

RFP Number OHB 10-02
Addendum # 1
Issued: November 22, 2010

This Addendum incorporates certain general comments and answers to questions posed before, during and after the optional pre-proposal conference held on November 17, 2010.

GENERAL

Verbal responses to questions at the Pre-Proposal Conference on March 17, 2010 are unofficial and are not binding. Only these written responses may be relied upon by offerors. Participants at the Pre-proposal Conference were required to register their attendance and to provide their business contact information. A list of all attendees at the conference is enclosed for informational purposes. Offeror submissions must include a signed copy of this Addendum as a part of their submission. Section 5.5 Criteria for Evaluation is hereby changed to reflect the following: Cost (15) and small, small/women owned, and small/minority owned businesses (20).

All offerors are asked to respond to the following as a part of their submission:

To comply with the mandatory reporting requirements under MMSEA (Medicare, Medicaid and SCHIP Extension Act of 2007), the claims administrators for our self-funded health plans now receive information that appears to match the information received through our VDSA (Voluntary Data Sharing Agreement) for purposes of identifying Medicare entitlement. As such, we would like for offerors to include their rationale for maintaining a separate VDSA.

All offerors shall sign and submit a copy of the Business Associate Agreement as a part of their submission. The agreement is included in this addendum.

Name and Address of Firm:

_____	Date: _____
_____	By: _____
_____	(PRINTED NAME)
_____	_____
_____ Zip Code: _____	(SIGNATURE IN INK)
Fax	Title: _____
Number: () _____	Telephone: () _____

The following questions and responses are provided:

1. The RFP in section 4.2.1...requests and original and five copies, while section 5.1 requests an original and six copies. Which is correct?
An original and five copies

2. Regarding RFP section 2.1.2, Please provide the expectations of The Commonwealth of Virginia in regards to the offeror identifying ESRD coordination periods. Can you expand on the description of ESRD services requested? When the reason for Medicare eligibility is identified as ESRD, it would be helpful to define the coordination period. This is particularly useful in the active population. Our experience is that counting 30 months from the entitlement date is not always an accurate calculation of the coordination period. CMS Data reporting, can it be provided in a dashboard format versus an excel spreadsheet? While we are accustomed to using the Excel format, feel free to provide the benefits of an alternate format.
Can you clarify if (1) week is referring to (5) business days for reporting requirements after a CMS response file is received by offeror? This is negotiable

3. Regarding RFP section 2.1.8 Develop a process for responding to Primary Payment Notices (PPN) question - Would it be feasible for “our company” to gain access to a DHRM or TPA system that houses beneficiary info. needed to complete the PPN form? Is there another reporting system that could provide this employment information to “our company”? The necessary information is not available on the VDSA.? The file that is currently provided contains some historical information. It has been our understanding that the accumulated data may be used to determine primacy. This will require additional discussion.

4. Regarding RFP section 2.1.9 Can “our company” propose more than one approach to identify participants who may be eligible for Social Security Disability Income Benefits (SSDIB)?
Will this program be funded by The Commonwealth or Virginia or by the participants (with administrative fees being taken from the participants retroactive SSDIB award)?
We are interested in your ideas for approaching this opportunity. If it is decided to move forward with a process, a decision regarding funding would be made at that time.
However, we would anticipate that the fee would be paid by the participant.

5. Regarding RFP section 4.2 Submission of Written Proposals: Delivery option. We are an out of state vendor. Can we arrange to have our package delivered by Fed Ex to DHRM as long as the envelope inside the package meets all the delivery specifications of the RFP?
Yes

6. Regarding **Organizational Questionnaire, II Communication Materials and Services**
1. b. Can you please clarify what is meant by "Communications to beneficiary regarding a potential discrepancy" or provide an example? “Our company” is not sure of the intent of the request. In response to question 1, please provide samples of any standard correspondence you would use to communicate with employees or retirees regarding move to Medicare primacy, claims issues, Medicare enrollment/Part B, or any proposed services.

7. Regarding RFP Section 2.0 Program Requirements:

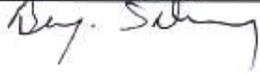
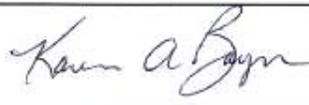
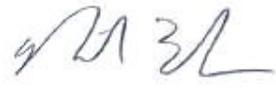
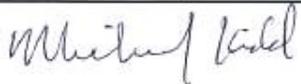
2.1.9 Offeror should be able to administer a program to identify participants who may be eligible for Social Security disability, assist with application, and ensure that Medicare becomes the primary payer immediately upon eligibility.

Does the state only want participants who would have Medicare as primary identified and enrolled? If a participant is eligible for Medicare only as secondary coverage, is the state interested in identification and enrollment?

The program uses information identifying beneficiaries with Medicare as a secondary payer (e.g., active employees/dependents not eligible due to ESRD) to provide notice of creditable prescription drug coverage to participants who are eligible for Medicare Part D. This is also useful when moving pre-65 employees into retiree coverage.

8. I have a question regarding conflicts of interest for this procurement. Would a contractor be considered to have a conflict of interest with the State of Virginia if they were the current Centers for Medicare and Medicaid Services Coordination of Benefits Contractor and if there was the possibility of future conflict of interest, what level of risk mitigation would be required of the offering contractor?
Within your submission, please identify any potential conflicts of interest, and your proposed solutions to mitigate the conflicts.
9. Could you further define the system security requirements?
The HIPAA Business Associate Agreement included in this addendum contains the IT security requirements that relate. Please insert your company name, sign that document and return it with your submission.
10. The RFP makes reference to providing assistance, and intercede on behalf of employees. Can you further define assistance?
Given that the population has varying levels of sophistication, we are interested in your approach as to how and when to intervene on behalf of the members.
11. Section 1.2 of the RFP discusses the TLC program, and identifies that the current process is not electronic. Would you want offeror to provide a solution to address that situation?
Yes.
12. Could you explain how SWaM points will be awarded?
An offeror that is a DMBE certified Small Business, and indicates the same in the RFP Exhibit One, will receive all 20 points. Percentage use of DMBE registered small business as a sub-contractor will receive proportional points for that sub-contracting effort. For example: If 50% of the work is slated for DMBE registered small business contractor, then the offeror would receive 50% of the SWaM points available (10 points).
13. Could you provide a listing of attendee for the Optional Pre-Proposal Meeting held on Wednesday November 17, 2010?

OHB10-02 Medicare Eligibility Determination Services
 Pre-Proposal Conference
 17-Nov-10
 Sign-in Sheet

Print Name	Company	Signature	Contact Info
Bryan Dorsey	Livanta, LLC		240-568-9012 x268 bdorsey@livanta.com
Karen Bayer	SSDC		248-277-9227 Karen.bayer@assurant.com
Tony Schy	HMS		812-285-8960 x1222 tony.schy@hms.com
NICK BEHREND'S	PCG		919-576-2214 nbehrends@pcgus.com
Michael Kido	Kido Int'l.		202-923-6600 Mike.Kido@kido-intl.com

Group Health Plan Business Associate Agreement

This agreement (“Agreement”) is effective as of **February 1, 2011** and is made among _____ (“Claims Administrator”), and the Commonwealth of Virginia Group Health Plan, administered by the Office of Health Benefits Programs (“Plan”) for the Department of Human Resource Management.

WITNESSETH AS FOLLOWS:

WHEREAS, the Commonwealth of Virginia has established and maintains the Plan as a program that provides health care coverage for employees pursuant to § 2.2-2818 of the Code of Virginia. The Plan meets the definition of a “health plan” under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64);

WHEREAS, the Plan has retained Claims Administrator to provide certain administrative services with respect to the Plan which are described and set forth in a separate Administrative Services Agreement among those parties procured under RFP numbered OHB06-1 (“ASO Agreement”) which is in effect on the effective date of this Agreement, as amended or replaced from time to time;

WHEREAS, the parties to this Agreement desire to establish the terms under which Claims Administrator may use or disclose Protected Health Information (as defined herein) such that the Plan may comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64) (“HIPAA Privacy Regulations”);

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan, and Claims Administrator hereby agree as follows:

PART 1—CLAIMS ADMINISTRATOR’S RESPONSIBILITIES

I. PRIVACY OF PROTECTED HEALTH INFORMATION

A. Confidentiality of Protected Health Information

Except as permitted or required by this Agreement, Claims Administrator will not use or disclose Protected Health Information without the authorization of the Covered Person who is the subject of such information or as required by law.

B. Prohibition on Non-Permitted Use or Disclosure

Claims Administrator will neither use nor disclose Covered Persons’ Protected Health Information except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by the Plan, (3) as authorized by Covered Persons, or (4) as required by law.

C. Permitted Uses and Disclosures

Claims Administrator is permitted to use or disclose Covered Persons’ Protected Health Information as follows:

1. Functions and Activities on Health Plan’s Behalf

Claims Administrator will be permitted to use and disclose Covered Persons’ Protected Health Information (a) for the management, operation and administration of the Plan, (b) for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 Code of Federal Regulations § 164.501, and (c) as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties provided such use or disclosure would not violate the HIPAA Privacy Regulations if done by the Plan.

2. **Claims Administrator's Own Management and Administration**

a. **Protected Health Information Use**

Claims Administrator may use Covered Persons' Protected Health Information as necessary for Claims Administrator's proper management and administration or to carry out Claims Administrator's legal responsibilities.

b. **Protected Health Information Disclosure**

Claims Administrator may disclose Covered Persons' Protected Health Information as necessary for Claims Administrator's proper management and administration or to carry out Claims Administrator's legal responsibilities only (i) if the disclosure is required by law, or (ii) if before the disclosure, Claims Administrator obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will (x) hold Covered Persons' Protected Health Information in confidence, (y) use or further disclose Covered Persons' Protected Health Information only for the purposes for which Claims Administrator disclosed it to the entity or as required by law; and (z) notify Claims Administrator of any instance of which the entity becomes aware in which the confidentiality of any Covered Persons' Protected Health Information was breached.

3. **Miscellaneous Functions and Activities**

a. **Protected Health Information Use**

Claims Administrator may use Covered Persons' Protected Health Information as necessary for Claims Administrator to perform Data Aggregation services, and to create Deidentified Information, Summary Health Information and/or Limited Data Sets.

b. **Protected Health Information Disclosure**

Claims Administrator may disclose, in conformance with the HIPAA Privacy Regulations, Covered Persons' Protected Health Information to make disclosures of Deidentified Information, Limited Data Set Information, and Summary Health Information, and to make Incidental Disclosures.

4. **Minimum Necessary**

Claims Administrator will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Covered Persons' Protected Health Information to accomplish the intended purpose.

D. Disclosure to Plan and the Commonwealth (and their Subcontractors)

Other than disclosures permitted by Section I.C above, Claims Administrator will not disclose Covered Persons' Protected Health Information to the Plan, the Commonwealth, or any business associate or subcontractor of such parties except as set forth in Section VIII.

E. Disclosure to Claims Administrator's Subcontractors and Agents

Claims Administrator will require each subcontractor and agent to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Covered Persons' Protected Health Information as this Agreement applies to Claims Administrator.

F. Reporting Non-Permitted Use or Disclosure

Claims Administrator will report to the Plan within 5 business days any use or disclosure of Covered Persons' Protected Health Information (whether by itself or by its subcontractors) not permitted by this Agreement or in writing by the Plan of which Claims Administrator becomes aware.

G. Termination for Breach of Privacy Obligations

Without limiting the rights of the parties set forth in the ASO Agreement, the Plan will have the right to terminate the ASO Agreement if Claims Administrator has engaged in a pattern of activity or practice that constitutes a material breach or violation of Claims Administrator's obligations regarding Protected Health Information under this Agreement and, on notice of such material breach or violation from the Plan, fails to take reasonable steps to cure the breach or end the violation. The Plan will follow the notice of termination procedures as set forth in the ASO Agreement.

H. Disposition of Protected Health Information

1. Return or Destruction Upon ASO Agreement End

The parties agree that upon cancellation, termination, expiration or other conclusion of the ASO Agreement, destruction or return of all Protected Health Information, in whatever form or medium (including in any electronic medium under Claims Administrator's custody or control) is not feasible given the regulatory requirements to maintain and produce such information for extended periods of time after such termination. In addition, Claims Administrator is required to maintain such records to support its contractual obligations with its vendors and network providers. Claims Administrator 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 consistent with applicable law for so long as Claims Administrator, or its subcontractors, maintains such Protected Health Information. Claims Administrator may destroy such records in accordance with its record retention policy that it applies to similar records, except to the extent a longer period of time is specified by the ASO Agreement or the law.

2. Exception When Claims Administrator Becomes Plan's Health Insurance Issuer

If upon cancellation, termination, expiration or other conclusion of the ASO Agreement, Claims Administrator (or an affiliate of Claim Administrator) becomes the Plan's health insurance underwriter, then Claims Administrator shall transfer any Protected Health Information that Claims Administrator created or received for or from the Plan to that part of Claims Administrator (or affiliate of Claims Administrator) responsible for health insurance functions.

3. Survival of Termination

The provisions of this Section I.H. shall survive cancellation, termination, expiration, or other conclusion of the ASO Agreement.

II. ACCESS, AMENDMENT AND DISCLOSURE ACCOUNTING FOR PROTECTED HEALTH INFORMATION

A. Access

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests for access to their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Claims Administrator will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Covered Person (or the Covered Person's personal representative), any Protected

Health Information about the Covered Person created or received for or from the Plan in Claims Administrator's custody or control, so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

B. Amendment

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests to amend their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

Upon receipt of written notice (includes faxed and e-mailed notice) from the Plan, Claims Administrator will amend any portion of the Protected Health Information created or received for or from the Plan in Claims Administrator's custody or control, so that the Plan may meet its amendment obligations under 45 Code of Federal Regulations § 164.526.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

C. Disclosure Accounting

1. Non-HIPAA requests

Claims Administrator will continue to respond to Covered Persons' routine requests for an accounting of disclosures of their Protected Health Information as part of Claims Administrator's normal customer service functions, if those requests do not qualify as a formal HIPAA request. In order to be deemed a "formal HIPAA request" the Covered Person must submit the request directly to the Plan, and follow all of the procedural requirements set forth in the Plan's Privacy Notice. All requests submitted directly to the Claims Administrator will be handled as a non-HIPAA request.

2. HIPAA requests

Claims Administrator will assist the Plan in responding to Covered Persons' formal HIPAA requests by performing the following functions:

So the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528, Claims Administrator will do the following:

a. Disclosure Tracking

Claims Administrator will record each disclosure that Claims Administrator makes of Covered Persons' Protected Health Information, which is not excepted from disclosure accounting under Section II.C.2.b.

The information about each disclosure that Claims Administrator must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address

of the person or entity to whom Claims Administrator made the disclosure, (c) a brief description of the Protected Health Information disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512.

For repetitive disclosures of Covered Persons' Protected Health Information that Claims Administrator makes for a single purpose to the same person or entity, Claims Administrator may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

b. Exceptions from Disclosure Tracking

Claims Administrator will not be required to record Disclosure Information or otherwise account for disclosures of Covered Persons' Protected Health Information (a) for Treatment, Payment or Health Care Operations, (b) to the Covered Person who is the subject of the Protected Health Information, to that Covered Person's personal representative, or to another person or entity authorized by the Covered Person (c) to persons involved in that Covered Person's health care or payment for health care as provided by 45 Code of Federal Regulations § 164.510, (d) for notification for disaster relief purposes as provided by 45 Code of Federal Regulations § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are incidental to a use or disclosure that is permitted by this Agreement or the ASO Agreement, (h) as part of a limited data set in accordance with 45 Code of Federal Regulations § 164.514(e), or (i) that occurred prior to the Plan's compliance date.

c. Disclosure Tracking Time Periods

Claims Administrator will have available for the Plan the Disclosure Information required by Section II.C.2.a above for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information (except Claims Administrator will not be required to have Disclosure Information for disclosures occurring before April 14, 2003).

d. Provision of Disclosure Accounting

Upon receipt of written notice (includes faxed and e-mailed notice) from the Plan, Claims Administrator will make available to the Plan, or at the Plan's direction to the Covered Person (or the Covered Person's personal representative), the Disclosure Information regarding the Covered Person, so the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528.

Claims Administrator will not respond directly to Covered Persons' formal HIPAA requests for an accounting of disclosures. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely accounting to the Covered Person.

D. Confidential Communications

Claims Administrator will promptly, upon receipt of notice from the Plan, begin to send all communications of Protected Health Information directed to the Covered Person to the identified alternate address.

Claims Administrator will respond directly to Covered Persons' requests for a confidential communication. If a Covered Person's request, made to Claims Administrator, extends beyond information held by Claims Administrator or Claims Administrator's affiliates or agents, Claims Administrator will inform the Covered Person to direct the request to the Plan, so that the Plan may coordinate the request. Claims Administrator assumes no obligation to coordinate any request for a confidential communication of Protected Health Information maintained by other business associates of Plan.

E. Restrictions

The Plan understands that Claims Administrator administers a variety of different complex health benefit arrangements, both insured and self-insured, and that Claims Administrator has limited capacity to agree to special privacy restrictions requested by Covered Persons. Accordingly, the Plan and the agrees that it will not commit Claims Administrator to any restriction on the use or disclosure of Covered Persons' Protected Health Information for Treatment, Payment or Health Care Operations without Claims Administrator's prior written approval.

Claims Administrator will promptly, upon receipt of notice from the Plan, restrict the use or disclosure of Covered Persons' Protected Health Information, provided the Claims Administrator has agreed to such a restriction.

Claims Administrator will not respond directly to Covered Persons' requests to restrict the use or disclosure of Protected Health Information for Treatment, Payment or Health Care Operations. Claims Administrator will refer the Covered Person to the Plan so that the Plan can coordinate and prepare a timely response to the Covered Person.

III. PLAN'S NOTICE OF PRIVACY PRACTICES

The Plan will be solely responsible for the content of any Notice of Privacy Practices that is created, including that its content accurately reflects the Plan's privacy policies, procedures and practices and complies with all the requirements of 45 Code of Federal Regulations § 164.520. The Plan shall not create any Notice of Privacy Practices that imposes privacy obligations on the Claims Administrator that have not been accepted in writing in advance by the Claims Administrator.

IV. SAFEGUARD OF PROTECTED HEALTH INFORMATION

Claims Administrator will develop and maintain reasonable and appropriate administrative, technical and physical safeguards, as required by Social Security Act § 1173(d) and 45 Code of Federal Regulation § 164.530(c), to ensure and to protect against reasonably anticipated threats or hazards to the security or integrity of health information, to protect against reasonably anticipated unauthorized use or disclosure of health information, and to reasonably safeguard Protected Health Information from any intentional or unintentional use or disclosure in violation of this Agreement.

Claims Administrator will also develop and use appropriate administrative, physical and technical safeguards to preserve the availability of electronic Protected Health Information, in addition to preserving the integrity and confidentiality of such Protected Health Information. "Availability" means the electronic protected health information is accessible and useable upon demand by an authorized person. The "appropriate safeguards" Claims Administrator uses in furtherance of 45 Code of Federal Regulation § 164.530(c), will also meet the requirements contemplated by 45 Code of Federal Regulation Parts 160, 162 and 164, as amended from time to time.

In addition to reporting to the Plan any use or disclosure of Protected Health Information not permitted by the Agreement, Claims Administrator will also report any security incidents of which Claims Administrator becomes aware. A security incident is an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, and involves only electronic Protected Health Information that is created, received maintained or transmitted by or on behalf of Claims Administrator, that is in electronic form

V. NOTICE OF BREACH - OBLIGATIONS AND ACTIVITIES OF CLAIMS ADMINISTRATOR

In the event of any "breach" of "unsecured PHI" in Claims Administrator's control, as both terms are defined in Sec. 13402 of the American Reinvestment and Recovery Act of 2009 ("ARRA") and as clarified pursuant to any regulations adopted pursuant thereto, Claims Administrator shall, in accordance with such section and any applicable regulations thereunder: (a) notify the Plan of such breach; (b) notify each affected individual of such breach; and (c) provide any other notice, on behalf of the Plan, that is required

under ARRA Sec.13402. This notice obligation shall take effect as of the effective date of the notice provisions of ARRA Sec. 13402.

VI. COMPLIANCE WITH STANDARD TRANSACTIONS

On and after October 16, 2003, Claims Administrator will comply with each applicable requirement for Standard Transactions established in 45 Code of Federal Regulations Part 162 when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with the Plan.

VII. INSPECTION OF BOOKS AND RECORDS

Claims Administrator will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information created or received for or from the Plan available to the U.S. Department of Health and Human Services to determine Plan's compliance with 45 Code of Federal Regulations Parts 160-64 or this Agreement.

VIII. MITIGATION FOR NON-PERMITTED USE OR DISCLOSURE

Claims Administrator agrees to mitigate, to the extent practicable, any harmful effect that is known to Claims Administrator of a use or disclosure of Protected Health Information by Claims Administrator or its subcontractors in violation of the requirements of the Agreement.

PART 2—DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN, AND OTHER BUSINESS ASSOCIATES

IX. DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following provisions apply to disclosures of Protected Health Information to the Plan, the Office of Health Benefits Programs for the Department of Human Resource Management in its role as plan sponsor and plan administrator, and other business associates of the Plan on behalf of the Plan. Ownership of Protected Health Information is governed by the ASO Agreement and applicable law.

A. Disclosure to Health Plan

Unless otherwise provided by this Section VII, all communications of Protected Health Information by the Claims Administrator shall be directed to the Office of Health Benefits Programs in its role as plan administrator.

B. Disclosure to the Commonwealth in its Role of Plan Sponsor

Claims Administrator may provide Protected Health Information regarding the Covered Persons in the Plan to the Commonwealth upon the Commonwealth's written request for the purpose either (a) to obtain premium bids for providing health insurance coverage for the Plan, or (b) to modify, amend or terminate the Plan. Claims Administrator may provide information to the Commonwealth in its role of plan sponsor on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any insurance coverage offered by the Plan

C. Disclosure to Other Business Associates and Subcontractors

Claims Administrator may disclose Covered Persons' Protected Health Information to other entities or business associates of the Plan if the Plan authorizes Claims Administrator in writing to disclose Covered Persons' Protected Health Information to such entity or business associate. The Plan shall be solely responsible for ensuring that any contractual relationships with these entities or business associates and subcontractors comply with the requirements of 45 Code of Federal Regulations § 164.504(e) and § 164.504(f).

PART 3—MISCELLANEOUS

X. AGREEMENT TERM

This Agreement will continue in full force and effect for as long as the ASO Agreement remains in full force and effect. This Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the ASO Agreement.

XI. AUTOMATIC AMENDMENT TO CONFORM TO APPLICABLE LAW

Upon the effective date of any final regulation or amendment to final regulations with respect to Protected Health Information, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement or to the ASO Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan, and Claims Administrator remain in compliance with such regulations, unless Claims Administrator elects to terminate the ASO Agreement by providing the Plan notice of termination in accordance with the ASO Agreement at least thirty (30) days before the effective date of such final regulation or amendment to final regulations.

XII. CONFLICTS

The provisions of this Agreement will override and control any conflicting provision of the ASO Agreement or other agreement. All other provisions of the ASO Agreement or other agreement remain unchanged by this Agreement and in full force and effect.

XIII. INTENT

The parties agree that there are no intended third party beneficiaries under this Agreement.

XIV. INTERPRETATION

Any ambiguity in this Agreement or the ASO Agreement or in operation of the Plan shall be resolved to maintain compliance with the rules enacted pursuant to HIPAA Administrative Simplification.

XV. DEFINITIONS

The following terms when used in this Agreement have the following meanings:

A. “Covered Employee” means the person to whom coverage under the Plan has been extended by the Health Plan and to whom Claims Administrator has directly or indirectly issued an identification card bearing the Plan group number.

B. “Covered Person” means the Covered Employee and the Covered Employee’s legal spouse and/or unmarried dependent children as specified in the plan document.

C. “Data Aggregation” means the combining of Protected Health Information that Claims Administrator creates or receives for or from the Plan and for or from other health plans or health care providers for which Claims Administrator is acting as a business associate or a covered entity to permit data analyses that relate to the Health Care Operations of the Plan and those other health plans or providers. (*See* 45 Code of Federal Regulations § 164.501.)

D. “De-Identified Information” has the same meaning as that term is defined in the HIPAA Privacy Regulations (*See* 45 Code of Federal Regulations § 164.514(b).)

E. “Health Care Operations” mean any of the following activities of a health plan, such as the Plan, as relate to the functions that make it a health plan (*see* 45 Code of Federal Regulations § 164.501):

1. Quality Improvement and Control

a. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines (except research or other studies or activities that have as their primary purpose obtaining generalized knowledge);

b. Conducting population-based activities relating to improving health or reducing health care costs;

c. Conducting protocol development, case management or care coordination;

d. Contacting health care providers and enrollees (such as Covered Persons) with information about treatment alternatives; and

e. Conducting other related functions that do not include treatment.

2. Credentialing and Training

- a. Reviewing the competence or qualifications of health care professionals;
- b. Evaluating health care provider performance;
- c. Evaluating health plan performance;
- d. Conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers;
- e. Conducting training of non-health care professionals; and
- f. Conducting accreditation, certification, licensing or credentialing activities.

3. Insuring Functions

- a. Engaging in underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; and
- b. Ceding, securing, or placing a contract of reinsurance of risk relating to claims for health care (including stop-loss insurance), subject to any applicable limitations of 45 Code of Federal Regulations § 164.514(g).

4. Audit and Legal Activities

- a. Conducting or arranging for medical review;
- b. Conducting or arranging for legal services;
- c. Conducting or arranging for audit functions; and
- d. Conducting activities involving fraud and abuse detection or compliance programs.

5. Business Strategy

- a. Engaging in business planning and development;
- b. Conducting cost-management and planning-related analyses related to managing and operating the health plan;
- c. Developing and administering a formulary; and
- d. Developing or improving methods of payment or policies of coverage.

6. Business Management and Administration

- a. Engaging in business management and general administrative activities of the health plan;
- b. Managing activities relating to implementation of and compliance with the requirements for the information privacy, security, transaction standards and other provisions of 45 Code of Federal Regulation Subtitle A, Subchapter C;
- c. Managing customer service, including provision of data analyses for policy holders, plan sponsors, or other customers (provided that no Protected Health Information is disclosed to the policy holders, plan sponsors, or other customers, except as otherwise provided for herein);
- d. Resolving internal grievances;
- e. Creating de-identified health information (consistent with the requirements of 45 Code of Federal Regulations §§ 164.514(a)-(c));
- f. Creating limited data set health information (consistent with the requirements of 45 Code of Federal Regulations § 164.514(e); and
- g. Conducting activities in connection with the sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity.

7. Wellness and Other Health-Related Communication

Provided that these activities are not performed under conditions that would cause the activity to constitute “marketing” as defined in 45 Code of Federal Regulations § 164.501:

- a. Communicating with health plan enrollees about health-related products or services (or payment for such products or services) that are provided by or included in the health plan or that are available only to a health plan enrollee that add value to, but are not part of, a health plan;

- b. Communicating with health plan enrollees about health care providers in the health plan's networks;
- c. Communicating with health plan enrollees about the health plan's coverage or benefits, or the replacement of, or enhancements to a health plan;
- d. Communicating with health plan enrollees concerning products or services of nominal value;
- e. Communicating with health plan enrollees face-to-face about any products or services;
- f. Communicating with health plan enrollees by newsletter or similar type of general communication device distributed to a broad cross-section of enrollees or other broad group of individuals; and
- g. Communicating with health plan enrollees for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

F. "Incidental Use or Disclosure" means a secondary use or disclosure that can not reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure under the HIPAA Privacy Regulations. Such a secondary use or disclosure shall only be considered an incidental use or disclosure if reasonable safeguards have been put in place to prevent such use or disclosure.

G. "Individually Identifiable Health Information" means information, including demographic information collected from an individual, that (1) is created or received by a health plan, health care provider, employer, or health care clearinghouse, (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (3) either identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. (*See* 45 Code of Federal Regulations § 164.103.)

H. "Limited Data Set" means Protected Health Information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

1. Names;
2. Postal address information, other than town or city, State, and zip code;
3. Telephone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers, including license plate numbers;
12. Device identifiers and serial numbers;
13. Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers;
14. Biometric identifiers, including finger and voice prints; and
15. Full face photographic images and any comparable images (*See* 45 Code of Federal Regulations § 164.514(e).)

I. "Payment" means any of the following activities of a health plan, such as the Plan (*see* 45 Code of Federal Regulations § 164.501):

1. Obtaining premium payments or reimbursement for the provision of health care;
2. Determining or fulfilling responsibility for coverage and provision of benefits under the health plan;
3. Determining an enrollee's eligibility or coverage;

4. Coordinating benefits, determining cost sharing amounts, adjudicating or subrogating health benefit claims;
5. Adjusting risk amounts due based on enrollee health status or demographic characteristics;
6. Engaging in billing, claims management, issuance of explanations of benefits, collection activities, and related health care data processing;
7. Obtaining payment under a contract of reinsurance (including stop-loss insurance and excess loss insurance);
8. Reviewing health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
9. Conducting utilization review, precertification and preauthorization of services, and concurrent and retrospective review of services; and
10. Disclosure to consumer reporting agencies not more than the demographic data permitted by 45 Code of Federal Regulations § 164.501 (“Payment” ¶ 2(vi)).

J. “Plan Administration Functions” means administrative functions performed by a plan sponsor on behalf of a group health plan and excludes functions performed by the plan sponsor in connection with (1) obtaining premium bids for providing health insurance coverage for the group health plan or for modifying, amending or terminating the group health plan, or (2) functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

K. “Protected Health Information” means Individually Identifiable Health Information that is transmitted or maintained electronically, on paper, orally or in any other form or medium. Education records covered by the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g); records described in Section 1232g(a)(4)(B)(iv) of Title 20 of the United State Code; and employment records held by a covered entity in its role as an employer are excluded from Protected Health Information. (*See* 45 Code of Federal Regulations § 164.501.)

L. “Summary Health Information” means information, which may be Individually Identifiable Health Information, (1) that summarizes the claims history, claims expenses, or types of claims experienced by enrollees for whom a plan sponsor has provided health care benefits under a group health plan, and (2) from which the identifiers specified in 45 Code of Federal Regulations § 164.514(b)(2)(i) have been deleted (except that the zip code information described in 45 Code of Federal Regulations § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five (5) digit zip code). (*See* 45 Code of Federal Regulations § 164.504(a).)

M. “Standard Transactions” mean health care financial or administrative transactions conducted electronically for which standard data elements, code sets and formats have been adopted in 45 Code of Federal Regulations Part 162.

N. “Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. (*see* 45 Code of Federal Regulations § 164.501)

XVI. REFERENCES

References herein to statutes and regulations shall be deemed to be references to those statutes and regulations as amended or recodified.

SIGNATURES

PLAN: COMMONWEALTH OF VIRGINIA EMPLOYEE GROUP HEALTH PLAN

By: _____
Title: _____
Date: _____

CLAIMS ADMINISTRATOR:

By: _____
Title: _____
Date: _____