

REQUEST FOR PROPOSALS (RFP)

ISSUE DATE: November 2, 2009
TITLE: Administrative Services for Medicare Eligible Retiree Health Benefits Plans – Medical/Surgical and Vision Benefits
RFP NUMBER OHB09-2
ISSUING AGENCY: Commonwealth of Virginia
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219
PERIOD OF CONTRACT: From January 1, 2011 through December 31, 2012, with three one-year renewal options as described within. (Reference Paragraph 8.15.)

Sealed proposals for furnishing services described herein will be received subject to the conditions cited herein until 2:00 p.m., Monday, December 7, 2009.

All Inquiries Must Be In Writing and Directed To:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219
Fax Number: (804) 225-2790
E-Mail: dan.hinderliter@dhrm.virginia.gov

SEND ALL PROPOSALS DIRECTLY TO THE ISSUING AGENCY ADDRESS SHOWN ABOVE.

Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, § 2.2-4343.1 or against a bidder or offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposals, and to all the conditions imposed therein and hereby incorporated by reference, the undersigned offers and agrees to furnish materials and services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiation.

Name and Address Of Firm:

_____ Zip Code: _____

Date: _____
By: _____
(PRINTED NAME)

(SIGNATURE IN INK)
Title: _____

Fax Number: () _____

Telephone: () _____

PRE-PROPOSAL CONFERENCE: A **mandatory** pre-proposal conference will be held on Tuesday, November 17, 2009, 10:00 a.m. at the James Monroe Building, Mezzanine Level, PDS Room #1. (Reference Paragraph 5.10)

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ATTACHMENTS

- ONE – Small Business and Business Owned By Women And Minorities
- TWO – Organizational Capabilities Questionnaire
- THREE – Cost Schedules
- FOUR – HIPAA Privacy Business Associate Agreement

APPENDICES

- 1 - Current Plan Description
- 2 - Standard DHRM Contract
- 3 - Cost & Enrollment Data
- 4 - Processes for Membership and Billing
- 5 - Specifications for Eligibility Files
- 6 - Specifications for Claims File
- 7 - Specifications for Direct Bill Report

1.0 PURPOSE AND GENERAL DESCRIPTION

The purpose of this Request for Proposals (RFP) is to secure administrative services for the Medicare primary retiree health benefits program for the Commonwealth of Virginia. The Department requests proposals for administrative services for three statewide plans to coordinate with Medicare. One of these plans includes a routine dental and vision benefit, and the other two plans have an optional dental and vision benefit. The three plans include an enhanced Medicare Part D prescription drug benefit. One of the plans is offered without prescription drug coverage (medical-only) to which the routine dental and vision benefit may be added. In addition, administrative services include the Medicare primary retiree health benefits program for retirees of The Local Choice Program, which does not include a prescription drug benefit. This RFP is specific to the medical, surgical and vision component of the retiree programs. The Department may consider proposals for a Medicare Advantage with Drug Plan, but is under no obligation to offer such a program.

1.1 General

The Department wishes to continue the self-insured plans it now offers to retirees, survivors, LTD participants and their covered dependents who are eligible for Medicare primary coverage under the state and TLC programs. (Medicare-eligible enrollees and dependents could be covered under separate plans and could be “linked” to a non-Medicare eligible participant. All memberships are single.) (1) The Supplemental Plan (Option II) covers the Part A deductible and coinsurance except for \$100, the Part B deductible and coinsurance, and provides major medical coverage (including out-of-country coverage) at 80% after a \$200 deductible. (2) The Complementary Plan (Option I) covers the Part A deductible and coinsurance except for \$100, the Part B coinsurance after a deductible of \$1,000, and provides basic diagnostic and routine dental services, and a routine vision benefit. (3) Advantage 65 covers the Part A deductible and coinsurance except for \$100, the Part B coinsurance but not the annual deductible and out-of-country major medical services at 80% after a \$250 deductible. An optional benefit providing basic diagnostic and routine dental services and a routine vision benefit is available under Option II and Advantage 65. Prescription drug coverage for all plans is an enhanced Medicare Part D plan (EGWP or Employer Group Waiver Plan) currently provided under a separate contract. There is an Advantage 65-Medical Only Option that excludes any prescription drug coverage to which routine dental and vision can be added, and there are plan codes that define recipients of the Medicare Part D low income subsidy (see 2.4.4 regarding premium billing) provided by CMS through the current prescription drug vendor. A legal description of each plan is contained in Appendix 1.

THE DEPARTMENT MAY WISH TO CHANGE SOME OF THE BENEFITS CURRENTLY OFFERED. HOWEVER, ALL PROPOSED DEVIATIONS FROM THE BENEFITS CONTAINED IN APPENDIX I MUST BE CLEARLY HIGHLIGHTED AND SPECIFICALLY APPROVED IN ADVANCE BY THE DEPARTMENT.

1.2 Policy Regarding Participation Of Small, Women, And Minority Owned Businesses

It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in state procurement activities. The Commonwealth encourages Contractors to provide for the participation of small businesses and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, and other contractual opportunities. Submission of a

report of past efforts to utilize the goods and services of such businesses and plans for involvement on this contract are required. By submitting a proposal, Offerors certify that all information provided in response to this RFP is true and accurate. Failure to provide information required by this RFP will ultimately result in rejection of the proposal.

All information requested by this RFP on the ownership, utilization, and planned involvement of small businesses, women owned businesses, and minority owned businesses must be submitted. If an Offeror fails to submit all information requested, the purchasing agency will require prompt submission of missing information after the receipt of vendor proposals in order for a non-compliance proposal to be considered.

1.3 Appendices

Appendix 1 contains a description of all plans, including the routine dental and vision benefit and the Medicare Part D prescription drug benefit, currently offered to Medicare-eligible retiree group participants. The most recently published handbooks and the notification letter to participants that includes all of the January 1, 2010, changes are included to reflect the current plan descriptions. Appendix 2 contains the Department's Standard Contract. Appendix 3 contains selected cost, enrollment, and utilization data for State retirees. Appendix 4 provides current processes for membership and billing. Appendix 5 provides current eligibility file specifications. Appendix 6 provides claims file specifications.

1.4 Attachments

Attachment One contains the required Small, Women, and Minority Owned Businesses forms. Attachment Two contains the technical organizational questionnaire that must be submitted with a proposal. Attachment Three contains the cost proposal schedules. Attachment Four is the HIPAA Business Associate Agreement that all Offerors must agree to sign.

1.5 Electronic Data Files and Response Forms

Files containing claims, enrollment data and the Attachment 2 schedules you will need to prepare and submit a proposal are available in electronic form. The CD containing these MS Excel and Word files will be available at the November 17 mandatory pre-proposal conference.

2.0 TASKS AND BENEFIT SPECIFICATIONS

2.1 General

The Contractor is required to maintain a level of effort during the life of the contract to perform these tasks as often as necessary, to revise deliverables (as to both quantity and form) in accordance with changing circumstances and directions from the Department, and to maintain information and systems on a current basis. Where applicable, tasks performed must be consistent with CMS required provisions.

2.2 Benefit Specifications, All Plans

2.2.1 The plans must offer all of the medical, surgical and routine benefits, and only the benefits contained in the contract books provided as Appendix 1. Any

changes suggested by the Offeror must be clearly highlighted and specifically agreed to by the Department.

2.2.2 In addition, the routine vision benefit should provide the Basic Vision services as described in the Dental/Vision Member Handbook Insert.

2.3 Claims Processing

2.3.1 Process all claims incurred during the life of this contract.

2.3.2 Receive, date and control claims within 24 hours of the day received.

2.3.3 Verify eligibility of claimant and period of coverage for every claim processed. The Contractor's eligibility file must include each dependent by name and individual ID number together with the period during which coverage has been in force.

2.3.4 Examine the licensure and participation status of the provider of services if not a Medicare-primary service.

2.3.5 Determine whether or not the services are covered or whether the services should be covered as primary by Medicare.

2.3.6 Price the services if not covered as primary by Medicare.

2.3.7 Generate and mail a check, as required, and an explanation of benefits (EOB) or denial notice. The form of the EOB and denial notice are subject to the Department's approval. Payments and denial notices must be mailed within five business days of the date on which the claim was processed. EOBs for payments secondary to Medicare should reflect the payment by Medicare as indicated on the Medicare Summary Notice.

2.3.8 Maintain a history of all claims paid. Not less than 18 months of claims history prior to the current calendar year shall be maintained on line.

2.3.9 Work with the specified contracted vendor who identifies Medicare eligibility, as necessary to process/retract/reprocess claims in response to Medicare secondary payor demands.

2.3.10 Contractor will have automatic crossover arrangement with Medicare.

2.3.11 Contractor will ensure that other coverage in addition to Medicare is identified and correctly coordinated.

2.4 System Capabilities

2.4.1 Contractor shall have in place an electronic interface (automatic crossover arrangement) with Medicare administrators in order to receive Medicare processed claims for enrollees direct from the administrators. This interface shall be in place by the effective date of this contract.

2.4.2 Contractor shall share claim and eligibility data with Contractors administering other components of the Medicare Retiree Health Program as needed for

coordination of benefits, billing, consolidated reporting and other agreed upon purposes.

2.4.3 The Department shall provide Contractor with eligibility/enrollment information for the State Program in the HIPAA 834 Transaction File format as described on the DHRM Website (<http://web1.dhrm.Virginia.gov/itech/itdocs.htm>) and in Appendix 5. Two types of eligibility files are provided:

- 834 Eligibility Transaction Daily Change File: The Daily Change File includes maintenance transactions that add or terminate coverage within the State Program. Change transactions are provided as term / add pairs. Daily Change Files are provided Tuesday through Saturday and are to be processed by the Contractor within one business day.
- 834 Eligibility Transaction Monthly Audit File: The Monthly Audit File is provided on the 3rd of the month and contains the State Program's full, active membership as of the 1st of that month. It is used only for comparison of information between the Department's system and the Contractor's system. The Contractor reports discrepancies to the Department no later than the 20th of the month.

2.4.4 Contractor must connect to the Department's secure FTP server for State Program file transfers by one of the following protocols: SFTP using SSH2 on port 22; or HTTPS for manual retrieval.

2.4.5 The eligibility/enrollment information for the TLC Program shall be provided by the Department to the Contractor in a manner finalized during the negotiation process. This exchange of data may be by U.S. mail, fax, on-line or by file transfer. It is possible that the Contractor for medical and vision benefits shall maintain and share eligibility/enrollment information for the TLC Program with Contractors for other components of the program.

2.4.6 Contractor shall report electronically to the Department on a weekly or bi-weekly basis as determined by the Department all claims, for both the State and TLC Programs, processed and paid under this contract. The claims file specifications are shown in Appendix 6.

2.4.7 Contractor shall provide direct billing and collection of premium for certain participants in the State Program and identified on the Daily Change File to include billing for other benefit contractors. This direct billing shall provide the options for payment by bank drafts or by prepayment by check on a monthly, quarterly, or annual basis or by electronic payment. The Contractor shall provide full accounting for these collections and transmittal to the Department on a monthly basis or upon request. Specifications for the direct bill report are contained in Appendix 7. The Contractor should be able to accommodate multiple plan/status codes to reflect premium differences based on Medicare low-income subsidies, the Advantage 65-Medical Only premium and continuation coverage premiums reflecting an administrative fee and late penalties. Contractor should be able to process manual credit or debits as directed by the Department to accommodate retroactive premium adjustments when moving from benefit deduction to direct premium billing. In addition, Contractor should be prepared to recognize and process a premium

code on the Daily Change File that indicates a hold on claims without terminating coverage.

2.4.8 Contractor shall provide direct billing and collection of premium for each employer group in the TLC Program. The Contractor shall provide full accounting for these collections and transmittal to the Department on a monthly basis. The format and process shall be finalized by the Department and the Contractor during the negotiation process.

2.5 Plan Inquiries

2.5.1 Contractor shall provide a toll-free customer service number which shall provide general information on the plan, claims status, and counseling to participants.

2.5.2 Contractor shall respond correctly and timely to inquiries received by telephone, by mail or in person.

2.5.3 Contractor must offer toll-free customer service telephone numbers at least three months before the effective date of the contract.

2.5.4 Contractor should provide a web site providing information on the plan.

2.6 Business Continuity Plan

Contractor shall provide to the Department copies of its disaster recovery, continuation of operations and/or business continuity plans outlining contingency plans in place to provide uninterrupted service in the event of disaster or emergency. These should include, but not be limited to, systems, customer service, claims processing, provider payment, and eligibility maintenance and determination.

2.7 Medical-Surgical and Routine Vision Plan Benefits Administration

2.7.1 Contractor shall develop enrollment applications acceptable to the Department. Enrollment applications may include elections for dental and/or prescription drug benefits administered by another vendor.

2.7.2 Contractor shall develop notices acceptable to the Department to enrollees regarding loss of coverage, coordination of benefits other than Medicare. Notify enrollees timely with respect to any of these events.

2.7.3 Contractor shall develop and distribute handbooks based on enrollment for enrollees (Member Handbook) which contains evidence of coverage, enrollee's responsibilities, and plan's responsibilities. This will include printing and distribution of dental and/or prescription drug insert for those plans that include those benefits. Form and content must be approved by the Department.

2.7.4 Contractor shall hold enrollees and covered dependents harmless with respect to services covered under this contract when such services are furnished by participating providers (for services covered by these plans but not covered by Medicare). This provision shall not apply to beneficiaries who remain institutionalized after receiving notice that institutionalization is/will be no longer medically necessary as of a specified date.

2.8 Accounting

- 2.8.1 Contractor shall issue enrollee identification cards. The form of the card is subject to the Department's approval and may include benefits provided by other vendors.
- 2.8.2 Contractor shall arrange for banking services which provide safety for funds collected and disbursed under this contract. Reconcile bank statements within 60 days of receipt. Credit claims paid for amounts representing stale dated checks.
- 2.8.3 Contractor shall act as fiduciary for monies received.
- 2.8.4 Contractor shall maintain such journals, ledgers and books of account as are required to account fully for all funds received and expended under this contract, and such supplemental records as are necessary to fulfill the reporting requirements specified in Section 4 below. Tab Five of vendor submission shall include a proposed monthly invoice, identifying all billing components identified in the offering. This submission shall utilize proposed amounts from the cost schedule and any potential ancillary line items.

2.9 The Local Choice Program

In addition to tasks specifically mentioned as pertaining to state retirees, survivors and LTD participants, the Complementary Plan (Option 1), the Advantage 65-Medical Only Plan, and the dental/vision option shall be made available to participants in The Local Choice (TLC) health benefits program. The terms and conditions are identical to those governing the state program, but the Department establishes the appropriate premium. TLC does not offer any prescription drug coverage to Medicare beneficiaries. Anthem Blue Cross Blue Shield has been awarded a contract to provide administrative services for active employees under TLC, and the Contractor will need to coordinate with Anthem the offering of the Complementary Plan and Advantage 65 Plan to retirees. The following, including necessary coordination with component and alternative benefits plans, are also specifically required.

- 2.9.1 Contractor shall design, development, production and distribution of educational, open enrollment and marketing materials.
- 2.9.2 Contractor shall maintain eligibility for TLC retiree members and transmit eligibility to dental and/or prescription drug vendor as required. Contractor shall provide an on-line eligibility and enrollment function for TLC member groups but shall also be able to accommodate paper enrollment and eligibility.
- 2.9.3 Contractor shall provide marketing support of existing individual groups and prospective new groups.
- 2.9.4 Contractor shall provide premium processing and billing on a monthly basis for TLC groups that provide benefits for Medicare-eligible retirees Transmission and accounting of premiums to the state, including enforcement of delinquency provisions of program regulations regarding payment of premiums.

- 2.9.5 Contractor shall provide transmission of HIPAA compliant eligibility information to related plans, if applicable.
- 2.9.6 Contractor shall provide weekly and monthly financial and service reporting.
- 2.9.7 Contractor shall provide quarterly and annual utilization reporting and analysis.
- 2.9.8 Contractor shall provide annual accounting and renewal analysis.

2.10 Claims File

To be awarded a contract, all plans must demonstrate the capability to provide the claims and eligibility tapes described in paragraph 2.10.1 below. Such demonstration will consist of submission and approval of a test file in the format described in Appendix 5. The timing and other logistics involved with this process will be determined during the proposal evaluation negotiations.

- 2.10.1 The plan must submit a paid claims test tape containing at least 500 claims in the format defined in Attachment 4 by April 1, 2010. The Department must be able to read and approve the tape formats no later than May 15, 2010 or no contract will be finalized.

PLEASE NOTE: Standard vendor tapes are not acceptable to fulfill this requirement.

3.0 STANDARDS OF PERFORMANCE

3.1 General

The Contractor shall be solely responsible to the Department and liable for any delay or non-performance of any portion of the contract which results from this RFP, and for erroneous payments. The Contractor shall not be responsible for delay or non-performance if the non-performance is caused by the failure of the Commonwealth, covered persons, or non-network providers to provide information necessary for the Contractor to meet its contractual obligations.

Certain performance obligations are of such importance that a Contractor's failure to achieve the requirements found herein jeopardizes the value which the Department expected of the contract. In acknowledgment of this, and in consideration of the extra expenses and other damages incurred by the Department should the Contractor fail to fulfill specified contractual obligations, both parties agree that the Contractor shall pay to the Department the amount contained in the appropriate schedule of liquidated damages (see paragraph 3.8) when the Contractor's performance fails to meet the specified standards of performance.

It is expressly agreed that, unless otherwise specified, the determination of liquidated damages, if any, shall be determined annually by comparing the system generated reports in Attachment TWO and THREE to the related Schedules submitted by the Contractor.

3.2 Claims Must Be Paid Correctly

- 3.2.1 The goal is 100% accuracy.

3.2.2 Below Standard:

- a. Total payment error rate in excess of 1% of benefit payments, where total payment error rate is the dollar amount of erroneous payments, including payments to an incorrect payee (any reason) or paid in an incorrect amount (any overpayment plus any underpayment) or any other payment error (including both incorrect payee and incorrect amount), divided by the total dollar amount of claims paid during the audit period, **OR**
- b. Total error rate in excess of 5% of claims processed, where total error rate is the number of claims with any kind of error (including payment errors) divided by the total number of claims processed during the audit period.

3.2.3 Compliance with this standard shall be determined by internal audit, verified by external audit. Should the internal and external audits arrive at results which materially affect the amount of liquidated damages, the Contractor and the Department shall negotiate the actual amount of the damages. If these parties cannot reach an agreement through negotiation, they shall jointly pay for an independent audit whose determination shall be binding on both parties.

3.3 Coordination Of Benefits Savings

The Contractor shall coordinate benefits and produce an annual report reflecting COB savings achieved under the plan other than with Medicare.

3.4 Access of Eligibility Files Updates

The Department will maintain current eligibility files for the state employee group. Enrollee eligibility changes may be made electronically without restriction to time of day or day of week. The Department will move these changes automatically to an electronic file for pickup by the Contractors. It is expected that each Contractor pick up changes daily.

3.5 Reporting

Reports containing the requested true information shall be submitted timely. The submission of a materially inaccurate report does not constitute timely submission for the purposes of this section. NOTE: Timely reporting also includes the submission of accurate and readable weekly claims files, paid claims invoices, and monthly administration invoices.

The Department shall determine compliance with this standard by the date of receipt of reports.

3.6 Invoice Processing

Process 90% of TLC premium invoices within 3 business days of receipt of payment and 100% of premium invoices within 5 days of receipt.

Compliance with this standard shall be determined by audit as described in 3.2.

3.7 Premium Projections

If the total discount representing the Net Payment after Application of Your Reimbursement Method reported on Projected Savings Report (Attachment 2, schedule 2-2) is less than 95% of the total discount representing the Net Payment after Your Application of Reimbursement Method projected on the Projected Savings Schedule for the same fiscal year such that the amount paid for claims is higher than projected, then 1% of the Contractor’s administrative fee shall be owing and due the Department as liquidated damages for each 0.1% by which the actual discount received is lower than 95% of the projected discount.

The Administrative fee projected rate buildup and projected savings (Attachment 2 – Schedules 2-1 and 2-2 shall be provided by September 15 of each year prior to the following July 1 effective date with the annual report (See paragraph 4.1.7). Separate fees and targets may be provided for the state employee group and the TLC program.

3.8 Schedule of Liquidated Damages – General

This schedule of liquidated damages is mutually agreed in view of the difficulty and the cost of measuring the actual damages incurred from complaints, lost productive time, intrusion into other business, etc., as a result of under-performance in the areas noted.

<u>Brief Reference</u>	<u>Liquidated Damage Award</u>
99% of benefit \$ paid correctly	3% of administrative costs for each 1% or fraction below standard
95% of claims paid without error	1% of administrative costs for each 1% or fraction below standard
Eligibility Files not picked up daily	\$100 per day, days 1-7, \$1,000 per day thereafter
COB savings of 2%	1% of administrative costs for each 1% or fraction below standard
Late/Missing Reports	\$100 per day, days 1-5; \$1,000 per day thereafter
Invoice Processing	\$500 per invoice not meeting standard
Inaccurate projections	1% of contracted administrative fee for each 0.1% of unrealized provider discount after 5%.
Patient Satisfaction	\$2,000 for each percent or fraction thereof below standard

The standards and liquidated damages stated above notwithstanding, it is the Department’s intent to measure and track performance on the same items being monitored currently. These may change over time as mutually agreed by the Contractor and the Department.

4.0 REPORTS AND DELIVERABLES

4.1 Utilization Of Small Businesses And Businesses Owned By Women And Minorities.

4.1.1 Periodic Progress Reports/Invoices. Within sixty days of each six months' operation under this contract, disclose the actual dollars contracted to be spent to-date with such businesses, and the total dollars planned to be contracted with such businesses on this contract. This information shall be provided separately for small businesses, women-owned businesses and minority- owned businesses.

4.1.2 Final Actual Involvement Report: The Contractor will submit, prior to completion of the contract and prior to final payment, a report on the actual dollars spent with women and minorities during the performance of this contract. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., comparison of the total actual dollars spent on this contract with the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value. A suggested format is as follows:

Business Class: Small, Women-Owned or Minority-Owned

FIRM NAME, ADDRESS AND PHONE NUMBER	TYPE GOODS/ SERVICES	ACTUAL DOLLAR S	PLANNE D DOLLARS	% OF TOTAL CONTRACT
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTALS FOR BUSINESS CLASS		_____	_____	_____

4.2 Report Set

The proposal shall contain a report set proposed by the Offeror which covers critical workload items for each program.

4.3 Annual Report And Accounting

By September 15 of each year, or such date as specified by the Department, the Contractor shall submit a comprehensive annual report to the Department containing the following information split between the state program and The Local Choice program. Each section shall show the expenditure of all funds paid to the Contractor in the last fiscal year (July 1 through June 30) by program and discuss all facets of the programs, including, but not limited to, enrollment, number and dollar amount of claims paid, utilization trends, an analysis of costs per contract (adjusted for age, sex and type of membership) by area, cost trends, coordination of benefits savings, provider discounts, interest credits, administrative expenses and special charges. The report shall also contain the Contractor's estimate of required premiums by plan and program for the next calendar year and the basis thereof.

4.4 Plan Files

All files, records, journals, and books of account of any description and in whatever form, or portions thereof, which deal exclusively with matters arising out of this contract shall be delivered to the Department within thirty days of the termination of this contract, unless requested sooner (that is, during the life of the contract) by the Department. Notwithstanding any other provision of the contract, this specifically includes all eligibility, claims and inquiry files.

4.5 Other Requirements

Enrollment materials, brochures describing plan benefits including any carved out benefits in popular language, applications, notices, claims forms, checks, remittance advices, articles, Member Handbooks, Administrative Manuals, provider networks, directories, forecasts, invoices, identification cards, criteria sets and such services and materials stated or implied anywhere in this RFP or the Contractor's response thereto.

4.6 Annual Accounting And Renewal

4.6.1 On or before September 15, or such date as specified by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit specified IBNR lag triangle data in the required form to the Department Actuary.

4.6.2 On or before September 15, or such date as specified by the Department, after the completion of 12 months' operations under the contract, the Contractor shall submit a complete accounting of its operations for the fiscal year ended the last June 30, and shall propose a rate, using the Rate Buildup Schedule, for the fiscal year beginning the next July 1. (Note: The rate is for forecasting purposes and the Department is not under any obligation to use them).

4.6.3 In addition, the Annual Report shall contain:

- a. costs paid by the plan by member type (retiree, linked dependent, LTD participant, survivor, etc.)
- b. a list of the fifty highest cost cases, paid by the plan secondary to Medicare or specifically covered by the plan and not covered by Medicare, (enrollees) with relevant detail on admissions, diagnoses, etc.,
- c. amounts paid by the plan secondary to Medicare to hospitals (including inpatient surgical per diem, inpatient acute medical per diem, inpatient outlier minimum charge per case and inpatient outlier rate, and outpatient case rates for those procedures which comprise 50% of outpatient hospital reimbursement, or for the 25 procedures which have the highest total dollar impact together with an indication of the percentage of total outpatient reimbursement these 25 procedures represent),
- d. show the fifty professional providers of services receiving the largest payments, and

4.6.4 Finally, the Annual Report shall provide a frequency distribution of contracts, claims and dollars paid in total and by type of benefit .

4.7 Reporting Requirements

Such other reports as may be necessary to document the performance of the Contractor and its adherence to the contracted standards. Reports and PowerPoint presentations relating to reports should be provided to the Department 5 business days before any meetings scheduled to discuss such materials.

5.0 PROCUREMENT PROCEDURES

5.1 Method of Award

5.1.1 The Department shall select two or more Offerors deemed to be fully qualified and best suited among those Offerors submitting proposals, unless the Department has made a determination in writing that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration. The selection of Offerors will be based on the evaluation factors included in this RFP. Negotiations shall be conducted with the selected Offeror(s). Price shall be considered when selecting finalists for negotiation, but shall not be the sole determining factor.

5.1.2 After negotiations have been conducted with each selected Offeror, the Department shall select the Offeror which, in its opinion, has made the best proposal. The Department shall award the contract to that Offeror. The Department may cancel this RFP, or reject proposals at any time prior to an award. The Department is not required to furnish a statement of the reason why a particular Offeror was not deemed to have made the best proposal (Section 2.2-4359, Code of Virginia).

5.1.3 Should the Department determine in writing, and in its sole discretion, that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror.

5.1.4 The contract will incorporate by reference all the requirements, terms and conditions of this RFP and the Contractor's proposal, except as either or both may be amended through negotiation. All statements and representations, written or verbal, relating to the award of this and renewal contracts must be construed to be consistent with the following.

5.2 Submission of Written Proposals

5.2.1 All proposals must be in the form requested. The data required on the schedules submitted in response to this RFP are subject to verification. Material errors shall be a basis for rejecting such a proposal. An original, five disks with electronic versions, and one disk with the redacted submission shall be delivered in a sealed box, and labeled as a proposal, with the words **"Do Not Open"** and **"Administrative Services for Medicare Eligible Retiree Health Benefits Plans – Medical/Surgical and Vision Benefits"** prominently displayed on the box. Proposals must be received no later than 2:00 p.m. on Monday, December 7, 2009, by:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street
Richmond, Virginia 23219

The original of the proposal should be bound in a loose-leaf notebook. All documentation submitted with the proposal should be contained in that single volume. (If necessary, additional notebooks may be submitted in clearly marked and referenced sequence.)

5.2.2 Data, materials and documentation submitted to the Department pursuant to the RFP shall belong exclusively to the Department and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an Offeror in its proposal shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of Section 2.2-4342 of the Code of Virginia, in writing, at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified as required and must indicate only the specific words, figures, or paragraphs which constitute trade secrets or proprietary information. The Department, in its sole discretion, may not consider proposals with unduly broad requests for protection against disclosure.

5.3 Modification of Proposals

Any changes, amendments or modifications of an Offeror's proposal prior to the deadline for receipt of proposals must be in writing and submitted in the same manner as the original proposals. All modifications must be labeled conspicuously as a change, amendment, or modification of the previously submitted proposal. Changes, amendments, or modifications of proposals will not be considered after the deadline for receipt of proposals, except when the Department requests modifications.

5.4 Oral Presentation

Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the Department. This provides an opportunity for the Offeror to clarify or elaborate on the proposal. This is a fact finding and explanation session only and does not include negotiation. The Department will schedule the time and location of these presentations. Oral presentations are an option of the Department and may or may not be conducted.

5.5 Inquiries Concerning the RFP

Any communication concerning this RFP or any resulting contracts must be addressed in writing to:

Mr. Dan Hinderliter
Department of Human Resource Management
James Monroe Building, 13th Floor
101 North 14th Street

Richmond, Virginia 23219
Fax Number: (804) 371-0231
E-mail Address: dan.hinderliter@dhrm.virginia.gov

5.6 Public Inspection of Procurement Records

Proposals will be subject to public inspection only in accordance with Section 2.2-4342 of the Code of Virginia.

5.7 Clarification Of Proposal Information

The Department reserves the right to request verification, validation or clarification of any information contained in any of the proposals. This clarification may include checking references and securing other data from outside sources, as well as from the Offeror.

5.8 Reference To Other Materials

The Offeror cannot compel the Department to consider any information except that which is contained in its proposal, or which is offered in response to a request from the Department. The Offeror should rely solely on its proposal. The Department, however, reserves the right, in its sole discretion, to take into consideration its prior experience with Offerors and information gained from other sources.

5.9 Cost For Proposal Preparation

Any costs incurred by Offerors in preparing, or submitting proposals are the Offerors' sole responsibility. The Department will not reimburse any Offeror for any costs incurred in merely seeking award of this contract or in gaining the capability to meet contract requirements.

5.10 Mandatory Pre-Proposal Conference

A mandatory pre-proposal conference will be held at 10:00 a.m. on Tuesday, November 17, 2009, in the James Monroe Building, PDS Room #1, Mezzanine Level, 101 North 14th Street, Richmond, Virginia. The purpose of this conference is to allow potential Offerors an opportunity to present questions and to obtain clarification relative to any facet of this procurement.

Attendance at this conference is a prerequisite to submitting a proposal. Offerors who intend to submit a proposal must attend. Any changes resulting from this conference will be issued in a written addendum to the RFP. Attendance at the conference will be documented by the representative's signature on the attendance roster.

It is requested that any known questions regarding the RFP be forwarded to Dan Hinderliter prior to date of conference to facilitate the conference. The fax number is (804) 225-2790 or they may be e-mailed to dan.hinderliter@dhrm.virginia.gov. Offerors should bring a copy of this RFP to the conference. Any changes, which result from this conference, will be issued in a written addendum to the RFP.

5.11 Timetable

RFP Published	November 2, 2009
Mandatory Pre-Proposal Conference	November 17, 2009
Proposals Due, 2:00 P.M.	December 7, 2009
Notice of Intent to Award	February 2, 2010

6.0 FORM OF RESPONSE AND CRITERIA

6.1 General

Original proposal shall be in the form of a loose-leaf binder, tabbed to point to each section below. In addition, one redacted version of the proposal shall be submitted electronically on a CD labelled "Redacted". The purpose of this version is to facilitate information sharing within state government, as well as for public information requests. Any information that is "redacted" from the original shall be listed in an index identifying the items removed and the statutory authority allowing their removal.

The original proposal shall contain a Cover Sheet bearing an original signature signed in BLUE ink and be labeled on the cover as "Original". Five separate CDs marked "Copy" shall be submitted in MS Word format. These "Copy" disks shall include all information submitted in the "original" proposal. These will be distributed to the review committee, who will need to make notes electronically (Thus write protected information is not acceptable).

6.2 Redline RFP noting demurrals (Tab 1)

Include a copy of the RFP. Using the *Track Changes* and *Highlight Changes* MS Word tools, annotate in redline **any and all** demurrals or deviations to the requirements of the RFP. You may also enter any substantive comments on the RFP provisions, but please restrict such to issues that are necessary to clearly understand your proposal. Information required in the tabs below need **NOT** be repeated in this tab. Also, affirmations or confirmations of compliance to RFP requirements are unnecessary in this tab and are **NOT** to be included. A copy of the RFP may be downloaded from DHRM's procurement website: <http://www.dhrm.virginia.gov/rfps/rfpmain.html>

6.3 Legally Correct Description of Benefits (Tab 2)

The Offeror shall submit a benefits booklet in the format that will be used in the versions that are currently in effect. This will include one booklet to cover all medical coverage under Option I, Option II, Advantage 65 and Advantage 65-Medical Only; one insert to reflect the dental and vision benefits that are a part of the Option I plan and optional for Option II and Advantage 65; and, an insert to reflect the Medicare Part D prescription drug benefit. These will constitute a complete, legally binding description of the benefits to be provided and exclusions from coverage. The benefits booklets shall accurately reflect, at a minimum, the benefits specifications identified in paragraph 2.2. Differences in benefit levels for varying types of facilities/settings providing the covered services must be clearly identified by type and benefit level.

6.4 Organizational Questionnaire (Tab 3)

Attachment TWO contains a questionnaire to be completed by each Offeror. To request a copy of the questionnaire, please send an email to Leah Snider, Paul Mack and Dan Hinderliter at the following email addresses:

Dan.Hinderliter@dhrm.virginia.gov
paul_j_mack@aon.com
Leah_Snider@aon.com

6.5 Cost Proposal (Tab 4)

Attachment THREE contains the schedule which, along with the Offeror's latest certified audit report, constitutes the cost proposal. Include in this tab, a copy of the audited report for the most recently completed fiscal year and a hard copy of the schedules. Also, the schedules must be submitted in Excel as directed in Attachment THREE instructions.

The attachment also contains schedules that provide the following cost proposal detail:

- 6.5.1 A detailed budget for start up costs, if any, for the period from the date of award through December 31, 2010. (The proposed budget, if accepted, will be treated as a firm, fixed price for the period in question. The Contractor may bill the Department only after the completion of discrete, budgeted tasks, and will be reimbursed upon a finding by the Department that the work has been satisfactorily completed.)
- 6.5.2 A firm, fixed price per contract month for the first contract year.
- 6.5.3 A firm, fixed price per contract month for the second contract year. This price may not be indexed to the price of the first contract year.
- 6.5.4 A guaranteed interest rate for funds in the operating account or an index which will constitute a minimum guarantee. (Offerors of insured plans are exempt from this sub-paragraph 6.5.4.)
- 6.5.5 A cost summary page.

6.6 Participation of Small, Women, and Minority Owned Businesses (Tab 5)

Complete the information required on Attachment ONE.

6.7 Criteria for Evaluation

Proposals will be evaluated on six criteria: Offeror's organization and financial stability (10); qualifications of staff (5); performance and quality (15); administrative capability (25); administrative costs (25); and small, women owned, and minority business (20).

7.0 GENERAL TERMS AND CONDITIONS

7.1 VENDORS MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.state.va.us/dps under "Manuals."

7.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, § 2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual*. The contractor shall comply with all applicable federal, state and local laws, rules and regulations.

7.3 ANTI-DISCRIMINATION

By submitting their (bids/proposals), (bidders/Offerors) certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the Virginia Public Procurement Act (VPPA). If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every contract over \$10,000 the provisions in 1. and 2. below apply:

7.3.1 During the performance of this contract, the contractor agrees as follows:

- a. The contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the contractor. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

- b. The contractor, in all solicitations or advertisements for employees placed by or on behalf of the contractor, will state that such contractor is an equal opportunity employer.
- c. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

7.3.2 The contractor will include the provisions of 7.3.1. above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

7.4 ETHICS IN PUBLIC CONTRACTING

By submitting their proposal, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

7.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By entering into a written contract with the Commonwealth of Virginia, the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

7.6 DEBARMENT STATUS

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia from submitting bids or proposals on contracts for the type of goods and/or services covered by this solicitation, nor are they an agent of any person or entity that is currently so debarred.

7.7 ANTITRUST

By entering into a contract, the contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

7.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS FOR RFPs

Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

7.9 CLARIFICATION OF TERMS

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact the buyer whose name appears on the face of the solicitation no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the buyer.

7.10 PAYMENT

7.10.1 To Prime Contractor:

- a. Invoices for items ordered, delivered and accepted shall be submitted by the contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the contractor at the contract price, regardless of which public agency is being billed.
- d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
- e. **Unreasonable Charges.** Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges which are not in dispute (*Code of Virginia, § 2.2-4363*).

7.10.2 To Subcontractors:

- a. A contractor awarded a contract under this solicitation is hereby obligated:

- (1) To pay the subcontractor(s) within seven (7) days of the contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
 - (2) To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold payment and the reason.
- b. The contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier contractor performing under the primary contract. A contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

7.10.3 Each prime contractor who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

7.10.4 The Commonwealth of Virginia encourages contractors and subcontractors to accept electronic and credit card payments.

7.11 PRECEDENCE OF TERMS

The following General Terms and Conditions VENDORS MANUAL, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

7.12 QUALIFICATIONS OF (BIDDERS/OFFERORS)

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services and/or furnish the goods contemplated therein.

7.13 TESTING AND INSPECTION

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

7.14 ASSIGNMENT OF CONTRACT

A contract shall not be assignable by the contractor in whole or in part without the written consent of the Commonwealth.

7.15 CHANGES TO THE CONTRACT

Changes can be made to the contract in any of the following ways:

7.15.1 The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

7.15.2 The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The contractor shall comply with the notice upon receipt. The contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

- a. By mutual agreement between the parties in writing; or
- b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the contractor accounts for the number of units of work performed, subject to the Purchasing Agency's right to audit the contractor's records and/or to determine the correct number of units independently; or
- c. By ordering the contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The contractor shall present the Purchasing Agency with all vouchers and records of expenses incurred and savings realized. The Purchasing Agency shall have the right to audit the records of the contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Purchasing Agency within thirty (30) days from the date of receipt of the written order from the Purchasing Agency. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes

provisions of the Commonwealth of Virginia Vendors Manual. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the contractor from promptly complying with the changes ordered by the Purchasing Agency or with the performance of the contract generally.

7.16 **DEFAULT**

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have.

7.17 **INSURANCE**

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the Code of Virginia. The Offeror further certifies that the contractor and any subcontractors will maintain these insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

7.17.1 MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

- a. Workers' Compensation - Statutory requirements and benefits. Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the Code of Virginia during the course of the contract shall be in noncompliance with the contract.
- b. Employer's Liability - \$100,000.
- c. Commercial General Liability - \$1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
- d. Automobile Liability - \$1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)

NOTE: In addition, various Professional Liability/Errors and Omissions coverages are required when soliciting those services as follows:

Profession/Service

Limits

Health Care Practitioner (to include Dentists, Licensed Dental Hygienists, Optometrists, Registered or Licensed Practical Nurses, Pharmacists, Physicians, Podiatrists, Chiropractors, Physical Therapists, Physical Therapist Assistants, Clinical Psychologists, Clinical Social Workers, Professional Counselors, Hospitals, or Health Maintenance Organizations)

\$1,925,000 per occurrence, \$3,000,000 aggregate (Limits increase each July 1 through fiscal year 2008, as follows:

July 1, 2008 - \$2,000,000.

This complies with §8.01-581.15 of the Code of Virginia.

Insurance/Risk Management

\$1,000,000 per occurrence, \$3,000,000 aggregate

7.18 ANNOUNCEMENT OF AWARD

Upon the award or the announcement of the decision to award a contract over \$50,000, as a result of this solicitation, the purchasing agency will publicly post such notice on the agency website as well as the DGS/DPS eVA web site (www.eva.virginia.gov) for a minimum of 10 days.

7.19 DRUG-FREE WORKPLACE

During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, “*drug-free workplace*” means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

7.20 NONDISCRIMINATION OF CONTRACTORS

An Offeror shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or

would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

7.21 **eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION**

The eVA Internet electronic procurement solution, website portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

7.21.1 eVA Basic Vendor Registration Service: \$25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.

7.21.2 eVA Premium Vendor Registration Service: \$25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

7.21.3 For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of \$500 per order.

7.21.4 For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:

- a. DMBE-certified Small Businesses: 1%, capped at \$500 per order.
- b. Businesses that are not DMBE-certified Small Businesses: 1%, capped at \$1,500 per order

7.22 **AVAILABILITY OF FUNDS**

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

8.0 **SPECIAL TERMS AND CONDITIONS**

8.1 **Cost Limits**

The Contractor is responsible for all the costs of implementing and administering the program. The Department is responsible for ensuring that the Contractor receives payment of all fees that are established pursuant to the contract which results from this RFP. Any cost incurred by the Contractor to address the tasks and responsibilities identified in this RFP which exceeds the contractually established fees is the risk of the Contractor.

8.2 Term/Renewal Of Contract

8.2.1 The term of this contract is January 1, 2011 through December 31, 2012 with three one-year renewal options.

8.2.2 This contract may be renewed by the Commonwealth for three (3) successive one-year periods under the terms and conditions of the original contract except as stated in 1. and 2. below. Price increases may be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew shall be given approximately 90 days prior to the expiration date of each contract period.

a. If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price for the additional one year shall not exceed the contract price of the original increased/decreased by more than the percentage increase/decrease of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

b. If during any subsequent renewal period, the Commonwealth elects to exercise the option to renew the contract, the contract price for the subsequent renewal period shall not exceed the contract price of the previous renewal period increased/decreased by more than the percentage increased/ decreased of the services category of the CPI-W section of the Consumer Price Index of the United States Bureau of labor Statistics for the latest twelve months for which statistics are available.

8.3 Cancellation Of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

8.4 Payments

Except for Tasks 3.1 and 3.2, the Contractor shall deliver only those services actually ordered by the Department. The Department will accept and pay only for those services which have been fully rendered. The Contractor shall invoice the Department each month for services provided during the prior month. The billing format shall be mutually agreed upon by the Department and the Contractor. The Contractor should include its proposed billing format in the proposal. Payment will be made by the Department within 30 days of receipt of an approved invoice by the Commonwealth's EDI payment method. Refer to Attachment Three for EDI information.

8.5 Audits

8.5.1 The Contractor shall assist the Department and the Department's auditors, who may be employees of the Department, employees of other Contractors, or agents of the Department, in the conduct of audits. This assistance shall

include the provision of secure, quiet office space, including furnishings and telephones needed by the auditors.

8.5.2 The Contractor agrees to retain all books, records, and other documents relative to the contract which results from this RFP for five (5) years after final payment, or until the conclusion of any audit by the Commonwealth, whichever is sooner. The Department, its authorized agents, and State Auditors, shall have full access to, and the right to examine, any of the Contractor's materials relevant to the contract which results from this RFP.

8.6 Contract Representatives

Both the Department and the Contractor shall appoint a contract representative who shall ensure that the provisions of this contract are adhered to. The Department reserves to request and receive a change in the Contractor's senior manager assigned to the Department's account at its discretion. Contractor shall designate a senior level individual to function as an escalation point if the Department is unable to resolve issues by working with the Contractor's account team or other staff within Contractor's organization. This individual must have the authority to effect change within the Contractor's organization.

8.7 Certified Corporate Annual Reports

Within 120 days of the close of its fiscal year, the Contractor shall furnish to the Department an annual report of its consolidated operations. This report shall be certified by an independent auditor.

8.8 Confidentiality Of Information

8.8.1 The Contractor shall treat all information utilized in its performance of the contract as confidential, personal information. The Contractor shall handle all confidential information in accordance with the Virginia Privacy Protection Act, Virginia Code Section 2.1-377 et seq. All files, computer data bases and other records developed or maintained pursuant to the execution of the contract are the property of the Department, and shall be delivered to the Department upon demand. The Contractor merely serves as the custodian of the files, and acts as agent for the Department in the payment for services and the performance of other assigned tasks, including assisting the Department with requests under the Virginia Freedom of Information Act.

8.8.2 The Contractor as an agent of the Department must be HIPAA compliant, including but not limited to privacy and the electronic security requirements, as would be required by the Department for any functions performed under this contract.

8.9 Severability

In the event any portion of the contract shall be determined by a court of competent jurisdiction to be invalid or unenforceable, such provision shall be deemed void and the remainder of the contract shall continue in full force and effect.

8.10 Force Majeure

Neither party shall be deemed to be in default of any of its obligations hereunder, if, and so long as, it is prevented from performing such obligations by an act of war, hostile foreign action, nuclear explosion, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

8.11 Subcontracting

The Contractor is fully responsible for all work performed under the contract. The Contractor may not assign, transfer, or subcontract any interest in the contract, without prior written approval of the Department. The Contractor shall require all subcontractors to comply with all provisions of this RFP. The Contractor will be held liable for contract compliance for all duties and functions whether performed by the Contractor or any subcontractor.

8.12 Disputes

8.12.1 In accordance with section 2.2-4363 of the Code of Virginia, disputes arising out of the contract, whether for money or other relief, may be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Director of the Department of Human Resource Management at the James Monroe Building, 12th Floor, 101 North 14th Street, Richmond, Virginia 23219. Disputes will not be considered if submitted later than sixty (60) days after the final payment is made by the Department under the contract. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at the time of the occurrence or at the beginning of the work upon which the dispute is based. The Department shall render a final written decision regarding the dispute not more than ninety (90) days after the dispute is submitted, unless the parties agree to an extension of time. If the Department does not render its decision within 90 days, the Contractor's sole remedy will be to institute legal action, pursuant to section 2.2-4364 of the Code of Virginia. The Contractor shall not be granted relief as a result of any delay in the Department's decision.

8.12.2 During the time that the parties are attempting to resolve any dispute, each party shall proceed diligently to perform its duties.

8.13 Contractor Affiliation

If an Affiliate (as defined below in this paragraph) of the Contractor takes any action which, if taken by the Contractor, would constitute a breach of the contract, the action taken by the affiliate shall be deemed a breach by the Contractor. "Affiliate" shall mean a "parent," subsidiary or other company controlling, controlled by, or in common control with the Contractor, subcontractor or agents of the Contractor.

8.14 Transfer Of Files

If for any reason the Department decides to no longer contract with the Contractor, the Contractor agrees to transfer to the party designated by the Department, at no cost, all data, records, computer files, other files, and materials of any sort that were maintained for the Commonwealth. The Contractor agrees to assist the Department in

understanding, using, and transferring all files and records, including those maintained in computer language.

8.15 Advertising

In the event a contract is awarded as a result of this RFP, the Contractor shall not advertise that the Commonwealth of Virginia, or any agency or institution of the Commonwealth, has purchased, or uses its products or services.

8.16 Indemnification

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages, and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the Department.

8.17 Identity Theft:

The Contractor assures that any and all personal information and data obtained as a result of performing contractual duties associated with this contract shall be held in strict confidence. Such information shall not be divulged without written permission from the individual and this Agency.

8.17.1 All personal information whether electronic or hard copy shall be stored in a manner that will prevent intrusion by unauthorized persons.

8.17.2 All intrusions or suspicion of intrusion into secured files containing personal information shall be reported to the Agency within 24 hours of detection.

8.17.3 All remedies suggested by the Contractor shall be approved by the Agency prior to being implemented.

Attachment One

Attachment One Small Business Subcontracting Plan

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of \$10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbv.org (Customer Service).

Offeror Name: _____

Preparer Name: _____ Date: _____

Instructions

- A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.
- B. If you are not a DMBE-certified small business, complete Section B of this form. For the offeror to receive credit for the small business subcontracting plan evaluation criteria, the offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified small business in this section. Points will be assigned based on each offeror's proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the offeror's total price.

Section A

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a (**check only one below**):

_____ Small Business

_____ Small and Women-owned Business

_____ Small and Minority-owned Business

Certification number: _____ Certification Date: _____

Attachment Two

**Organizational Capabilities Questionnaire
(electronic file from Aon)**

Attachment Three

Cost Schedules

Attachment Four

Office of State Health Benefits Programs
of the
Department of Human Resource
Management

H I PAA Privacy
Business Associate
Agreement
With
(Insert Company Name)

Effective Date:
(Insert Date)

1. PREAMBLE

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. Section 84,462 et seq. (Dec. 28, 2000) and all subsequent provisions and Federal guidance ("HIPAA Privacy Rule"), the Commonwealth of Virginia's Office of Health Benefits Programs ("Covered Entity"), and (name of the Business Associate), a (state) corporation, ("Business Associate"), (jointly "the Parties"), wish to enter into this Business Associate Agreement ("Agreement") that addresses the requirements of the HIPAA Privacy Rule with respect to "business associates" as that term is defined in that Rule.

This Agreement is intended to ensure that the Business Associate will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" (as defined in the HIPAA Privacy Rule and copied below) that the Business Associate may create, receive, use, or disclose in connection with certain functions, activities, or services (collectively "Services") to be provided by Business Associate to Covered Entity. These Services are identified in a separate agreement between the Parties entitled RFP-OHB09-2 and dated (Insert date) ("Service Agreement").

The Parties acknowledge and agree that in providing Services, Business Associate will create, receive, use, or disclose Protected Health Information. In connection with Business Associate's creation, receipt, use, or disclosure of Protected Health Information, Business Associate, and Covered Entity hereby agree as follows:

II. DEFINITIONS

- (a) *General definitions.* All capitalized terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103 and 164.501.
- (b) *Specific definitions.*
- (i) *Individual.* "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
 - (ii) *Privacy Rule.* "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
 - (iii) *Protected Health Information.* "Protected Health Information" ("PHI") shall mean individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to: (A) the past, present, or future physical or mental health or condition of an individual; (B) the provision of health care to an individual; or (C) the past, present, or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual. Protected Health Information does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the Privacy Rule.
 - (iv) *Designated Record Set.* "Designated Record Set" shall mean a group of records maintained by or for the Covered Entity that is:
 - (A) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
 - (B) Used, in whole and in part, by or for the Covered Entity to make decisions about individuals.

For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Covered Entity.

(v) *Data Aggregation*. "Data Aggregation" shall mean, with respect to Protected Health Information created or received by the Business Associate in its capacity as the Business Associate of the Covered Entity, the combining of such Protected Health Information by the Business Associate with the Protected Health Information received by the Business Associate in its capacity as business associate of another entity to permit data analyses that relate to the health care operations of the respective entities.

(vi) *Required By Law*. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

(vii) *Secretary*. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") or his designee.

III. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

- (a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (d) Business Associate agrees to report to Covered Entity within five (5) business days any use or disclosure of Protected Health Information (whether by itself or by its subcontractors) not permitted for by this Agreement.
- (e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- (f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
- (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
- (h) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- (j) Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with Section III (i) of this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

- (k) Business Associate agrees to: (i) implement the administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on Covered Entity's behalf; (ii) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate standards to protect the information; and (iii) agrees to report to Covered Entity any security incident of which it becomes aware that involves the information. Business Associate agrees that that the obligations set forth in Section III (k) shall be implemented by the final compliance date for the Security Standards to the extent required by law.

IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

- (a) *General Uses and Disclosures.* Business Associate agrees to create, receive, use, or disclose Protected Health Information only in a manner that is consistent with this Agreement or the Privacy Rule and only in connection with providing Services to the Covered Entity identified in the Service Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity. In providing Services, Business Associate, for example, will be permitted to use and disclose Protected Health Information for "treatment, payment and health care operations" in accordance with the Privacy Rule.
- (b) *Other Uses and Disclosures:*
- (i) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- (ii) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided the disclosures are Required By Law or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- (iii) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

V. OBLIGATIONS OF THE COVERED ENTITY

- (a) *Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions:*
- (i) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.
- (ii) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.
- (iii) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522.
- (b) *Permissible Requests by Covered Entity.* Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except Protected Health Information for those activities performed by the Business Associate in accordance with the provisions of the Service Agreement between the parties.

VI. TERM AND TERMINATION

- (a) *Term.* The Term of this Agreement shall be effective as of January 1, 2011, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the Termination provisions in this Section.
- (b) *Termination for Cause.* Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. If Business Associate does not cure the breach or end the violation within the time agreed to by the Parties, or if Business Associate has breached a material term of this Agreement and cure is not possible, Covered Entity may terminate this Agreement [and the applicable Sections of the Service Agreement] upon written notice to Business Associate.
- (c) *Effect of Termination:*
 - (i) Except as provided in paragraph (c)(ii) of this Section IV, upon Termination of this Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - (ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for as long as the Business Associate maintains such Protected Health Information.

VII. MISCELLANEOUS

- (a) *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended and for which compliance is required.
- (b) *Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.
- (c) *Survival.* The respective rights and obligations of Business Associate under Section VI(c)(i)&(ii) of this Agreement shall survive the termination of this Agreement.
- (d) *Interpretation:*
 - (i) Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.
 - (ii) In the event of an inconsistency between the provisions of this Agreement and the Privacy Rule, as may be amended from time to time, as a result of interpretations by HHS, a court, or another regulatory agency with authority over the Parties, the interpretation of HHS, such other court or regulatory agency shall prevail.
 - (iii) In the event provisions of this Agreement differ from those mandated by the Privacy Rule but are nonetheless permitted by the Rule, the provisions of this Agreement shall control.
- (e) *Complete Integration.* This Agreement constitutes the entire agreement between the parties and supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written, unless expressly incorporated herein, related to the subject matter of the Agreement. Unless expressly provided otherwise herein, this Agreement may not be modified unless in writing signed by the duly authorized representatives of both parties. If any provision or part thereof is found to be invalid, the remaining provisions shall remain in full force and effect.

- (f) *Successors and Assigns.* This Agreement will inure to the benefit of and be binding upon the successors and assigns of Covered Entity and Business Associate. However, this Agreement is not assignable by either party without the prior written consent of the other party, except that Business Associate may assign or transfer this Agreement to any entity owned or under common control with Business Associate.
- (g) *Limitation of Liability.* Except as otherwise provided for in the Privacy Rule, neither party shall be liable for other party's loss of profits, attorney's fees or interest, or for any incidental, indirect, special, or consequential damages as a result of this Agreement.
- (h) *No Third Party Beneficiaries.* Except as expressly provided for in the Privacy Rule, there are no third party beneficiaries to this Agreement. Business Associate's obligations are to Covered Entity only.
- (i) *Confidentiality.* Except as otherwise provided for in the Privacy Rule or this Agreement, neither party will disclose the terms of this Agreement to any third party without the other party's written consent.
- (j) *Counterparts.* This Agreement may be executed in two or more counterparts, each of which may be deemed an original.

VIII. ACKNOWLEDGEMENT AND SIGNATURES

THE PARTIES ACKNOWLEDGE THAT THEY HAVE READ THIS AGREEMENT,
UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS.

For :	For Department of Human Resource Management
By:	By:
Print Name:	Print Name: Sara Redding Wilson
Title:	Title: Director
Date:	Date:

Current Plan Description

(Click on the link below for the current Plan Description PDF.)

<http://www.dhrm.virginia.gov/hbenefits/retirees/medicarePlanOptions.pdf>

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

STANDARD CONTRACT

This contract is entered into this , hereinafter called "Contractor" and the Commonwealth of Virginia, Department of Human Resource Management, hereinafter called "Purchasing Agency".

WITNESSETH that the Contractor and the Purchasing Agency, in consideration of the mutual covenants, promises and agreements herein contained, agree as follows:

SCOPE OF SERVICES: The Contractor shall provide to the Purchasing Agency as set forth in the Contract Documents.

PERIOD OF CONTRACT: From as described in the contract documents.

COMPENSATION AND METHOD OF PAYMENT: The Contractor shall be paid monthly according to the terms of its accepted proposal.

CONTRACT DOCUMENTS: The Contract Documents shall consist of this signed Contract; the Request for Proposals; the General Terms and Conditions, Special Terms and Conditions, specifications, and other data contained in the Request for Proposals.

Any contractual claims shall be submitted in accordance with the contractual dispute procedures set forth in the Request for Proposals.

In witness whereof, the parties have caused this Contract to be duly executed intending to be bound thereby.

PURCHASING AGENCY: Department of Human Resource Management

By: _____ By: _____

_____ Print Name _____ Print Name

Title: _____ Title: _____

Date: _____ Date: _____

CONTRACTOR:

By: _____

_____ Print Name

Title: _____

Date: _____

Approved as to Form: _____

Office of the Attorney General Date

Cost & Enrollment Data

This information will be provided on CD upon request.

Processes for Medicare Retiree Program Membership and Billing

A. Membership and Billing under the State Program

Participants use a secure, web-based, self-service tool called EmployeeDirect or submit a paper enrollment form to their agency's benefits administrator to request enrollment or election changes.

(Click on the link below for the Enrollment form PDF.)

<http://www.dhrm.virginia.gov/hbenefits/openenroll09/StateRetireeEnrollForm09.pdf>

Approved requests are entered into a central Benefits Eligibility System (BES). BES collects, validates, and distributes eligibility and enrollment data for the Program's participants and their dependents and is the Commonwealth's official source of eligibility and enrollment.

New enrollments, terminations, and changes in enrollment are provided to all Contractors using the HIPAA 834 Transaction File format. Contractors must connect to the Commonwealth's secure FTP server for file transfers. It is expected that all Contractors use the Daily Change File to update their eligibility system daily so members have ready access to their benefits and timely, accurate claims processing. Manual updates are not to be entered in the Contractor's system unless approved by a representative from the Commonwealth's Office of Health Benefits.

The Commonwealth also provides to all Contractors a Monthly Audit File using the HIPAA 834 Transaction File format. Contractors must compare this data to their system's data and report discrepancies to the Commonwealth.

The Contractor for Medical/Vision benefits shall provide a direct billing and collection of premium for certain participants identified on the Daily Change File. This direct billing shall provide options for payment by check or bank draft. The Contractor shall provide full accounting for these collections and transmittal to the Commonwealth on a monthly basis.

B. Membership and Billing under the TLC Program

Participants submit an enrollment form to their employer's group administrator to request enrollment or election changes.

(Click on the link below for the Enrollment form PDF.)

http://www.thelocalchoice.state.va.us/planinfo/plans2009_10/TLCEnrollmentForm20092010.pdf

New enrollments, terminations, and changes in enrollment are provided to the Contractor in a manner determined by the Commonwealth and the Contractor. This may be by federal mail, fax, on-line, or by file transfer and will be finalized during the negotiation process. It is expected that the Contractor update their eligibility system daily so members have ready access to their benefits and timely, accurate claims processing. Updates are not to be entered in the Contractor's system unless approved by the group administrator or a representative from the Commonwealth's Office of Health Benefits.

The Contractor for Medical/Vision benefits shall provide a direct billing and collection of premium for each employer group. The Contractor shall provide full accounting for these collections and transmittal to the Commonwealth on a monthly basis.

C. Billing for Self-funded Plans

The services billed under the self-funded plans fall into two categories. These are billing for claims payments and billing for administrative fees as records accumulated, and invoiced in total to the

Department on a weekly basis. The OHB staff reviews the invoice and the Contractor is reimbursed through an electronic transfer of funds within 48 hours of the receipt of the billing documentation. The billing documentation will at a minimum consist of: a cover invoice which provides the net claim dollars to be paid broken between the state and the TLC retiree program, and support documentation for each program that provides the claims dollars paid for each benefit category during the period covered by the invoice and year to date. This procedure will be finalized with each Contractor as part of the negotiation process and the cycle may be varied based upon compelling reasons, such as claim volume and dollars.

Administrative expenses are invoiced monthly to OHB by each Contractor by the 15th of the following month. In this process, the OHB will review the invoice and authorize reimbursement through the EDI process. Again the billing documentation will consist of a cover invoice providing the administrative dollars in total for each program with a summary for all programs, and documentation which supports the summary invoice. This support will at minimum consist of a breakdown by each program of billing units by price per unit, shown for the current period and year to date. The number of billing units for each employer under the TLC program will also be required. The monthly administrative invoice may also be used as the financial transfer document for miscellaneous non-claim items that are either due from or to the Department when supported by clear documentation. This procedure will also be finalized during final negotiations.

Specifications for Eligibility Files

A. Commonwealth of Virginia State Program

(Click on the links for the PDF for each type of file.)

1. 834 Eligibility Transaction Daily Change File

<http://web1.dhrm.virginia.gov/itech/files/ChangeFileLayout.pdf>

2. 834 Eligibility Transaction Monthly Audit File

<http://web1.dhrm.virginia.gov/itech/files/AuditFileLayout.pdf>

B. Commonwealth of Virginia TLC Program

During the negotiation process, the Commonwealth and the Contractor shall determine if a file transfer will be used. The file specifications will be provided once the determination is made.

Commonwealth of Virginia
 Claims Database
 Claims File
 Data Specifications to be Effective July 1, 2006

Transmittal

Frequency: Weekly or biweekly as determined by the Commonwealth.

Medium: (1) FTP/PGP or
 (2) Upload to secure site or
 (3) CDROM/DVD. ASCII.

Data

Requirements: All dollar amounts should have leading sign, 2 decimal places and implied decimal point. Field can be zero or blank filled. E.g. a 9 byte field containing the value (\$100.00) could be coded either 'bbb-10000' or '-00010000'. Positive amounts can either have '+' sign or be unsigned. \$100.00 can be represented as '+00010000', '000010000', 'bbb+10000', or 'bbbb10000'.

All dates should be provided CCYYMMDD where CC denotes Century, YY denotes year, MM denotes Month, and DD denotes Day. E.g. July 11, 1946 is '19460711'. If date is Not Applicable, field should be coded '00000000'.

File will consist of 6 type records: Header, Facility, Professional (including Dental), Pharmacy, UB92 Revenue and Trailer. There will be 1 Header record as the first record on the file, 1 Trailer record at the end of the file, and the remaining records between the Header and Trailer records.

The file should contain all claims processed on behalf of the Commonwealth during the transmittal period, regardless of the funding type or billing arrangement. Denied claims (Total Charges = Not Covered Charges) and adjustments to denied claims should be included on the file. Where capitated arrangements are in place, the claims file should still contain the underlying claims. Dollar amounts for capitated claims should be completed to the level of detail for which data is available.

Fields highlighted in pink represent additional data elements to the feed in place prior to July 1, 2005.

Record type	8.1 Field Name	Pos	Size	Data type	Comments
Prof	Claim Check Date	168	8	Date	Date on the check when issued.
Prof	Claim Paid Date	176	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Prof	Claim Disposition	184	1	Char	“O” : Original Claim “P” : Positive Adjustment “N” : Negative Adjustment
8.1.1.1	Optional Benefit Utilization (Expanded Benefit – Key Advantage, Key Share or COVA Care)	185	1	Char	“Y” : Used expanded benefit, i.e. claim would not have been paid under Basic Coverage. “N” : Did not use expanded benefit or expanded benefit option not part of this plan design
Prof	Optional Benefit Utilization	186	1	Char	Space
Prof	Optional Benefit Utilization (COVA Care out of network)	187	1	Char	Y – Out of Network Benefit Applies N – Out of Network Benefit not part of this plan design or part of plan design but not used on this claim.
8.1.2	Claim Approved/Denied	188	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Prof	Capitated/Non-Capitated	189	1	Char	Space or “N” – Non-capitated “C” - Capitated
Prof	Inpatient/Outpatient	190	1	Char	“I” : Inpatient “O” : Outpatient
Prof	Place of Treatment	191	5	Char	See attached list of valid codes.
Prof	Type of Service	196	5	Char	See attached list of valid codes.
Prof	Claim Primary Payer	201	1	Char	“I” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Prof	Claim Secondary Payer	202	1	Char	“I” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer “U” : Secondary payer not verified
Prof	Claim Tertiary Payer	203	1	Char	“I” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer “U” : Tertiary payer not verified
Prof	Principal HCPCS Code	204	5	Char	Actual Code or “N/A”. HCPCS includes Level 1 (CPT), Level 2
Prof	HCPCS Code Modifier	209	5	Char	Modifier or blank
Prof	Additional HCPCS Code	214	5	Char	Actual Code or “N/A”
Prof	HCPCS Code Modifier	219	5	Char	Modifier or blank

Record type	8.1 Field Name	Pos	Size	Data type	Comments
Prof	CDT-2 Code	224	5	Char	American Dental Association code. Actual Code or "N/A".
Prof	CDT-2 Level	229	1	Char	N – Not applicable, no CDT-2 code 1 – Dental Claim processed as Block 1 (Diagnostic and Preventive) 2 – Dental Claim processed as Block 2 (Primary) 3 – Dental Claim processed as Block 3 (Major) 4 – Dental Claim processed as Block 4 (Orthodontic) M – Dental Claim paid under medical plan.
Prof	ICD-9 Principal Diagnosis Code	230	6	Char	Actual Code with "." or "N/A". Required.
Prof	ICD-9 Secondary Diagnosis Code	236	6	Char	Actual Code with "." or "N/A"
Prof	Provider ID type	242	2	Char	FI – Federal Taxpayer's ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Prof	Provider ID	244	15	Char	
Prof	Provider Name	259	50	Char	
Prof	Provider Type	309	2	Char	See attached list of valid codes.
Prof	Provider Specialty	311	2	Char	See attached list of valid codes.
Prof	Provider Location – City	313	20	Char	
Prof	Provider Location – State	333	2	Char	
Prof	Provider Location – Zip Code	335	10	Char	
Prof	Provider Referral	345	1	Char	"P" : Provider is PCP "R" : PCP referral "S" : Self referral 8.1.3 "T" Specialist referral
Prof	Provider In/Out Network	346	1	Char	"I" : Provider in Network "P" : Participating Provider not in Network "N" : Non-participating Provider
Prof	Provider Contract Level	347	10	Char	"HMO" "HMO POS" "EPO" "POS PPO" "PPO" "PHO" "INDEMNITY"
Prof	Total Charges	357	10	Amount	

Record type	8.1 Field Name	Pos	Size	Data type	Comments
Prof	Non-benefit Charges not covered	367	10	Amount	e.g. convenience items
Prof	Benefit Charges not covered	377	10	Amount	e.g. a benefit not covered by COV's plan.
Prof	Discount	387	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered – Schedule of Allowance. Otherwise, Discount is zero.
Prof	Schedule of Allowance	397	10	Amount	Applicable to this procedure, provider, and to the COV.
Prof	Eligible Charges	407	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered.
Prof	Deductible	417	10	Amount	
Prof	8.1.4 Coinsurance	427	10	Amount	Copayment is stored in separate field
Prof	COB	437	10	Amount	
Prof	Net Payment After Application of Reimbursement Method	447	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Coinsurance + Deductible = Eligible Charge.
Prof	Internal Claim ID	457	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
8.1.5	8.1.6 Copayment	477	10	Amount	Copayment separate from Coinsurance
8.1.7	Contract Type	487	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
	Record length		487		
Fac	Record Type	1	1	Char	Value = 'F'
Fac	Carrier Code	2	3	Char	To be defined by COV

Record type	8.1 Field Name	Pos	Size	Data type	Comments
Fac	Covered Group	5	1	Char	“C” – Commonwealth of Virginia “S” – TLC School Group “G” – TLC Governmental Group
Fac	Plan Code	6	4	Char	To be defined by COV
Fac	Subscriber ID from BES – REF*OF	10	9	Char	
Fac	Contract Number (Subscriber SSN)	19	9	Char	No ‘-‘
Fac	Subscriber Birth Date	28	8	Date	
Fac	Subscriber Sex	36	1	Char	“M” : Male “F” : Female
Fac	Subscriber Zip Code	37	10	Char	
8.1.8	Subscriber Agency/ TLC Group	47	3	Char	For State, Agency Code from BES 834 feed. For TLC, School or Government Group Identifier from Anthem 834 feed.
Fac	Patient SSN	50	9	Char	Optional. No ‘-‘.
Fac	Patient Last Name	59	20	Char	
Fac	Patient First Name	79	15	Char	
Fac	Patient Birth Date	94	8	Date	
Fac	Patient Relationship to Subscriber	102	1	Char	“E” : Self “S” : Spouse “C” : Child “O” : Other
Fac	Patient Sex	103	1	Char	“M” : Male “F” : Female
Fac	Patient Zip Code	104	10	Char	
Fac	Claim Number	114	20	Char	
Fac	Claim Number Suffix	134	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Fac	Claim Incurred Date - Begin	136	8	Date	
Fac	Claim Incurred Date – End	144	8	Date	
Fac	Admit Date	152	8	Date	Form Locator 17 on UB92
Fac	Discharge Date	160	8	Date	Thru Date from Form Locator 6 on UB92
Fac	Discharge (Patient Status) Code	168	2	Char	Form Locator 22 on UB92
Fac	Number of Days Covered	170	5	Num	Signed. Right Justified. 0 Decimal places. Should be negative for negative adjustment.
Fac	Claim Received Date	175	8	Date	
Fac	Claim Adjudicated Date	183	8	Date	
Fac	Claim Processed Date	191	8	Date	
Fac	Claim Check Date	199	8	Date	Date on the check when issued.
Fac	Claim Paid Date	207	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Fac	Claim Disposition	215	1	Char	“O” : Original Claim

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					“P” : Positive Adjustment “N” : Negative Adjustment
8.1.8.1	Optional Benefit Utilization (Expanded Benefit – Key Advantage, Key Share or COVA Care)	216	1	Char	“Y” : Used expanded benefit, i.e. claim would not have been paid under Basic Coverage. “N” : Did not use expanded benefit or expanded benefit option not part of this plan design
Fac	Optional Benefit Utilization	217	1	Char	Space
Fac	Optional Benefit Utilization (COVA Care out of network)	218	1	Char	Y – Out of Network Benefit Applies N – Out of Network Benefit not part of this plan design or part of plan design but not used on this claim.
Fac	Claim Approved/Denied	219	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Fac	Capitated/Non-Capitated	220	1	Char	Space or “N” – Non-capitated “C” - Capitated
Fac	Inpatient/Outpatient	221	1	Char	“I” : Inpatient “O” : Outpatient
Fac	Place of Treatment	222	5	Char	See attached list of valid codes.
Fac	Type of Service	227	5	Char	See attached list of valid codes.
Fac	Claim Primary Payer	232	1	Char	“T” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Fac	Claim Secondary Payer	233	1	Char	“T” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer “U” : Secondary payer not verified
Fac	Claim Tertiary Payer	234	1	Char	“T” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer “U” : Tertiary payer not verified
Fac	DRG Code	235	3	Char	For inpatient facility claims, carrier should provide DRG Code, ICD-9 Principal Diagnosis Code, and ICD-9 Principal Procedure Code. If carrier cannot provide DRG Code, then carrier must provide all ICD-9 diagnosis and procedure codes.
Fac	ICD-9 Principal Diagnosis Code	238	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	244	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	250	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	256	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	262	6	Char	Actual Code with “.” or “N/A”

Record type	8.1 Field Name	Pos	Size	Data type	Comments
Fac	ICD-9 Other Diagnosis Code	268	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	274	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	280	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	286	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Principal Procedure Code	292	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	298	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	304	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	310	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	316	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	322	6	Char	Actual Code with “.” or “N/A”
Fac	Ambulatory Patient Classification (APC) Group Number	328	5	Char	For outpatient facility claims, carrier should provide APC Group Number. If carrier cannot provide APC Group Number, then carrier must provide all Uniform Billing (UB-92) Revenue Codes coded on the claim.
Fac	Ambulatory Surgical Center (ASC) Group	333	5	Char	Blank or 1-8 as appropriate.
Fac	Provider ID type	338	2	Char	FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval)
Fac	Provider ID	340	15	Char	
Fac	Provider Name	355	50	Char	
Fac	Provider Type	405	2	Char	See attached list of valid codes.
Fac	Provider Location – City	407	20	Char	
Fac	Provider Location – State	427	2	Char	
Fac	Provider Location – Zip Code	429	10	Char	
Fac	Pre-Certified Admission	439	1	Char	“Y” : Yes “N” : No or Not Applicable
Fac	Provider In/Out Network	440	1	Char	“I” : Provider in Network “P” : Participating Provider not in Network “N” : Non-participating Provider
Fac	Provider Contract Level	441	10	Char	“HMO” “HMO POS” “EPO”

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					“POS PPO” “PPO” “PHO” “INDEMNITY”
Fac	Total Charges	451	10	Amount	
Fac	Non-benefit Charges not covered	461	10	Amount	e.g. convenience items
Fac	Benefit Charges not covered	471	10	Amount	
Fac	Eligible Charge	481	10	Amount	Should be equal to Total Charges – Non-benefit Charges not covered – Benefit Charges not covered
Fac	Deductible	491	10	Amount	
Fac	8.1.9 Coinsurance	501	10	Amount	Copayment is stored in separate field
Fac	COB	511	10	Amount	
Fac	Facility Liability (pre-discount)	521	10	Amount	Amount owed facility if no discount relationship in place. Expected relationship of amounts is: Facility liability (pre-discount) + COB + Copayment + Deductible = Eligible Charge.
Fac	Facility Liability (post-discount)	531	10	Amount	Amount contracted with Facility.
Fac	Discount retained by carrier	541	10	Amount	Portion of total discount retained by carrier for ASO. Remainder of discount is assumed to be Commonwealth's, which may consist of 2 portions: a guaranteed portion which is credited immediately and a settlement amount which is credited later, usually after the close of the fiscal year.
Fac	Discount guaranteed to Commonwealth	551	10	Amount	Amount of discount credited to Commonwealth on initial bill
Fac	Commonwealth's settlement discount	561	10	Amount	Amount of discount credited (or due to be credited, if known in advance) to Commonwealth after close of fiscal year.
Fac	Net Payment After Application of Reimbursement Method	571	10	Amount	The expected relationship is that Net Payment After Application of Reimbursement Method = Facility Liability (pre-discount) – Discount guaranteed to Commonwealth – Commonwealth's Settlement Discount
Fac	Internal Claim ID	581	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.

Record type	8.1 Field Name	Pos	Size	Data type	Comments
8.1.10	8.1.11 Copayment	601	10	Amount	Copayment separate from Coinsurance
8.1.12	8.1.13 Contract Type	611	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
	Record length		611		
UB92	Record Type	1	1	Char	Value = 'U' 1 record for each revenue code/units/HCPCS item on UB92
UB92	Carrier Code	2	3	Char	To be defined by COV
UB92	Covered Group	5	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
UB92	Plan Code	6	4	Char	To be defined by COV
UB92	Subscriber ID from BES – REF*OF	10	9	Char	
UB92	Claim Number	19	20	Char	Same Claim Number from corresponding Facility Record
UB92	Claim Number Suffix	39	2	Char	Same Claim Number from corresponding Facility Record
UB92	Revenue Code	41	3	Char	No '-'
UB92	Revenue Code Units	44	7	Num	Whole number. Right Justified
UB92	Revenue Code HCPCS	51	5	Char	HCPCS code or 'N/A' if not provided
	Record length		55		
Pharm	Record Type	1	1	Char	Value = 'D'
Pharm	Carrier Code	2	3	Char	To be defined by COV
Pharm	Covered Group	5	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Pharm	Plan Code	6	4	Char	To be defined by COV
Pharm	Subscriber ID from BES – REF*OF	10	9	Char	
Pharm	Contract Number (Subscriber SSN)	19	9	Char	No '-'
Pharm	Subscriber Birth Date	28	8	Date	
Pharm	Subscriber Sex	36	1	Char	"M" : Male "F" : Female
Pharm	Subscriber Zip Code	37	10	Char	
Pharm	Subscriber Agency/ TLC Group	47	3	Char	For State, Agency Code from BES 834 feed. For TLC, School or Government

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					Group Identifier from Anthem 834 feed.
Pharm	Patient SSN	50	9	Char	Optional. No ‘-’.
Pharm	Patient Last Name	59	20	Char	
Pharm	Patient First Name	79	15	Char	
Pharm	Patient Birth Date	94	8	Date	
Pharm	Patient Relationship to Subscriber	102	1	Char	“E” : Self “S” : Spouse “C” : Child “O” : Other
Pharm	Patient Sex	103	1	Char	“M” : Male “F” : Female
Pharm	Patient Zip Code	104	10	Char	
Pharm	Claim Number	114	20	Char	
Pharm	Claim Number Suffix	134	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Pharm	Claim Incurred Date	136	8	Date	
Pharm	Claim Received Date	144	8	Date	
Pharm	Claim Adjudicated Date	152	8	Date	
Pharm	Claim Processed Date	160	8	Date	
Pharm	Claim Check Date	168	8	Date	Date on the check when issued.
Pharm	Claim Paid Date	176	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Pharm	Claim Disposition	184	1	Char	“O” : Original Claim “P” : Positive Adjustment “N” : Negative Adjustment
Pharm	Optional Benefit Utilization (Expanded Benefit)	185	1	Char	‘N’
Pharm	Optional Benefit Utilization	186	1	Char	Blank
Pharm	Optional Benefit Utilization	187	1	Char	Blank
Pharm	Claim Approved/Denied	188	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Pharm	Capitated/Non-Capitated	189	1	Char	Space or “N” – Non-capitated “C” - Capitated
Pharm	Claim Primary Payer	190	1	Char	“T” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Pharm	Claim Secondary Payer	191	1	Char	“T” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer “U” : Secondary payer not verified
Pharm	Claim Tertiary Payer	192	1	Char	“T” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					“U” : Tertiary payer not verified
Pharm	NDC Drug Code	193	11	Char	In 5-4-2 format.
Pharm	Prescription Number	204	15	Char	
Pharm	Refill Flag	219	1	Char	‘N’ – New Prescription, ‘R’ - Refill
Pharm	Dispense as Written	220	1	Char	‘Y’ – Specified Dispense as Written ‘N’ – Dispense as Written not specified
Pharm	Therapeutic Class Code, Standard	221	2	Char	00-99 from NDDF User Manual
Pharm	Generic Drug Category	223	1	Char	“B” : Brand Drug with NO generic equivalent “E” : Brand Drug with generic equivalent “G” : Generic Drug
Pharm	Number Days Drug Supplied	224	5	Num	Signed. 0 assumed decimal places. If negative adjustment, signed negative.
Pharm	Metric Quantity Drug Dispensed	229	13	Num	Signed. 3 assumed decimal places. If negative, adjustment, signed negative.
Pharm	Pharmacy ID type	242	2	Char	FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number NA – National Association of Boards of Pharmacy Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Pharm	Pharmacy ID	244	15	Char	
Pharm	Pharmacy Name	259	50	Char	
Pharm	Pharmacy Type	309	2	Char	See attached list of valid Provider codes.
Pharm	Pharmacy Location – City	311	20	Char	
Pharm	Pharmacy Location – State	331	2	Char	
Pharm	Pharmacy Location – Zip Code	333	10	Char	
Pharm	Provider In/Out Network	343	1	Char	“T” : Provider in Network “P” : Participating Provider not in Network “N” : Non-participating Provider
Pharm	Provider Contract Level	344	10	Char	“HMO” “HMO POS” “EPO” “POS PPO” “PPO” “PHO” “INDEMNITY”
Pharm	Prescriber ID type	354	2	Char	FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number NA – National Association of Boards of Pharmacy Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval)

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					COV plans to require HCFA ID if the National Provider ID is mandated for use.
Pharm	Prescriber ID	356	15	Char	
Pharm	Prescriber Name	371	50	Char	
Pharm	Prescriber Type	421	2	Char	See attached list of valid Provider codes.
Pharm	Prescriber Location – City	423	20	Char	
Pharm	Prescriber Location – State	443	2	Char	
Pharm	Prescriber Location – Zip Code	445	10	Char	
Pharm	Total Charges	455	10	Amount	
Pharm	Non-benefit Charges not covered	465	10	Amount	e.g. convenience items
Pharm	Benefit Charges not covered	475	10	Amount	e.g. a benefit not covered by COV's plan.
Pharm	Discount	485	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered – Schedule of Allowance. Otherwise, discount is zero.
Pharm	Schedule of Allowance	495	10	Amount	Applicable to this procedure, provider, and to the COV.
Pharm	Eligible Charges	505	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered.
Pharm	Deductible	515	10	Amount	
Pharm	8.1.14 Coinsurance	525	10	Amount	Copayment is stored in separate field
Pharm	COB	535	10	Amount	
Pharm	Net Payment After Application of Reimbursement Method	545	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Deductible = Eligible Charge.
Pharm	Drug Acquisition Cost	555	10	Amount	
Pharm	Drug Dispense Fee	565	10	Amount	Expected relationship is Drug Acquisition Cost + Drug Dispense Fee = Eligible Charge.
Pharm	Drug Process Fee	575	10	Amount	
Pharm	Internal Claim ID	585	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit

Record type	8.1 Field Name	Pos	Size	Data type	Comments
					report.
8.1.15	8.1.16 Copayment	605	10	Amount	Copayment separate from Coinsurance
8.1.17	Payment Tier	615	1	Char	Blank or 'N' – Payment Tier Not Applicable '1' – Tier 1 '2' – Tier 2 '3' – Tier 3
8.1.18	Contract Type	616	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
Pharm	Dosage Form of Drug	617	2	Char	Unit of Measure applicable to Metric Quantity Drug Dispensed Blank – Not Specified "ML" – Milliliters "GM" – Grams "EA" - Each
	Record length		618		
Trailer	Record Type	1	1	Char	Value = 'Z'
Trailer	Carrier Code	2	3	Char	To be assigned by COV
Trailer	File type	5	10	Char	Value = "CLAIM"
Trailer	Lowest processing date on file	15	8	Date	Claim Processed Date
Trailer	Highest processing date on file	23	8	Date	Claim Processed Date
Trailer	Number of Professional records on file	31	7	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Professional Total Charges on file	38	12	Amount	
Trailer	Number of Facility records on file	50	7	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Facility Total Charges on file	57	12	Amount	
Trailer	Number of Pharmacy	69	7	Numeric	Unsigned. Right Justify. 0 decimals.

Record type	8.1 Field Name	Pos	Size	Data type	Comments
	records on file				
Trailer	Amount of Pharmacy Total Charges on file	76	12	Amount	
Trailer	Number of UB92 records on file	88	7	Numeric	Unsigned. Right Justify. 0 decimals
	Record length		94		

Specifications for Direct Bill Report

This report shall be in Excel format and submitted electronically each month by the Medical/Vision benefits Contractor responsible for direct billing of certain participants in the State Program. The schedule is determined by the Department. At a minimum, the following data elements must be included:

- Participant's Identification Number
- Participant's Last Name
- Participant's First Name
- Participant's Middle Initial
- Participant's Suffix
- Participant's Address 1
- Participant's Address 2
- Participant's City
- Participant's State
- Participant's Zip code + 4
- Participant's Country
- Participant's Plan
- Participant's Membership
- Participant's Premium Amount
- Participant's Month Premium Covers
- Participant's Paid To Date
- Participant's Agency Code
- Participant's Group Code
- Participant's Premium Code