dept# Changes	Practitioner OOC Pre-Auth Appeals
Employee Record Card - OOP	Provider Account Maintenance
Fair PharmaCare Paper Registrations	Recert Verification
Group Applications	Refugee Claimants
Health Canada (Native)	Temporary Absences
Immigration Renewal	Temporary Doc App
Immigration Renewal - Other	Temporary Doc App - Other

Objective 2 – Documents archived per ORCS schedule

- HIBC Operational Records (electronic and physical copies).

Exclusions:

Objective 1 - % Processed within 30 business days

- Document types not identified in above list.
- Incomplete documents of types listed in above list. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of calculation they will be included in the month in which they are completed.

Objective 2 – Documents archived per ORCS schedule

- None.

Example:

Objective 1 - % Processed within 30 business days
A total of 64000 documents were completed in a given month, and the completions are broken up into the following groups:

- 63960 aged 30 days or less from Received Date to Completion
- 40 aged 31 days or more from Received Date to Completion

Then the SLO performance is measured as follows:

- 99.9% within 30 Business days (63960/64000)

Objective 2 – Documents archived per ORCS schedule
This process is audited every two years, records are retained in order to provide assurance that documents are handled in accordance with ORCS schedule.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

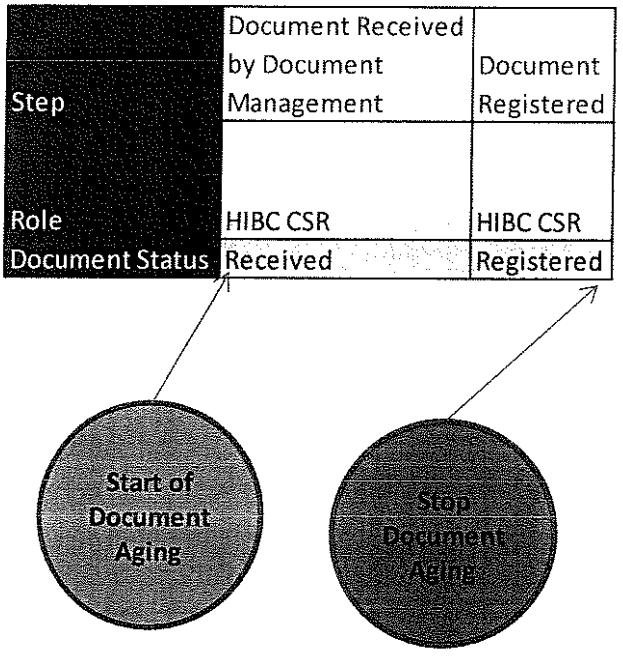
SLO 39

Service Function:	Document Pre-processing. Mail Room Activities (including registration and scanning)
Schedule E Reference:	Section 4.4
Service Level Objectives:	Document Pre-processing/Mail Room Activities completed within 3 Business Days of receipt.

Definition:

HIBC receives mail daily through multiple channels; this SLO serves to track the time from which the correspondence is received, through to the point where it is ready for processing by a CSR. Not all mail is suitable for scanning due to form type, physical size of document, or other issues.

Age of Document (Age from Receipt to Registered in Business Days)		
	0-3	4+
100% within 3 Business Days	Within Target	Outside Target



Calculation Method:

- Attainment of the SLA is measured based on the Daily DMC stats report produced at month end (example attached on page 3).
- The report lists various document categories and associated mail-room activities, by date of receipt.

- The report provides the status of mail-room inventory, by date of receipt. For example; an 'Opened To' date of 4-Sep-2012 on 5-Sep-2012, means that all mail received up to 4-Sep-2012 has been opened.

- Oldest 'Registered To' date for the various categories is compared against the calendar date to determine what the processing delay was on each work day. If the maximum is no more than 3 business days, then the work has gone through pre-processing within 3 days of receipt.

Inclusions:

- All correspondence for Providers, Beneficiaries or PharmaCare groups received during the reporting month.
- All correspondence types that will be processed by an HIBC agent.

Exclusions:

- Returned mail.

Example:

Throughout the prior month, the oldest 'registered to' date for all categories is no more than 2 business days behind the calendar date, except for the 20th, when the oldest 'registered to' date for one category was 4 business days behind the calendar date. This would result in a failure of the SLO.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

Provider Services Mail											
Date	Benefit Services (In Prov)			Out of Country Claims			PharmaCare Documents			Oldest	Delay From Receipt
	Opened To	Sorted To	Registered To	Opened To	Sorted To	Registered To	Opened To	Sorted To	Registered To	Registered Date	to Registration
1-Sep-12	SAT										
2-Sep-12	SUN										
3-Sep-12	STAT										
4-Sep-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	31-Aug-12	8/31/12	2
5-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	4-Sep-12	9/04/12	1
6-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	5-Sep-12	9/05/12	1
7-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	6-Sep-12	9/06/12	1
8-Sep-12	SAT										
9-Sep-12	SUN										
10-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	7-Sep-12	9/07/12	1
11-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	10-Sep-12	9/10/12	1
12-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	11-Sep-12	9/11/12	1
13-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	12-Sep-12	9/12/12	1
14-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	13-Sep-12	9/13/12	1
15-Sep-12	SAT										
16-Sep-12	SUN										
17-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	14-Sep-12	9/14/12	1
18-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	17-Sep-12	9/17/12	1
19-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	18-Sep-12	9/18/12	1
20-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	19-Sep-12	9/19/12	1
21-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	20-Sep-12	9/20/12	1
22-Sep-12	SAT										
23-Sep-12	SUN										
24-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	21-Sep-12	9/21/12	1
25-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	24-Sep-12	9/24/12	1
26-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	25-Sep-12	9/25/12	1
27-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	26-Sep-12	9/26/12	1
28-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	27-Sep-12	9/27/12	1
29-Sep-12	SAT										
30-Sep-12	SUN										
						Maximum Delay from Receipt to Registration (business days)					2

SLO 40

Service Function:	Province Access and Reports
Schedule E Reference:	Section 4.5
Service Level Objective:	**Objective 1** - Provides access to required systems/applications within 2 business days of request **Objective 2** - Withdraws access within 1 business day of request

Definition:

HIBC receives requests for Province Access and Reports from the Province. Requests are received either by email or fax and not scanned or registered. Requests are filed within department. The SLO is not easily measurable without manual tracking and background information will be made available for audit purposes.

Calculation Method:

- Attainment of the SLO is measured on a complaint basis
- Individuals with concerns are first advised to submit their issue in writing to the Director of Operations, HIBC. The complaint is logged at this stage.
- If the issue is not resolved to their satisfaction, they may then submit it to the Ministry of Health Services.
- These issues are then further investigated and if necessary, transferred to HIBC for follow-up and resolution.
- HIBC reports the number of complaints logged that are related to SLO 40 functions in the monthly SLO report.

Inclusions:

- All complaints received through the complaints escalation process related to SLO 40 for the current month

Exclusions:

- Out of scope issues (MoH Policy complaints, or complaints for other services)

Example:

A concern is received in writing by the Director of Operations, HIBC and it is resolved at that stage. It would be included in complaint based reporting, notwithstanding resolution.

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

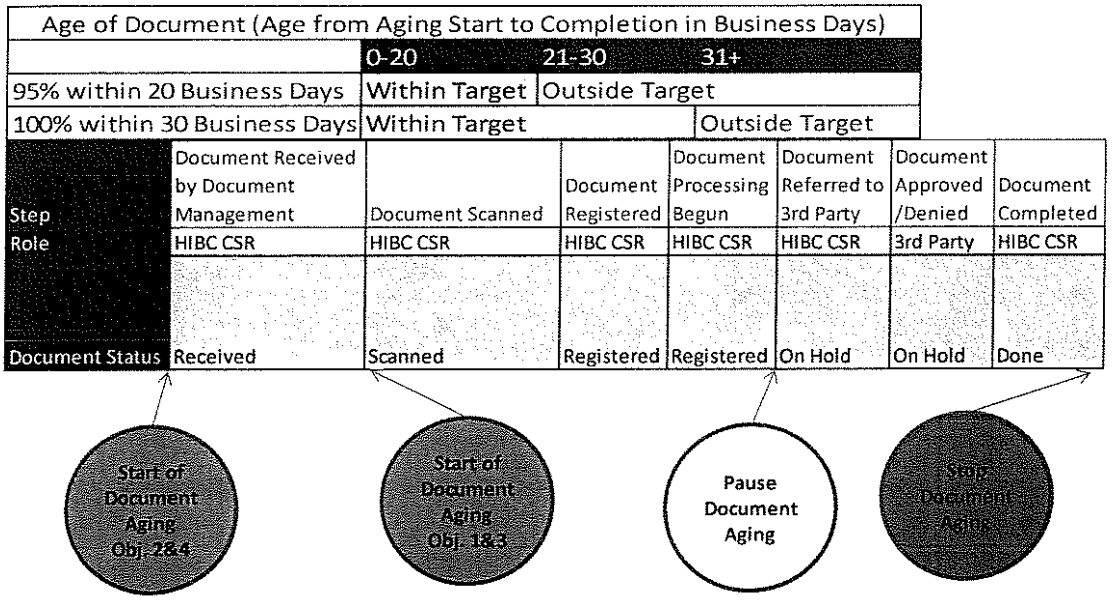
SLO 41

Service Function:	Information Requests
Schedule E Reference:	Section 4.6
Service Level Objectives:	**Objective 1** - 95% of correctly submitted Personal Information requests are processed within 20 business days from date scanned **Objective 2** - 100% of Personal Information requests processed within 30 business days of receipt **Objective 3** - 95% of correctly submitted ICBC requested listings are processed within 20 business days of date scanned **Objective 4** - 100% of ICBC requested listings processed within 30 business days of receipt

Definition:

HIBC receives requests from patients for their own MSP claim and PharmaNet claims history and/or other documents relating to them, requests for claims history from the Ministry of Children and Families on their client/family, court order requesting claim history and documents on individuals or medical providers, information requests from third parties such as ICBC or WCB, Ombudsman, Coroner's office, Office of the Public Trustee, information requests under the Freedom of Information and Privacy Act, information requests from other Province programs, etc.

Objectives 2 & 4 were previously measured under SLO 38. These measures are now grouped with Objectives 1&3 in order to align all related measures for CSR support in once place. It can take up to 3 days (as defined under SLO 39) from date of Receipt, for mail to be Registered. This time is included in Objectives 2 & 4, and the time from Scanning to Registration is included in Objectives 1 & 3.



Calculation Method:

- Attainment of the SLA is measured based on the Monthly MaxImage SLR report generated on the first day of each month.

- The report provides document completion volumes and percent completed in target for each SLA measurement for the previous month.

Measurement of % processed within 20 Business Days:

- Documents aged 20 days or less at completion are within target.

- Documents aged 21 days or more at completion are outside of target.

- Therefore the % processed within 20 Business Days is the number of documents completed within 20 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Measurement of % processed within 30 Business Days:

- Documents aged 30 days or less at completion are within target.

- Documents aged 31 days or more at completion are outside of target.

- Therefore the % processed within 30 Business Days is the number of documents completed within 30 or fewer Business Days, divided by the total number of documents completed (within or outside of target).

Inclusions:

Objective 1 & 2

- Personal Information requests completed within the calendar month
- Personal Information requests Document Types
  - PharmaCare FOI Request
  - Beneficiary/MSP FOI Request
  - Provider FOI Request

Objective 3&4

- ICBC requests completed within the calendar month
- ICBC requests Document Types
  - History Printout to Settle Claims

Exclusions:

- Incomplete Information Requests are excluded. Incomplete documents are documents that are in inventory at month end, but that have not yet been processed. For purposes of SLR calculation they will be included in the month in which they are completed.
- Non-SLO 41 related documents

Example:

Objective 1 & 3 – 95 % within 20 business days from date scanned
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 980 aged 20 days or less
- 20 aged 21+ days

Then the SLO performance is measured as follows:

- 98% within 20 Business days (980/1000)

Objective 2 & 4 – 100 % within 30 business days from date received
A total of 1000 documents were completed in a given month, and the completions are broken up into the following groups:

- 998 aged 30 days or less
- 2 aged 31+ days

Then the SLO performance is measured as follows:

- 99.8% within 30 Business days (998/1000)

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 42

Service Function:	Policy and Procedures (Operations) Manuals
Schedule E Reference:	Section 4.7
Service Level Objective:	**Objective 1** - Procedures manuals are comprehensive and in a current state **Objective 2** - Updates as a result of Policy Changes are made within 5 business days of receiving approval

Definition:

HIBC maintains up to date Policy and Procedures (Operations) Manuals. These manuals describe the procedures and practices followed by HIBC staff to provide various services. HIBC receives notification of policy changes through multiple medium: email, face to face meeting, phone call.

For changes to existing procedures the HIBC Operations Business Owner will be the initial point of contact, who will then involve the Procedure Writer. After drafting, the procedures and work instructions go to the Business Owner for approval.

For new procedures and procedures implemented as a result of a new program/service, the Project Management team will typically be the first point of contact who will then engage the Procedure Writer, following their project management methodology. After drafting, the procedures and work instructions go to the Business Owner for approval.

Role	Ministry Staff	Business Owner and/or PM	Procedure Writer	Business Owner and/or PM	Procedure Writer	Ministry staff	Procedure Writer
Step	Advise of Policy Change	Engages Procedure Writer	Drafts Procedures and Work Instructions	Review and Approve Draft for Posting on external SharePoint site for Ministry review	Posts documentation on external SharePoint site	Review and Approve Document on external Sharepoint site	Post updates to internal SharePoint site and bulletin sent out

Calculation Method:

- Compliance will be subject to audit, and communications retained where available.
- Procedure manuals are uploaded to an extranet site accessible to designated Ministry of Health, BMO and HIBC staff.

Inclusions:

Any policy changes that come from the MOH requiring a change in HIBC procedure.

Exclusions:

None.

Example:

MSP determines that they are no longer accepting a particular immigration document as proof of temporary residency. The HIBC Operations business owner will be the initial point of contact and would then contact the Procedure Writer. Procedures will be drafted, sent to the HIBC Operations Business Owner and possibly other internal stakeholders for approval. Once approved, the policy will be posted on the shared extranet site. After Ministry and BMO staff have had an opportunity to review the procedures they will be posted internally for HIBC staff. A bulletin will be sent out to internal staff, Pension Corp, ServiceBC as applicable.

Service Level Agreement:

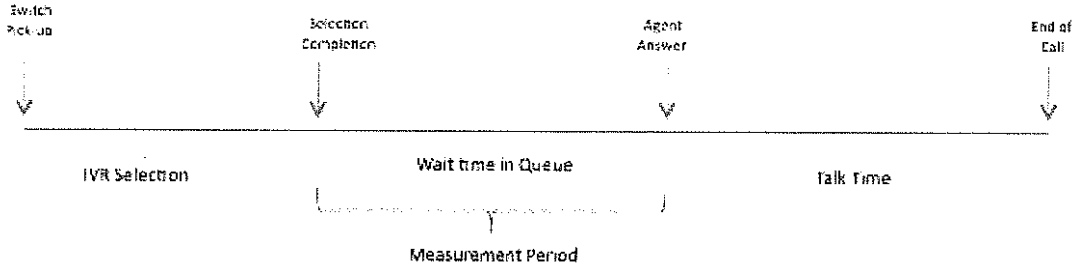
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director, Operations HIBC

SLO 43

Service Function:	MSP Enrolment Specialist Secondary Call Queue
Schedule E Reference:	Sections 1.2, 2.16
Service Level Objectives:	ASA < 10 minute 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for Enrolment Specialist Secondary Call Queue before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53). Level one calls are handled under SLR 9 and callers needing level 2 assistance are transferred to the Enrolment Specialist Queue.



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the Enrolment Specialist Secondary Call Queue.

Exclusions:

Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up.
Any calls that are handled by Voicemail or Callback.
Any level 2 calls that are abandoned before being picked up by a level 2 agent.
Level 1 calls.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

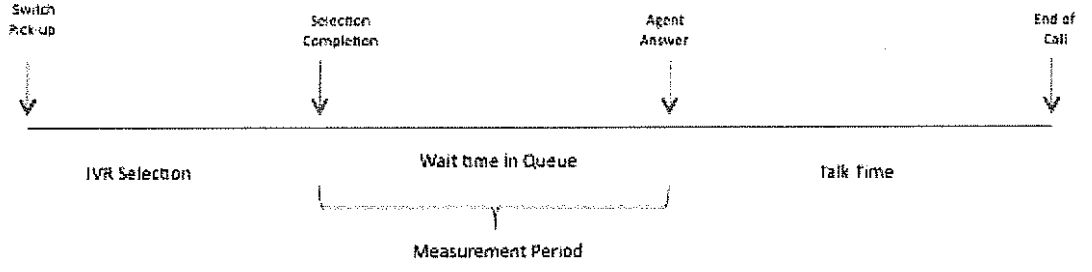
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 44

Service Function:	Group Administrator and Government Agent Call Queue
Schedule E Reference:	Section 1.2
Service Level Objectives:	**Objective 1** - ASA < 5 minutes 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly for level 1 calls **Objective 2** - ASA < 5 minutes 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly for level 2 calls

Definition:

Average Speed to Answer is the wait time in the queue for Group Administrator and Government Agent Secondary call queue before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53). Level one calls for this phone queue are answered in the Contact Centre; callers requiring second level support will be transferred to the MSP Document Enrolment Department. The ASA of 5 minutes applies to both levels.



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

For purposes of averaging the ASA, transfers to the level 2 agents are counted as a second call, with their own independent wait times.

Inclusions:

All agent answered calls received in the Group Administrator and Government Agent call queue.

Objective 1 – Level 1 Calls

- Calls answered in the level 1 call workgroup

Objective 2 - Level 2 Calls

- Calls answered in the level 2 call workgroup

Exclusions:

Objective 1 – Level 1 Calls

- Any calls that are abandoned after the IVR hands over the call to the queue and before a level 1 agent picks it up.
- Any calls that are handled by Voicemail or Callback.

Objective 2 - Level 2 Calls

- Any calls that are abandoned before a level 2 agent picks it up.
- Calls resolved by a level 1 agent.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

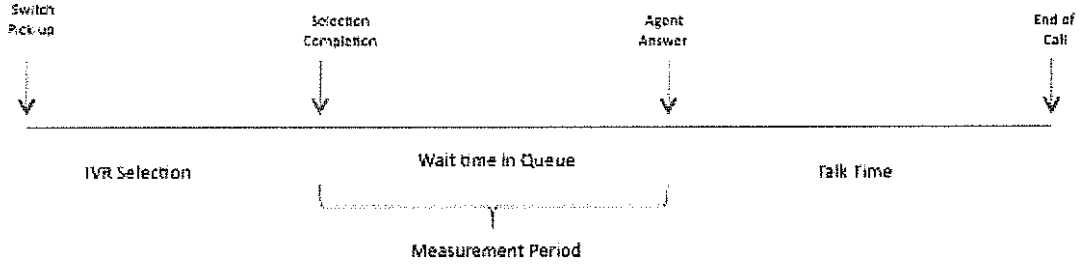
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 45

Service Function:	Practitioner Checking Patient Coverage for MSP – Call In
Schedule E Reference:	Section 2.13
Service Level Objectives:	ASA < 5 minutes 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for Practitioner Patient Coverage before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53). Callers have the option to go directly to the Patient Coverage queue, rather than the IVR. There is no secondary queue needed for this service.



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the Patient Coverage Queue.

Exclusions:

Any calls that are abandoned after the IVR hands over the call to the queue and before an agent picks it up.
Any calls that are handled by Voicemail or Callback.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

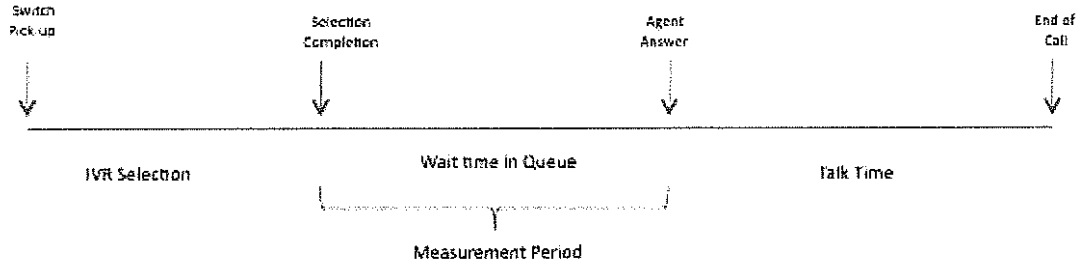
Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SLO 46

Service Function:	PharmaCare General Public Secondary Call Queue
Schedule E Reference:	Sections 3.14
Service Level Objectives:	ASA < 5 minutes 8:00am - 4:30pm on Monday through Friday except statutory holidays, averaged monthly

Definition:

Average Speed to Answer is the wait time in the queue for PharmaCare General Public Secondary call queue before an agent picks up the phone, averaged over the month in minutes and seconds (e.g., 2:53). On Saturdays and on weekdays from 4:30-8:00 pm, this queue will also handle level 1 calls as the Contact Centre is not open to provide level 1 support. These level 1 and 2 calls will automatically transfer to the PharmaCare HelpDesk outside of regular business hours.



Calculation Method:

Total number of seconds callers were waiting in the queue

/

(Total number of calls accepted minus Total number of calls abandoned, minus Total number of calls handled by Voicemail or Callback)

Expressed in minutes and seconds.

Inclusions:

All agent answered calls received in the PharmaCare General Public level 2 call queue.
Level 1 calls answered during the hours of 4:30pm-8:00pm (weekdays) and 8:00am-8:00pm, Saturdays.

Exclusions:

Calls abandoned after the IVR hands over the call to the queue and before an agent picks it up.
Any calls that are handled by Voicemail or Callback.
Level 2 calls that are abandoned before being answered by an agent.
Level 1 calls answered during the hours of 8:00am-4:30pm.

Example:

X= number of calls accepted
Y = number of calls abandoned
Z = Total number of seconds caller are waiting in the queue
W = number of calls handled by Voicemail or Callback

Where X=30,000 calls accepted, Y = 2500 calls abandoned and Z=4,325,000 seconds, W = 2500

4,325,000 / (30,000 – 2500 - 2500) = 173

173 = 2 minutes 53 seconds

Average Speed to answer = 2:53

Service Level Agreement:

Date:	Date:
Guy Cookson	Laura Podgorenko
Executive Director, Business Management Office, Ministry of Health	Director Operations, HIBC

SCHEDULE H
ONGOING DELIVERABLES

1.0 Plans and Reports Due from the Service Provider

The following table sets out plans, reports and other deliverables to be prepared or caused to be prepared by the Service Provider pursuant to this Agreement (as such plans, reports and other deliverables are modified in accordance with Article 11 of the Agreement):

Item	Description	Frequency
	Plans	
Transition Plan	• The Initial Transition Plan will be attached to this Agreement as Schedule B and will be as described in Article 3 of this Agreement. • The Working Transition Plan will be as described in Article 3 of this Agreement.	• Initial Transaction Plan due on the Effective Date. • Working Transaction Plan is due 60 days after the Effective Date.
Communication Plan	• This plan will be attached to this Agreement as Schedule K and will outline protocols for communication for various types/reasons of communication including internal, external, Freedom of Information and Privacy Act (FOI) requests, brochures, Interactive Voice Response scripts, Service Provider broadcast messages, media releases and Ministerial inquiries.	• The Communication Plan is due on the Effective Date, and shall be updated in the manner contemplated therein.
Disaster Recovery/Business Continuity Plan	• This plan will provide a detailed back up and recovery plan in the event of a major problem or disaster to ensure minimal interruption to the Services and will expressly address all Force Majeure events and Labour Disputes. • This plan will be an update of the Province's existing Disaster Recovery/Business Continuity Plans as set forth in Schedule M attached to this Agreement. • This plan will include a business continuity plan for the purpose of mitigating any undue exposure to the Service Provider's ability to continue conducting its business and	• On or before the Hand-Over Date as part of the Transition Services, the Service Provider will review the Province's existing Disaster Recovery/Business Continuity Plans as set forth in Schedule M attached to this Agreement and will update such plans as reasonably determined by the Service Provider and Approved by the Province. • This plan is to be tested by the Service Provider within six months of the Hand-Over Date and to be reviewed on a annual basis in accordance with Section 6.6 of this Agreement. • This plan may be revised

Item	Description	Frequency
	providing the Services in the normal course in the event of any emergency, crisis, Labour Dispute or Force Majeure event and, within 12 months of the Hand-Over Date, a form of Termination Assistance Plan that could reasonably be used as a basis for developing a more complete version of such plan in the manner contemplated in Article 22. • This plan will also incorporate all reasonable suggestions provided by the Province in respect of such plan.	pursuant to Section 6.6 of this Agreement.
Risk Management Plan	• This plan will document the activities and procedures used to manage risk throughout the Term and identify who is responsible for managing various areas of risk, how risks will be tracked throughout the Term, how contingency plans will be implemented and where applicable, how financial reserves will be allocated to handle risk. • This plan will incorporate operational and financial risks and mitigation plans. • This plan will updated and maintained by the Service Provider.	• Due 14 days after the Effective Date. • Modified as required.
Training Plan	• This plan describes the training budget, plans, certification programs, orientation procedures for Service Provider Personnel. • This plan is to ensure achievement of privacy, business, service and quality objectives.	• Due prior to the Hand-Over Date. • Modified as required – e.g. as new systems are implemented or as processes are modified.
Procedures and Training Manuals	• The operational procedures Manual is as described in Section 6.15 of this Agreement. • Training manuals are reference materials used for training and reference by MAXIMUS Group staff. Such training manuals	• An interim operational procedures manual, subject in form and substance to the Province's Approval, is due no later than four months after the Effective Date. • The Manual is due no later than

Item	Description	Frequency
	shall form part of the Manual.	the end of the Transition Period. • The Manual is to be updated to reflect changes in the operations or procedures. • The training manuals are due prior to the Hand-Over Date. • The training manuals are to be updated as required.
WIP Plan	• This plan will be included in the working Transition Plan to be within 60 days of the Effective Date. • This Plan will contain a list of all of the WIP as determined by the Province and the Service Provider plan for transferring, financing and completing all of such WIP. It will be based on list of WIP to be provided by the Province to the Service Provider.	• Due 60 days after the Effective Date.
Annual Operating Plan	• This plan will be as described in Section 11.6 of this Agreement.	• The first Annual Operating Plan is due on or before November 30, 2005. • Thereafter, the Service Provider's proposed Annual Operating Plan (subject to approval of the Joint Executive Committee in accordance with Section 11.6) is due no later than 90 days prior to the commencement of the Province's annual planning cycle.
Quality Management Plan	• This plan is as described in Section 6.13(d) of this Agreement and will identify procedures and methods to ensure all Services are delivered in accordance with the Agreement and all Service Levels are satisfied and continually improved upon.	• Due prior to the Hand-Over Date. • Updated as changed.
Termination Assistance Plan	• This plan will be as described in Section 21.1(c) of this Agreement. • This plan will be based on the form preliminary termination services plan included in the Disaster Recovery/Business	• Form of this plan to be prepared within 12 months of the Hand-Over Date pursuant to Section 6.6(m). • Such plan to be kept current during the Term.

Item	Description	Frequency
	Continuity Plan.	• Immediately upon commencement of the Termination Assistance Period the Service Provider will develop a full and complete version of this plan in accordance with Section 21.1(c) of this Agreement, based upon form of plan in the Disaster Recovery/Business Continuity Plan and will deliver such Termination Assistance Plan to the Alternative Service Provider within 30 days pursuant to Section 21.1(b)(i)
Transformation Plan	• This plan will be as described in Section 5.2 of this Agreement.	• The initial Transformation Plan is due on the Effective Date. • The working Transformation Plan is due on or before sixty (60) days after the Hand-Over Date in accordance with Section 5.3 of this Agreement.
Reports and Other Documents		
Financial Reports	• These reports consist of the unaudited reports described in Section 12.5 and Schedule I of this Agreement together with the audited annual financial statements of the Service Provider and MAXIMUS Canada (based on their fiscal year), including without limitation the officer's certificate described in Schedule I. • Accounting for Profit in these reports will be in accordance with Schedule I and independent of any transfer pricing[1] or other profit relocation strategies.	• The reports described in Section 12.5 and Schedule I of this Agreement will be provided annually within 60 days of the end of each Contract Year. • The audited annual financial statements of the Service Provider and MAXIMUS Canada will be provided annually within 90 days of the fiscal year end of the MAXIMUS Group. • The officer's certificate described in Schedule I will be provided within 90 days of the fiscal year end of the MAXIMUS Group.
Service Reports	• Operational performance reports will be as described in Section 8.9 and Schedule E and Schedule F of this Agreement, including metrics, complaints, number of non-English speaking calls that could not be resolved routinely.	• Subject to Section 2.0 of this Schedule, provided on a monthly basis in accordance with Section 8.9 of this Agreement or such other frequency as contemplated in this Agreement.

[1] Transfer pricing and other profit relocation strategies which shift profit from relatively high tax to relatively low tax jurisdictions.

Item	Description	Frequency
Invoices	• Invoices will be as described in Schedule I of this Agreement.	• Monthly.
Technology Reports	• This report is as described in Schedule J of this Agreement.	• As set out Schedule J of this Agreement.
Change Register	• A accurate and complete record of all changes to the Services (including costs) pursuant to Article 7 of this Agreement , as described in Section 7.13 of this Agreement.	• Maintained by the Parties on an on-going. • The Service Provider is to make such corrections to this register as the Province may reasonably request to ensure the register is accurate and complete, in all material respects, at all times throughout the Term.
Summary of all Gainsharing Activities	• Prepared by both the Service Provider and the Province independently. • Lists all activities related to finding gainsharing or revenue opportunities for both Parties.	• Annually.
Inventory of Hardware/ Software and Other Assets	• This report will provide an updated (valued) inventory of Designated Assets, including the capitalized amount of the hardware, software and other Dedicated Assets at the time of acquisition, as well as the unamortized amount remaining.	• Inventory will be kept current by the Service Provider throughout Term. • Inventory report is due at least twice annually, following the fourth month and eighth month in any Contract Year, and is due 30 days prior to end of Termination Services Period or otherwise upon the request of the Province.
Organization Structure and Key Positions	• This document will be as described in Section 10.7 • The initial Organization Structure will be attached as Schedule D to this Agreement.	• The initial Organization Structure is due on the Effective Date. • Thereafter as required in accordance with Section 10.7.
Quality Assurance Activities	• These reports will provide results of all quality assurance activities.	• Annually.
Security and Privacy Incident Reports	• These reports will detail any security and privacy breaches in accordance with Schedule X of this Agreement, including causal factors for breaches and near-breaches and the steps that were considered and steps taken to mitigate against future occurrences and risks.	• As set out in Schedule X of this Agreement.
List of Key Supplier,	• This list is as described in	• To be updated from time to time

Item	Description	Frequency
Material Subcontractors and Key Providers	Section 16.2(r) of this Agreement. • The initial list is attached as Schedule U to this Agreement	as contemplated in Section 16.2(r) of this Agreement.
Benchmarking Reports	• These reports are as described in Section 12.9 of this Agreement	• To be delivered upon the request of the Province as contemplated in Section 12.9 of this Agreement.
Customer Satisfaction Reports	• These reports are described in Section 8.15 of this Agreement.	• On or before the first anniversary of the Hand-Over Date, the Province and the Service Provider shall prepare or cause to be prepared a customer satisfaction report based on a survey of then current Province Customers and Stakeholders as contemplated in Section 8.15 of this Agreement • The Service Provider may prepare or cause to be prepared additional customer satisfaction survey reports in accordance with Section 8.15 of this Agreement.
Document aging reports	These reports are described in and are required with respect to: • Service Level Requirement Descriptions 1(a), 3, 4, 6, 8, 16(a) attached as Appendix A to Schedule F • Service Level Objective Descriptions 5, 22, 24, 28, 29, 31, 33, 38, 41 attached as Appendix B to Schedule F	• Monthly or as otherwise requested by the Province
Processing delay analysis	These reports are described in and are required with respect to Service Level Requirement Descriptions 12, 13 and 14(a) attached as Appendix A to Schedule F	• Periodically and no later than 7 days before any given payment date
CCA reports	These reports are described in and are required with respect to: • Service Level Requirement Descriptions 9, 10 and 10(a) attached as Appendix A to Schedule F • Service Level Objective Descriptions 5, 28, 43, 44, 45 and 46 attached as Appendix B to Schedule F	• Monthly or as otherwise requested by the Province

Item	Description	Frequency
Telus report	This report is described in and is required with respect to Service Level Requirement Description 11 attached as Appendix A to Schedule F	• Monthly or as otherwise requested by the Province
DMC stats reports	This report is described in and is required with respect to Service Level Objective Description 39 attached as Appendix B to Schedule F	• Daily or as otherwise requested by the Province
System incident logs	These reports are described in and are required with respect to: • Service Level Requirement Descriptions 19, 20(a) and 23(a) attached as Appendix A to Schedule F Service Level Objective Descriptions 8 and 23 attached as Appendix B to Schedule F	• At the request of the Province
Results of quality monitors	This report is described in and is required with respect to Service Level Requirement Description 26 attached as Appendix A to Schedule F	• Monthly or as otherwise requested by the Province
TAC/TDU transactions	This report is described in and is required with respect to Service Level Objective Description 23 attached as Appendix B to Schedule F	• At the request of the Province
Complaints Log	These reports are described in and are required with respect to Service Level Objective Description 8, 10, 14, 15, 25, 28, 29, 31, 33 and 40 attached as Appendix B to Schedule F	• Monthly or as otherwise requested by the Province
ITG report	This report is described in and is required with respect to Service Level Objective Description 9 attached as Appendix B to Schedule F	• Quarterly or as otherwise requested by the Province
PharmaCare Production Support job run reports	This report is described in and is required with respect to Service Level Objective Description 30 attached as Appendix B to Schedule F	• At the request of the Province

2.0 TRANSITION/INITIAL REPORTING

During the initial period of the Term from the Effective Date to the date which is five months after the Hand-Over Date, the Service Provider will provide reports on the performance of the Services and of its obligations under this Agreement to the Province in substantially the same form, content and timing as

the current internal reports of the Province as of the Hand-Over Date, subject to implementation of a different reporting system agreed to by the Parties pursuant to this Agreement.

3.0 PLANS AND REPORTS DUE FROM THE PROVINCE

The following table sets out plans, reports and other deliverables to be prepared or caused to be prepared by the Province pursuant to this Agreement:

Item	Description	Frequency
	Plans	
Disaster Recovery/Business Continuity Plans of the Province	• These plans are the Province's current disaster recovery/ business continuity plans. • These plans will be attached to this Agreement as Schedule M.	• Due on the Effective Date.
Reports and Other Documents		
List of WIP	• List of WIP determined by the Province which is to be provided to the Service Provider for purposes of preparing the WIP Plan.	• Due within 30 days of the Effective Date.
Change Register	• A accurate and complete record of all changes to the Services (including costs) pursuant to Article 7 of this Agreement , as described in Section 7.13 of this Agreement.	• Maintained by the Parties on an on-going basis. • The Province is to make such corrections to this register as the Service Provider may reasonably request to ensure the register is accurate and complete, in all material respects, at all times throughout the Term.
Benchmarking Reports	• These reports are as described in Section 12.9 of this Agreement	• To be delivered upon the request of the Service Provider as contemplated in Section 12.9 of this Agreement.
Customer Satisfaction Reports	• These reports is described in Section 8.15 of this Agreement.	• On or before the first anniversary of the Hand-Over Date, the Province and the Service Provider shall prepare or cause to be prepared a customer satisfaction report based on a survey of then current Province Customers and Stakeholders as contemplated in Section 8.15 of this Agreement • The Province may prepare or cause to be prepared additional customer satisfaction survey reports in accordance with Section 8.15 of this Agreement.

Item	Description	Frequency
Systrust Reports	• These reports are as described in Section 14.6 of this Agreement.	• Annually (for each Contract Year) as contemplated in Section 14.6 of this Agreement.

SCHEDULE I
FEES

1. **General Principles**

The Parties agree to the following:

(a) This Schedule defines and describes the Fees and deal structure including the amount and timing of the payment of Fees.

(b) The Fees are subject to possible adjustment to address Cost Overages and Cost Underages. The treatment of Costs Overages and Cost Underages is dependent on when they occur. The mechanisms for addressing these items are outlined in this Schedule.

(c) The Province may be issued credits against Fees by the Service Provider including, without limitation, Fee Rebate Credits. If the Service Provider earns Excess Spread, the Service Provider will issue Fee Rebate Credits to the Province in accordance with a mechanism outlined in this Schedule.

(d) This Schedule will determine the reporting elements that will be required for the calculation of adjustments to Fees.

(e) This Schedule will determine the monthly payments to be made by the Province to the Service Provider.

(f) This Schedule also addresses the following:

(i) audits with respect to Fees;

(ii) Termination fees; and

(iii) gainsharing.

2. **Definitions and Interpretation**

Capitalized terms used in this Schedule will have the meanings set forth in this Section 2. Capitalized terms not defined in this Schedule shall have the meanings set forth in Schedule A or otherwise in this Agreement.

(a) "**Actual Costs**" means the actual Costs incurred by the Service Provider during the Period.

(b) "**Actual G&A Costs**" means the actual cost incurred by the Service Provider in respect of general and administrative expenses during the Period.

(c) "**Actual Labour Costs**" means the actual cost incurred by the Service Provider in respect of the salary, wages and Benefits of Personnel and Non-Dedicated Staff during the Period, except only to the extent of the actual portion of the salary and wages directly relating to the provision of Services under this Agreement in the case of Non-Dedicated Staff.

(d) "**Actual Overhead Costs**" means the actual cost incurred by the Service Provider in respect of overhead during the Period.

(e) "**Base Services Payments**" has the meaning given to it in Section 9(e) of this Schedule.

(f) "**Basic Infrastructure Fee**" means an amount that is added to the monthly Fees payable by the Province to the Service Provider in every month of the Term in which a credit is issued by the Service Provider in respect of the Basic Infrastructure Amount. Any such amount added to the Fees for a particular month of the Term shall be equal to the amount credited by the Service Provider in respect of the Basic Infrastructure Amount for such same month.

(g) "**Benefits**" means vacation, leave, sick leave, statutory time, medical insurance, disability insurance, pension, or other similar economic benefits directly payable with respect to and on behalf of employees.

(h) "**Costs**" mean all Direct Costs, Overhead and G&A.

(i) "**Cost Overages**" mean the Actual Costs that are above the Planned Amount for the applicable Period, that apply to the normal course of business and which are approved by the Joint Executive Committee.

(j) "**Cost Underages**" mean the Actual Costs that are below the Planned Amount for the applicable Period and apply to the normal course of business.

(k) "**Direct Costs**" mean the costs directly attributable to the provision of the Services by the Service Provider and directly incurred by the Service Provider, being the following specific costs as more particularly described in the Economic Model:

(i) Direct Labour Costs

(ii) Benefits;

(iii) direct out-of-pocket travel costs;

(iv) technology buyout costs;

(v) hardware and software costs;

(vi) Subcontractor costs;

(vii) miscellaneous/other costs;

(viii) Systems Subcontractor costs;

(ix) telephone usage cost;

(x) office copiers;

(xi) postage;

(xii) rent;

(xiii) tenant improvements; and

(xiv) amortization.

(l) "**Direct Labour Costs**" mean the salary and wages of Personnel and Non-Dedicated Staff except only to the extent of the actual portion of the salary and wages directly relating to the provision of Services under this Agreement in the case of Non-Dedicated Staff.

(m) "**Excess Spread**" refers to Spread that is above 12.5% of Actual Costs.

(n) "**G&A**" means the amount in respect of general and administrative expenses calculated at the fixed rate of 5% of all Direct Labour Costs, Benefits and Overhead.

(o) "**Inflation**" means the increase in Fees at the rate of 1.25% per Contract Year, compounded annually, to account for the Province's share of the increases in Actual Costs due to inflation.

(p) "**Interest**" means interest on any overdue amounts calculated in accordance with Section 12.2(b) of this Agreement.

(q) "**Material Cost Overages**" means Cost Overages that are above the Planned Amount for the applicable Period by 5% or more.

(r) "**Material Cost Underages**" mean Costs Underages that are below the Planned Amount for the applicable Period by 5% or more.

(s) "**Monthly Threshold Number of Transactions**" means the monthly threshold number of transactions set out in Table 3 in Section 9(d), as revised from time to time and Approved by the Province.

(t) "**Non-Dedicated Staff**" means employees of MAXIMUS Group entities other than the Service Provider.

(u) "**Outstanding Claims**" has the meaning given to it in Section 17 of this Schedule.

(v) "**Overhead**" means the amount in respect of overhead calculated at the fixed rate of 10% of all Direct Labour Costs and Benefits.

(w) "**Period**" refers to the major time intervals of the Agreement, being each Contract Year during the Term.

(x) "**Planned Amount**" means the planned fixed amount of Costs for each Period as set out in the Economic Model.

(y) "**Settlement Amount**" has the meaning given to it in Section 17 of this Schedule.

(z) "**Special Infrastructure**" has the meaning given to it in Section 16 of this Schedule.

(aa) "**Spread**" means Fees that are in excess of Costs and where referenced as a percentage, shall be calculated as a percentage of Actual Costs.

(bb) "**Transaction Fee**" means the fee associated with a transaction set out in Table 3 in Section 9(d), as revised from time to time and Approved by the Province.

(cc) "**Year**" means Contract Year.

3. **Payment Terms**

The Parties agree to the following:

(a) The Fees to be paid by the Province to the Service Provider pursuant to this Agreement shall, subject to adjustments and credits so contemplated in this Agreement and any Changes, be paid in accordance with Section 9 of this Schedule. Fees shall be fixed at the monthly amounts set forth in Tables 1, 2 and 3 in Section 9 of this Schedule, as adjusted, plus the following amounts, if applicable:

(i) the Basic Infrastructure Fee; and

(ii) reimbursable costs for Special Infrastructure as described in Section 16 below.

(b) Fees shall be payable by the Province on a monthly basis and the amount of the Fees for a particular month will be the monthly amount for the applicable Period, as described in Sections 3(a) and 9 of this Schedule.

(c) Any adjustments to the Fees will be subject to the provisions in this Agreement (including this Schedule).

(d) Change Orders shall be separately priced, based on negotiated values in accordance with Article 7 of this Agreement.

(e) Unless otherwise specifically provided in this Agreement, where amounts are credited against Fees pursuant to this Agreement they shall be offset against Fees in accordance with Section 12.6 of this Agreement.

(f) Any unused credits, including, without limitation, Service Level Credits, owed to the Province by the Service Provider pursuant to this Agreement will be paid to the Province in accordance with Section 12.6 of this Agreement within 30 days after the expiration or termination of this Agreement.

4. **Adjustments to Fees For Cost Overages and Underages**

(a) The Parties agree that the Fees shall be adjusted for Cost Overages or Cost Underages occurring in the Transition Period and Years 1 and 2 provided that:

(i) the Cost Overages or Cost Underages are Material Cost Overages or Material Cost Underages, as applicable;

(ii) the Service Provider provides written notice to the Province of such Material Cost Overages or Material Cost Underages, as applicable, as soon as reasonably possible and the same are approved by the Joint Executive Committee, with notice of the same setting forth a description and the amount of the proposed adjustment and is accompanied by the supporting information required pursuant to Section 7 of this Schedule;

(iii) the Service Provider's proposed adjustment to the Fees is based on Actual Costs and is calculated in a manner consistent with the determination of amounts as set forth in the Economic Model; and

(iv) such proposed adjustment to the Fees is approved by the Joint Executive Committee, in its sole discretion.

If the Joint Executive Committee approves a proposed adjustment to the Fees pursuant to this Section 4(a), such proposed adjustment shall be deemed to be a Change Order. For greater certainty, any decision made by the Joint Executive Committee pursuant to this Section 4(a) of this Schedule shall not be subject to the dispute resolution procedure set out in this Agreement.

(b) An adjustment to Fees pursuant to Section 4(a) of this Schedule will be reflected on the next invoice issued by the Service Provider to the Province after the adjustment is Approved by the Joint Executive Committee. Any such adjustment shall be pursuant to this Section 4.

(c) Transition Period, Year 1 and Year 2 Cost Overages and Cost Underages approved pursuant to Section 4(a) of this Schedule will be shared between the Parties according to the following principles and formulas, as applicable:

(i) Transition Period Cost Overages will be shared between the Parties, with 50% attributed to each of the Parties and Cost Underages will be shared between the Parties, with 50% credited to the Province and 50% retained by the Service Provider.

For example if Actual Costs in the Transition Period exceed the Planned Costs for the Transition Period by $100,000, each party will be responsible to fund the Cost Overage by $50,000.

(ii) Year 1 Cost Overages will be shared between the Parties, with 40% attributed to the Province and 60% to the Service Provider and Cost Underages will be shared between the Parties, with 40% credited to the Province and 60% retained by the Service Provider.

(iii) Year 2 Cost Overages will be shared between the Parties, with 25% attributed to the Province and 75% to the Service Provider and Cost Underages will be shared between the Parties, with 25% credited to the Province and 75% retained by the Service Provider.

(iv) In the Transition Period, Year 1 and Year 2, the Spread will be fixed at 7.5% of the Costs budgeted in the Economic Model and Spread will not be applied to Cost Overages and will not be reduced against Cost Underages.

(v) In the Transition Period, Year 1 and Year 2, Overhead and G&A will be applied as a fixed percentage of applicable direct Actual Costs.

5. **Adjustment to Fees for Credits**

Fees shall in all cases be adjusted for credits in the manner contemplated in Section 12.6 of the Agreement.

6. **Fee Rebate Credits**

If the Service Provider earns Excess Spread in Year 3 and forward during the Term calculated based upon prior Contract Years, the Service Provider will grant a rebate of future Fees to the Province according to the following principles and formulas, as applicable:

(a) If Spread is less than or equal to 12.5%, no rebate of Fees will be granted by the Service Provider.

(b) If Spread is greater than 12.5% and less than or equal to 15% for a Period, the Service Provider will issue to the Province a Fee Rebate Credit calculated as follow:

Fee Rebate Credit = 25% x Excess Spread

(c) If Spread is greater than 15% and less than or equal to 17.5%, the Service Provider will issue to the Province a Fee Rebate Credit calculated as follow:

Fee Rebate Credit = (25% x (Spread greater than 12.5% and less than or equal to 15%)) + (50% x (Spread greater than 15% and less than or equal to 17.5%))

(d) If Spread is greater than 17.5%, the Service Provider will issue to the Province a Fee Rebate Credit calculated as follow:

Fee Rebate Credit = (25% x (Spread greater than 12.5% and less than or equal to 15%)) + (50% x (Spread greater than 15% and less than or equal to 17.5%) + (75% x (Spread greater than 17.5%)

(e) For the purpose of calculating Fee Rebate Credits, Spread will be determined as the Spread of the deal to date (excluding the Transaction Period, Year 1 and Year 2).

By way of example, if a Fee Rebate Credit is payable in Year 4, the amount of such credit will be determined based on Spread earned in Year 3 calculated based upon Fees and Actual Costs for Year 3. If a Fee Rebate Credit is payable in Year 5, the amount of such credit will be determined based on Spread for Years 3 and 4 net of Actual Costs for such same Years.

(f) Fee Rebate Credits, if payable, will be issued to the Province by the Service Provider on a Contract Year basis commencing in Year 4 and any Fee Rebate Credit issued by the Service Provider shall be calculated based on Spread earned prior to its Year of issuance. Notwithstanding the foregoing, if this Agreement is terminated or expires and the Service Provider earns Excess Spread in the final Year or portion thereof of the Term, as applicable, the Service Provider will issue a Fee Rebate Credit to the Province in the Termination Assistance Period calculated in accordance with this Section 6 and such credit will be set off against charges for Termination Services as described in Section 22.3 of this Agreement and any other future amounts payable by the Province to the Service Provider pursuant to this Agreement.

(g) Fee Rebate Credits will be calculated based on the Spread earned by the Service Provider to date after Year 2, net of any previous Fee Rebate Credit adjustments under this Section 6, and will be credited to the Province in accordance with Sections 12.5 and 12.6 of this Agreement. For greater certainty, any Fee Rebate Credits issue by the Service Provider shall be set off against future Fees payable by the Province.

7. Reporting

The Parties agree that the Service Provider shall report the Spread, total Fees and all Actual Costs to the Province on an annual (Contract Year) basis and such report shall include the following Actual Costs for the Basic Services, as well as a separate report for Projects where the Fees are not included in Table 1 or 2:

(a) Actual Labour Costs;

(b) Actual Overhead Costs;

(c) Actual G&A Costs; and

(d) all other Actual Costs.

For greater certainty, the financial statements to be delivered pursuant to Section 12.5 of this Agreement shall be in accordance with the reporting requirements set out in this Section 7.

8. **Audit Certificate**

On an annual basis, based on the Service Provider's regular fiscal year, the Service Provider will cause its accounting for Spread to be financially audited by an independent, accredited auditor with copies promptly provided to the Province. Within 90 days of the end of the fiscal year end of the Service Provider the president of MAXIMUS Canada will provide an officer's certificate to the Province certifying that the Spread reported in the most recent financial statements delivered pursuant to Section 12.5 of this Agreement in accordance with GAAP, as adjusted in accordance with this Agreement, for the applicable Contract Year. For greater certainty, such letter shall be delivered by the Service Provider together with the regular audited annual financial statements of the Service Provider and MAXIMUS Canada in accordance with Schedule H attached to this Agreement.

9. **Monthly Fee Amounts**

The Parties agree as follows:

(a) Monthly Fee payments in accordance with this Amendment Agreement #4 will commence at the end of the first full month after the Effective Date of this Amendment Agreement #4.

(b) Tables 1, 2 and 3 set out below details the monthly Fee payment amounts for each Contract Year, as may be adjusted pursuant to this Schedule and generally pursuant to this Agreement from time to time.

(c) Tables 1, 2 and 3 as adjusted in accordance with this Agreement, set out below reflects all payments to be made by the Province to the Service Provider from Year 8 to Year 15, inclusive, pursuant to this Agreement including adjustments for Inflation, but excluding the Basic Infrastructure Fee, if applicable, and any reimbursable costs for Special Infrastructure as described in Section 16 below.

(d) Any changes to the monthly payment amounts set out below in Tables 1, 2 and 3 shall be made pursuant to the applicable mechanisms set out in this Agreement.

Table 1: Monthly Fee Amount per Contract Year for Base Services including PharmaNet Services

Year	Monthly Payment ($)	
Year 8*	Apr. – Jan.	$2,935,274
	Feb. – Mar.	$2,976,833
Year 9**	$3,461,652	
Year 10	$3,515,113	
Year 11	$3,589,621	
Year 12	$3,665,737	
Year 13	$3,743,496	
Year 14	$3,822,934	

Year	Monthly Payment ($)
Year 15	$3,904,088

**The Fees for Contract Year 8 do not include PharmaNet Services, as fees in respect of PharmaNet Services are covered under a separate Service Request until March 31, 2013.*

***The Fees for Contract Years 9 and following includes certain amounts in respect of fees for Change Order 43 (Patient Transfer Fee Processing Services), Change Order 36 (eHealth Disclosure Directive Service – Interim Operations) and Service Request 542396 (Smoking Cessation – Ongoing Operational Costs) that were previously billed separately, as follows:*

Change Order 43	*$ 16,072.47*
Change Order 36	*$ 59,259.26*
Service Request 542396	*$ 95,489.89*
Total	*$170,821.62*

Both Parties agree that the Province is entitled to Service Levels and volumes for Change Order 43, Change Order 36 and Service Request 542396 that result in aggregate annual billing of up to the $170,821.62 total shown above, as billed in accordance with the respective transaction types, units, volume descriptions and calculations set out in Change Order 43, Change Order 36 and Service Request 542396, respectively. Any volume changes in Change Order 43, Change Order 36 and/or Service Request 542398 that would result in aggregate annual billing greater than the $170,821.62 total costs above, resulting from factors beyond the Service Provider's control, will be managed through the Change Request Procedure. For greater certainty, any volume changes in Change Order 43, Change Order 36 and/or Service Request 542396 that do not result in an annual aggregate billing amount greater than the $170,821.62 total costs above will not result in any additional charges under any of Change Order 43, Change Order 36 or Service Request 542396. For example, in Contract Year 9, should fees for transactions under Change Order 43 exceed $16,072.47, but should the total aggregate annual billing still remain below $170.821.62, then the Service Provider will not be entitled to any additional charges under Change Order 43, Change Order 36 or Service Request 542396.

Table 2: Monthly Fee Amount for BC Services Card Services

The Fees payable for the BC Services Card Services commencing on the day immediately following the: (i) first date the BC Services Card Services are accessible to the public; and (ii) the effective date of B.C. Reg. 223/2012, as amended.

Month	Contract Year (Month)	Monthly Payment ($)
1*	8 (11)	$361,087
2	8 (12)	$361,087
3 - 12	9 (1 – 10)	$365,600
13 – 14	9 (11 – 12)	$233,176
15 – 26	10 (1 – 12)	$236,091
27 – 38	11 (1 – 12)	$239,042
39 – 50	12 (1 – 12)	$242,030
51 – 62	13 (1 – 12)	$245,055
63 – 74	14 (1 – 12)	$248,119
75 – 86	15 (1 – 12)	$251,220

**In the event the BC Services Card Services commence after the first (1st) day of the first (1st) month, the monthly Fees shall be pro-rated on a daily basis.*

Table 3: Transaction Fees*

In the event the monthly number of transactions exceeds the monthly threshold numbers set out in the table below (the "**Monthly Threshold Number of Transactions**"), the Service Provider may invoice for each additional transaction over the Monthly Threshold Number of Transactions the transaction fee set out in the table below (the "**Transaction Fee**"):

Description of Transaction	Monthly Threshold Number of Transactions	Transaction Fee/Transaction
Calls (consisting of all calls directly answered by an agent including escalations and transfer queues but excluding any abandoned calls or calls resolved through voicemail or callback)	145,739	$3.387
Inbound Documents (consisting of all document types for Service Level Request 3, 4 and 6 with a Maximage status measure of "DONE*" with the exception of multi-year MSP Premium Assistance documents)	72,590	$3.883
Template Letters	2,167	$3.076
Automated Notification Letters	0	$0.862

**The above Monthly Threshold Number of Transactions and Transaction Fee will be in effect for the twelve (12) months following the Effective Date of this Amendment Agreement, after which the Parties will update this Table 3 in accordance with the methodology set out in the BC Services Card Operational Change Order dated November 21, 2012, and to the extent there is a Dispute with regard to updating of this Table 3, the Dispute resolution procedure set out in Article 23 of the Agreement will apply to settle such Dispute. The Transaction Fee will be subject to Inflation.*

(e) The Province will make the Year 8 through Year 15 (inclusive) monthly fee amount payments set out in Table 1 above as Fees in consideration for the Service Provider's performance of the Services for Year 8 through Year 15 (inclusive) (the "**Base Services Payments**"), provided however that the Base Services Payments exclude any amounts payable by the Province in respect of Change Orders or Service Requests. Notwithstanding the foregoing, the Base Services Payments include any amounts payable: (i) for Year 8 under Change Orders 20, 21a, 21b, 26, 27, 32, 39, and 46; and (ii) for Year 9 through Year 15 (inclusive) under Change Orders 20, 21a, 21b, 26, 27, 32, 36, 39, 40, 43 and 46 and Service Request 54239.

(f) The monthly fee amounts set out in Tables 1 and 2 will be increased by way of a lump sum payment after the end of each Contract Year for Year 13 through 15 (inclusive) by the CPI Adjustment (if greater than 0%).

The CPI Adjustment means the following calculation for each Contract Year starting in Year 13 as follows:

(i) if the average British Columbia Consumer Price Index, as published by Statistics Canada, is greater than two and a half percent (2.5%) for the prior three (3)

Contract Years (the "**CPI Adjustment Difference**") then the CPI Adjustment will equal fifty percent (50%) of the CPI Adjustment Difference; and

(ii) otherwise the CPI Adjustment will be zero percent (0%) (collectively, the "**CPI Adjustment**").

For example if in Year 13 the 3-year average for Years 11, 12 and 13 is 2.45%, then there would not be any Adjustment to the monthly Fees in Year 13.

If in Year 14 the 3-year average is 2.72% then there would be an overage of 0.22% and 0.11% would be applied to the monthly fees charged in Year 14 and paid by the Province in a lump sum after the end of Year 14.

(g) For certainty, the monthly fee amounts set out in Tables 1, 2 and 3 above include any Fees to be paid by the Province to the Service Provider in respect of Additional Transformation Resources.

10. **Other Fees**

The Province shall pay the Service Provider as follows:

(a) in respect of the PharmaNet Modernization Release 2 build, as described in Change Order 10 dated as of February 14, 2008, as amended from time to time (the "**PharmaNet Modernization Release 2 Change Order**") and as set out in the PharmaNet Modernization Project Joint Executive Committee Budget Projections update dated September 21, 2012, a total of $5,612,337 and payable at such times as are set out in the PharmaNet Modernization Release 2 Change Order;

(b) in respect of the British Columbia Services Card project, as described in Service Request ITG 510579/T10R0047, as amended by the amendment agreement dated January 24, 2013 and as amended from time to time thereafter (the "**BC Services Card Service Request**"), a total of $14,260,060 and payable at such times and in such manner as is set out in the BC Services Card Service Request; and

(c) a one-time risk-premium payment of $300,000, payable on the effective date of the Amendment Agreement, for completion of both the Pharmanet Modernization Release 2 build as set out in the PharmaNet Modernization Release 2 Change Order and the BC Services Card Service project as described in the BC Services Card Service Request.

11. **Termination for Convenience**

(a) Termination for Years 8 through 10

If the Province terminates this Agreement for convenience where such termination is effective during Contract Year 8 through Contract Year 10, the Province will pay to the Service Provider the Termination for Convenience Fee, calculated as set out below based on the time of Termination:

A. an amount equal to X as calculated in accordance to following formula:

$$X = \$12{,}293{,}995 - \left(\begin{array}{l}\text{(number of full months elapsed from Hand-Over Date)}\end{array} \times (\$102{,}450) \right)$$

B. $100,000.00 per outstanding Contract Year (pro-rated for partial years) not completed (i.e. after the Termination Date).

(b) Termination for Years 11 through 15

If the Province terminates this Agreement for convenience where such termination is effective during Contract Year 11 through Contract Year 15, the Province will pay to the Service Provider the Termination for Convenience Fee, calculated as set out below based on the time of Termination; provided however that such amount will not be less than zero:

Termination for Convenience Fee	=	$18,440,992 –	(	(number of full months elapsed from Hand-Over Date)	x	($102,450)	)

12. **No Fault Termination After Year 1**

If the Province terminates this Agreement as a result of a No Fault Trigger pursuant to Section 21.4 of this Agreement after Year 1 of the Term, in addition to any other amounts owing by the Province to the Service Provider pursuant to the terms of this Agreement up to the Termination Date, the Province will pay to the Service Provider the No Fault Termination Fee, calculated in accordance to the following formula and based on the time of Termination; provided however that such amount will not be less than zero:

No Fault Termination Fee	=	$12,293,995 –	(	(number of full months elapsed from Hand-Over Date)	x	($102,450)	)

The Parties acknowledge and agree that the risk of not earning Spread will decrease over the course of the relationship between the Parties and that the No Fault Termination Fee will decrease over the Term to reflect such decreasing risk.

13. **Changes in Scope of Services**

At any time during the Term, the Province will have the right to make a Material Change to the scope of Services pursuant to Article 7 of this Agreement and the impact to the Fees resulting from exercise of such right will be assessed through the process described in Article 7 of this Agreement. Where a Material Change to the Fees is made as a result of such process (i.e. Change Request process), upon the approval of the Joint Executive Committee the Parties will adjust the monthly Fee amounts set out in Tables 1, 2 and 3 (as applicable) in Section 9 of this Schedule to reflect such change in Fees.

14. **Gainsharing**

Gain sharing will be determined on a case by case, opportunity by opportunity basis in accordance with the principles set forth in Section 13.1 of this Agreement, the provisions on this Agreement applicable thereto, and otherwise as agreed by the Parties, each acting reasonably.

15. **PharmaNet Modernization Assets**

Upon the Province's written request, the Service Provider will purchase the tangible assets associated with the PharmaNet Services from the Province in the form of the Asset Conveyance Agreement set out in Schedule L.

16. **Special Infrastructure**

The Province will be entitled to acquire or direct the Service Provider to acquire on the Province's behalf any hardware, equipment, software and communications equipment that will be used in connection with the performance of the Services, including, without limitation, any MAXIMUS Technology, provided that the Province provides prior written notice of its intention to acquire such technology infrastructure to the Service Provider. If the Province provides any such notice to the Service Provider, the following provisions shall apply in respect of the technology infrastructure described in such notice (the "**Special Infrastructure**"):

(a) if the Special Infrastructure is included in the MAXIMUS Technology and the Province acquires the Special Infrastructure on its own, then the Service Provider will not be obligated to obtain such Special Infrastructure to deliver and perform the Services in accordance with this Agreement, but, for greater certainty, shall continue to obligated to set-up, implement, operate, maintain and upgrade the Special Infrastructure in accordance with Section 10.15 of this Agreement;

(b) the Infrastructure will at all times be owned by the Province, but the Service Provider will operate and maintain the Special Infrastructure on behalf of the Province,

(c) the Service Provider has and will have no ownership or other interest in the Special Infrastructure other than the rights of access to and use of the Special Infrastructure to deliver and perform the Services in accordance with this Agreement;

(d) the Province will make available to the Service Provider such access to and use of the Special Infrastructure as is required by the Service Provider to deliver and perform the Services in accordance with this Agreement;

(e) the Service Provider will pay all costs for the Special Infrastructure, including, without limitation, any acquisition, licensing, maintenance and renewal costs, any where such costs are initially paid by the Province then the Service Provider will provide the Province with a credit against Fees in respect of the same; and

(f) notwithstanding paragraph (e) above, the Province will reimburse the Service Provider for any costs, without profit or markup, for any Special Infrastructure that is not in respect of the MAXIMUS Technology and is not otherwise covered by the Fees payable by the Province and is otherwise not required in respect of the provision of the Services and any such reimbursable costs shall be added to the Fees payable by the Province.

Notwithstanding the foregoing, the Parties agree that this Section 16 shall not apply to Province Shared Infrastructure. This Section 16 is subject to Article 7 of this Agreement, which shall be applicable in respect of any changes having a material impact on the cost of providing the Services that result from the Service Provider complying with this Section.

17. **Settlement Payment**

In consideration of the $2,450,000 settlement amount (the "**Settlement Amount**"), the Service Provider agrees to forever release and discharge the Province from any and all claims or disputes related to any action, inaction or delay by the Province that occurred up to October 15, 2012 and the consequences of

that action, inaction or delay, but excluding the claims related to the Medigent Implementation Project Impact Assessment required to incorporate functionality deployed in release 1 of the BC Services Card project, and the enterprise master patient index integration project as set out in Change Order 49, which are still being negotiated by the Parties (collectively, the "**Outstanding Claims**"). The Settlement Amount shall be paid by the Province to the Service Provider on a date to be agreed between the Parties, provided that such date shall be no later than September 30, 2013.

The Service Provider represents that, as of the Effective Date, it is unaware of any outstanding matters that may give rise to a claim, dispute or further change order under the Agreement other than the Outstanding Claims.

SCHEDULE N
LOCATION OF SERVICE CENTRE

1. This Schedule, in conjunction with the Agreement (including Section 6.8 and Schedule X) describes the principles the Service Provider will use to secure the facilities for the Service Centre, being the only location from which Services pursuant to this Agreement shall be provided except as otherwise specifically contemplated in this Agreement, and certain other permitted facilities contemplated in this Agreement.

2. The Service Provider will secure such appropriate facilities for the Service Centre and other facilities in connection with this Agreement (as contemplated below) in accordance with the following principles:

   (a) The Service Provider will provide the Services from the Service Centre, which shall be located in Victoria, British Columbia;

   (b) The Service Provider will ensure that the Service Centre meets the relevant Victoria, British Columbia, and/or Canadian regulations, laws, and requirements for safe business operations occupancy;

   (c) Subject to the prior Approval of the Province, the Service Provider may provide select technical services comprising the Services from a location in another province or provinces in Canada conditional upon compliance with all other provisions in this Agreement in respect of the same including those provisions set forth in Schedule X; and

   (d) The Service Provider will retain secure appropriate Key Suppliers and/or off-site locations for the storage of paper records, electronic data, including data back-ups, in British Columbia or another suitable location within Canada provided that:

      (i) storage locations outside of British Columbia will be subject to prior Approval by the Province; and

      (ii) The Service Provider complies with this Agreement including compliance with Schedule X, Section 6.8, Section 10.14 and Article 14.

3. Subject to Section 6.8 of this Agreement and to the other provisions of this Agreement, the Province agrees to reasonably Approve Canadian locations for select technical services and/or storage outside of British Columbia.

4. Upon determination of the Service Centre location, the Service Provider shall immediately notify the Province and this Schedule shall, upon delivery of such notice, immediately be deemed to be amended to include such location.

5. Set out below are the Service Centre and other location from which Services pursuant to this Agreement may be provided:

Service Centre
716 Yates St
Victoria, BC

IT Service Centre
722 Cormorant St Victoria, BC
V8W 1P8

Deltaware (MAXIMUS Canada Services, Inc.)
90 University Ave, Suite 300
Charlottetown, Prince Edward Island
C1A 4K9

TELUS - Call Centre Anywhere Data Centre
3777 Kingsway
Burnaby, BC

TELUS Data Centre
4000 Seymour Place
Victoria, BC

TELUS Remote Data Centre
1525 - 10th Ave. SW
Calgary, Alberta

SSBC Data Centre
4000 Seymour Place,
Victoria, BC

SSBC Regional Network Centre (1)
800 Hornby Street
Vancouver, BC

HBO/SSBC Regional Network Centre (2)
865 Hornby Street
Vancouver, BC

SSBC Calgary Data Centre
5300 – 86th Avenue SE
Calgary, Alberta
T2C 4L7

Lason Canada Company (CD ROM's processing service)
204 W. Sixth Avenue
Vancouver, BC,

Giesecke & Devrient Systems Canada, Inc. (Care card Production)
316 Markland Street, Markham, Ontario L0E 1R0

Moore Canada d/b/a RR Donnelley (Printing Services)
6100 Vipond Drive, Mississauga, Ontario, L5T 2X1

SSBC/HP (Data Centre for Mainframe)
5300 – 86th Avenue SE
Calgary, Alberta
T2C 4L7

SCHEDULE Q
DESIGNATED EXPEDITED ARBITRATOR LIST

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SCHEDULE U
KEY SUPPLIERS, MATERIAL SUBCONTRACTORS AND KEY PROVIDERS

Set out below is a list all of the Key Suppliers, Material Subcontractors and Key Providers of the Service Provider as of the Effective Date (all of which have been Approved in accordance with the terms of this Agreement):

Key Suppliers

Oracle, NetApp, VMWare and Microsoft

Material Subcontractors

Lason Canada Company, Giesecke & Devrient Systems Canada, Inc., Moore Canada d/b/a RR Donnelley, Catamaran, Inc. (SXC)

Key Providers

TELUS and SSBC/HPAS

SCHEDULE V
SPECIFIC APPLICABLE LAWS

1. *Canada Health Act (Canada)*
2. *Child, Family and Community Service Act* (British Columbia)
3. *Continuing Care Act* (British Columbia)
4. *Controlled Drugs and Substances Act* (Canada)
5. *Document Disposal Act* (British Columbia)
6. *Employment and Assistance Act* (British Columbia)
7. *Employment and Assistance for Persons with Disabilities Act* (British Columbia)
8. *Employment Standards Act* (British Columbia)
9. *Financial Administration Act* (British Columbia)
10. *Food and Drugs Act* (Canada)
11. *Freedom of Information and Protection of Privacy Act* (British Columbia), including, without limitation, *Freedom of Information and Protection of Privacy Amendment Act* (British Columbia)
12. *Health Professions Act* (British Columbia), including, without limitation, *Naturapathic Physicians Regulation*
13. *Hospital Act* (British Columbia)
14. *Hospital Insurance Act* (British Columbia)
15. *Immigration and Refugee Protection Act* (Canada)
16. *Income Tax Act* (British Columbia)
17. *Income Tax Act* (Canada)
18. *Infants Act* (British Columbia)
19. *Insurance (Vehicle) Act* (British Columbia), including, without limitation *Insurance (Vehicle) Regulation*
20. *Insurance Corporation Act* (British Columbia)
21. *Investment Canada Act* (Canada)
22. *Labour Relations Code* (British Columbia)
23. *Medicare Protection Act* (British Columbia), including, without limitation, *Medical and Health Care Services Regulation*
24. *Mental Health Act* (British Columbia)

25. *Ministry of Health Act* (British Columbia)

26. *Name Act* (British Columbia)

27. *Ombudsman Act* (British Columbia)

28. *Pharmacy Operations and Drug Scheduling Act* (British Columbia)

29. *Pharmaceutical Services Act* (British Columbia)

30. *Workers Compensation Act* (British Columbia)