

REQUEST FOR PROPOSALS
(RFP)

ISSUE DATE: March 16, 2011

TITLE: Administrative Services for fully-insured voluntary TRICARE supplemental health coverage

Number: OHB 11-01

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 September 1, 2011 through June 30, 2014, with three one-year renewal options as described within. The Start date is contingent upon negotiations and implementation timeline.

Sealed proposals for furnishing services described herein will be received subject to the conditions cited herein until 2:00 p.m., April 28, 2011.

All Inquiries Must Be In Writing And Should Be Directed To:

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

Contract Participation: Under authority of the *Code of Virginia*, § 2.2-4304 which authorizes public bodies to utilize cooperative procurement to satisfy requirements for goods and non-professional services; This contract is made available for use by public bodies within the Commonwealth of Virginia.

The lead agency shall not be held liable for any costs or damages incurred by any other participating public bodies as a result of any authorization by the Contractor to extend the contract. It is understood and agreed that the lead agency is not responsible for the acts or omissions of other public bodies and will not be considered in default of the Agreement no matter the circumstances.

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: _____

Fax Number: _____ () _____

Date: _____

By: _____
(PRINTED NAME)

(SIGNATURE IN INK)

Title: _____

Telephone
: _____ () _____

PRE-PROPOSAL CONFERENCE: An optional pre-proposal conference will be held on Tuesday, April 1, 2011, at the James Monroe Building. (Reference Paragraph 5.9)

1.0 INTRODUCTION

1.1 Purpose

The purpose of this Request for Proposals (RFP) is to secure an administrator for a voluntary TRICARE supplemental health program for state employees and their dependents eligible for such coverage. The cost of this coverage will be paid in full by employees who elect such coverage, and there will be no employer contribution toward the cost of the coverage. Employee contributions for coverage will be taken on a pre-tax basis under the Commonwealth's IRC section 125 cafeteria plan, and employees who elect such coverage for themselves and their dependents must meet eligibility criteria and comply with provisions of the Commonwealth's section 125 cafeteria plan.

Non-Medicare retirees eligible for coverage under the state employee health program may also elect such coverage. There will be no employer contribution toward the cost of coverage for non-Medicare retirees.

1.2 Background

The Department of Human Resource Management (the Department) is the authorized agent of the Governor in administering the state employee health benefits program. The program is delivered through approximately 250 state agencies to some 95,000 active, full-time employees, retirees not eligible for Medicare, and extended coverage (COBRA) enrollees, and to the dependents of these enrollees. Agencies distribute program materials, assist employees in applying for coverage or changes in coverage according to rules developed by the Department, payroll-deduct employee premiums, post eligibility information onto the Benefits Eligibility System (BES), and otherwise assist employees in accessing the program's benefits. To support employees and agencies' benefit personnel, the Department operates Employee Direct (E-Direct) which is a web-based system through which employees may make enrollment and coverage changes without the use of paper forms, and which serves as a portal to benefits related information including wellness and medical management sites.

The Department has developed plans and programs with the advice of consultants, vendors, employees and others, and has delivered benefits through Contractors, either insurers or third party administrators. The coverages currently available may be found on the state employees' web site: www.dhrm.virginia.gov/employeebenefits.html.

1.3 General Description

The Department currently offers a statewide self funded plan, a PPO called COVA Care (COVA Connect in the Hampton Roads area) and a regional fully insured HMO. The Department also offers a statewide self funded High Deductible Health Plan (HDHP).

The TRICARE supplemental health coverage plan would be offered as a voluntary fully-insured alternative to these programs for employees and their dependents eligible for TRICARE benefits. This is the first proposed offering of a voluntary TRICARE supplemental health coverage plan under the state employee health program.

Note: The statewide self funded plans and the regional fully insured HMO include basic dental coverage. Offerors may include a basic dental component with their proposal.

This RFP is divided into sections, such as this numbered Section 1.0, Introduction. A section is one of the principal divisions of this RFP. Within these sections, numbered paragraphs are the second principal division and normally contain the number of the section in which they are located, such as this paragraph numbered 1.3.

It is imperative that offerors respond to all applicable requirements and complete all applicable schedules and exhibits described in the Form of Response, Section 6. Any offeror confusion about which sections and/or paragraphs may be applicable to a potential offeror should be clarified no later than the optional offerors' conference.

1.4 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-compliant proposal to be considered. (See Exhibit TWO)

1.5 Appendices

Appendix 1 is the current standard contract. Appendix 2 provides a link to a Summary Description of All Plans Offered to COVA Groups. Appendix 3 contains a description of the State Employee Membership and Billing System. Appendix 4 contains the EDI payment procedures that are used for the state employee group.

1.6 Attachments

Attachment 1 contains the technical questionnaire that must be submitted with a proposal.

1.7 Exhibits

Exhibit **One** contains a sample HIPAA Privacy Business Associate Agreement (see paragraph 8.23). Exhibit **Two** contains the Small Business and Business Owned By Women and Minorities report that is required to be submitted under paragraph 6.6.

1.8 Electronic Data Files and Response Forms

File containing Attachment 1 technical questionnaire you will need to prepare and submit a proposal is posted on the DHRM website <http://www.dhrm.virginia.gov/rfps/rfpmain.html>

2.0 MEDICAL BENEFIT SPECIFICATIONS, TASKS, AND MANDATORY QUALIFICATIONS

2.1 Statewide Medical Plans

The Department is required to offer at least two statewide benefit plans for the state employees program. The Department will continue the self-insured arrangements and the Contractor will provide a voluntary TRICARE supplemental health plan as a fully-insured alternative to existing self-insured and HMO options. If so desired, the Contractor will also provide a basic dental component with the voluntary TRICARE supplemental health plan.

2.2 MANDATORY QUALIFICATIONS FOR OFFERORS

To be awarded a contract, all plans must demonstrate the capability to provide and receive eligibility files in a format required by the Department. Such demonstration will consist of submission and approval of a test file in the format provided to finalists. The timing and other logistics involved with the process will be determined during the proposal evaluation negotiations. The Department will assign, and the Contractor

must comply with the Department's personal identification number requirements. See Appendix 3 for details.

2.3 MEDICAL SURGICAL PLAN CLAIMS PROCESSING

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

2.3.2. Verify eligibility of claimant and period of coverage for every claim processed.

2.4 MEDICAL SURGICAL PLAN EMPLOYEE INQUIRIES

Respond correctly and timely to inquiries received by telephone, by mail, e-mail or in person

2.5 MEDICAL SURGICAL BENEFITS ADMINISTRATION

2.5.1 The Contractor shall check the eligibility of claimants against the eligibility files that will be supplied electronically by the Department.

2.5.2 The Contractor shall develop employee communication materials, which fully and accurately describe, including any companion carve out benefits:

1. the benefits of the program,
2. how the program works,
3. where, how, and when additional information can be obtained,
4. how to access care,
5. what to do in an emergency,
6. how to appeal the determination of the Contractor with respect to a denial of benefits for any reason,
7. employee assistance services available,
8. such other information as would be required to meet the standards of a summary plan description as that term is defined in the Employee Retirement Income Security Act (ERISA).

2.5.3 The Contractor shall provide a legal defense against all claims arising out of this contract.

2.6 MANDATORY QUALIFICATIONS FOR MEDICAL OFFERORS

2.6.1 The plan must offer a toll-free customer service telephone number before the effective date of the contract.

2.6.2 The plan must provide a web site that is available before the effective date of the contract.

3.0 STANDARDS OF PERFORMANCE

3.1 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 on a regular working basis, and in all cases, at least once daily.

3.2 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.

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

3.3 Minimum Enrollment

Average monthly enrollment shall equal or exceed 200 enrolled employees. If average monthly enrollment for a 12 month period, measured at the end of the state employee health program's annual open enrollment period, falls below 200 enrolled employees, the voluntary TRICARE supplemental health program will be discontinued effective the first day of the upcoming plan year. Employees enrolled in the plan will be notified and permitted to make a special open enrollment election for the upcoming plan year and may also continue voluntary TRICARE supplemental health coverage directly with the Contractor.

3.4 Premium Projections

Contractor must provide premium projections for the upcoming plan year no later than the first day of March prior to the July 1 plan year. Premiums cannot be changed during the plan year.

4.0 REPORTS

4.1 Rate Schedule

Offer should submit a rate schedule that includes a breakout of applicable rate components by coverage category and membership level. If a basic dental benefit is included, the rate schedule should break out each class of benefits separately.

4.2 Extended Coverage (COBRA) Transactions

The Contractor will be responsible for Extended Coverage (COBRA) administration for participants of the voluntary TRICARE supplemental health program and will report all changes (adds, deletes) to the previous month's Extended coverage enrollment, and provide a monthly file denoting current Extended Coverage enrollment.

4.3 Annual Accounting and Renewal

On or before February 15, or such date as determined 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 the fiscal year beginning the next July 1. Due to the special enrollment the first year of the contract (anticipated to take place during the fall of 2011), the first annual accounting and renewal, due on or before February 15, will include only operations for the contract to date.

4.4 All Contractors: Utilization of Small Businesses and Businesses Owned by Women and Minorities.

UTILIZATION OF SMALL BUSINESSES AND BUSINESSES OWNED BY WOMEN AND MINORITIES

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.
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 small businesses, women-owned and minority-owned businesses 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

<u>FIRM NAME, ADDRESS AND PHONE NUMBER</u>	<u>TYPE SERVICES</u>	<u>GOODS/ DOLLARS</u>	<u>ACTUAL DOLLARS</u>	<u>PLANNED DOLLARS</u>	<u>%OF TOTAL CONTRACT</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
TOTALS FOR BUSINESS CLASS			_____	_____	_____

4.5 Other Deliverables

4.5.1 The Contractor agrees to furnish and warrants that the premium quoted includes all enrollment materials, benefits booklets, and brochures describing plan benefits, applications, notices, claims forms, checks, remittance advices, 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.

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 submission instructions.

5.2 Submission of Written Proposals

- 5.2.1 All proposals must be in the form requested (See paragraph 6.0 and Attachment 1). 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**, a **Redacted** and six additional copies shall be delivered in a sealed container, and labeled as a proposal, with the words "**Do Not Open**" and **the type of benefit plan enclosed** prominently displayed on the outside. Proposals must be received no later than 2:00 p.m. on April 28, 2011, by:

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

One hard copy of the proposal should be bound in a **loose-leaf notebook**. (The remaining six copies may be submitted electronically.) 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.)

The electronic redacted version must be included on a compact disk labeled "Redacted Proposal OHB11-1" and your "company name". The format of material on disk shall be either .PDF, Microsoft Word, or Microsoft Excel. All information provided in the original version of the proposal shall be included in the "redacted" version with the exception of proprietary and confidential information. Pricing information is not confidential and proprietary.

- 5.2.2 Ownership of all data, materials and documentation originated and prepared for 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 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 that 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
E-mail: 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 Optional Pre-Proposal Conference

An optional pre-proposal conference will be held at 10:00 a.m. April 1, 2011, in the James Monroe Building, Conference Room B, 1st Floor, 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 not a prerequisite to submitting a proposal. 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. Offerors should bring a copy of this RFP to the conference

It is requested that any known questions regarding the RFP be sent by e-mail to Dan Hinderliter prior to date of conference to facilitate the conference. See E-mail address in paragraph 5.5.

5.10 Timetable

RFP Published	March 16, 2011
Optional Pre-Proposal Conference	April 1, 2011
Proposals Due, 2:00 P.M.	April 28, 2011
Notice of Intent to Award	June 1, 2011

6.0 FORM OF RESPONSE AND CRITERIA

General

Each proposal shall be in the form of a loose-leaf binder tabbed to point to each section below. Before the first tab:

- Place the executed RFP Cover Sheet followed by a statement defining those sections of your proposal which may not be released because they are proprietary. Each page so designated shall also be marked "Confidential: Proprietary Information," and, if not so marked, shall not be protected.
- Following the executed Cover Sheet and statement of confidentiality, if any, place a properly

An original proposal, a redacted electronic version and six copies of the original are required. The original shall contain a Cover Sheet bearing an original signature signed in BLUE ink and be labeled on the cover as "Original".

6.1 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.

6.2 Benefits Brochure (Tab 2)

The offeror shall submit a model brochure containing supplemental information for employees to help them understand how the plan works.

6.3 Technical Questionnaire (Tab 3)

Attachment 1 contains the Technical Questionnaire, which constitutes the technical proposal. It must be completed in accordance with the instructions contained in the Questionnaire.

6.4 Cost Proposal (Tab 4)

Tab 4 should include rate schedules which, along with the offeror's latest certified audit report, constitute the cost proposal. Include in this tab (1) a copy of the audited report for the most recently completed fiscal year and a hard copy of the schedules; and (2) a copy of the offeror's most recent SAS 70 audit report. The attachment also contains schedules that provide a firm, fixed price per contract month for the first contract year and a cost summary page.

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

Complete the information required on Exhibit TWO.

6.6 MEDICAL SURGICAL CRITERIA

Proposals will be evaluated on six criteria:

- Offeror's organization and financial stability (15%)
- Qualifications of staff (10%)
- Administrative capability (25%)
- Plan benefits and premium (25%)
- Small, women owned and minority owned businesses (25%).

7.0 GENERAL TERMS AND CONDITIONS

7.1 VENDOR'S MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia Vendor's Manual and any revisions thereto, which are hereby incorporated into this contract in their entirety. A copy of the manual is normally available for review at the Department's office on the 13th floor of the James Monroe Building. In addition, a copy can be obtained from the Department of General Services' Division of Purchases and Supply by calling (804) 786-3842.

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 Contractor shall comply with all applicable federal, state, and local laws, rules, and regulations.

7.3 ANTI-DISCRIMINATION

By submitting their proposals, 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 Section 2.2-4311 of the Virginia Public Procurement Act.

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

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 or national origin, or disabilities, except where religion, sex or national origin 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.
2. The Contractor will include the provisions of 1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each sub contractor or vendor.

7.4 ETHICS IN PUBLIC CONTRACTING

By submitting their proposals, Offerors certify (1) 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 sub contractor in connection with their proposal, and (2) that they have not conferred on or promised, 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, unless consideration of substantially equal or greater value was exchanged.

7.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986

By submitting their proposals, Offerors certify that they do not and will not, during the performance of this contract, employ illegal alien workers or otherwise violate the provisions of 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 proposals for the type of goods 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 the 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

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 Dan Hinderliter in writing no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the Department.

7.10 PAYMENT

1. To Prime Contractor:

- a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payments 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 payments 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.

2. To Subcontractors:

- a. A Contractor awarded a contact 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) day 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.

7.11 PRECEDENCE OF TERMS

Paragraphs 7.1 - 7.10 of these General Terms and Conditions 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 OFFERORS

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services 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 contemplated therein.

7.13 TESTING AND INSPECTION

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

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 one of the following ways:

- 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.
- 2. The Department 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 such things 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 Department 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 Department'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 to 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 Department with all vouchers and records of expenses incurred and savings realized. The Department 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 Department within thirty (30) days from the date of receipt of the written order from the Department. 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 resolve in accordance with the procedures for resolving disputes provided by the Disputes Clause (paragraph 8.12) of this contract and in accordance with the disputes provisions of the Commonwealth of Virginia's Vendor's Manual. Neither the existence of claim or 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 Department 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 bidder or offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded. The bidder or offeror further certifies that the contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

INSURANCE COVERAGES AND LIMITS REQUIRED:

1. Worker's Compensation - Statutory requirements and benefits.
2. Employee Liability - \$100,000
3. Commercial General Liability - \$500,000 combined single limit. Commercial General Liability is to include Premises/Operations Liability, Products and Completed Operations Coverage, and Independent Contractor's Liability or Owner's and Contractor's Protective Liability. The

Commonwealth of Virginia must be named as an additional insured when requiring a Contractor to obtain Commercial General Liability coverage.

7.18 ANNOUNCEMENT OF AWARD

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the Agency's web site, <http://www.dhrm.virginia.gov/rfps/rfpmain.html>, 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 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 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

A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is made to a faith-based organization and an individual, who applies for or received 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, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The 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, and complete the Ariba Commerce Services Network registration.

- a. eVA Basic Vendor Registration Service: \$25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, online registration, and electronic bidding, as they become available.
- b. eVA Premium Vendor Registration Service: \$200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is \$500 per order. 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, and ability to research historical procurement data, as they become available.

- c. Ariba Commerce Services Network Registration. The Ariba Commerce Services Network (ACSN) registration is required and provides the tool used to transmit information electronically between state agencies and vendors. There is no additional fee for this service.

Note: Vendors are strongly encouraged to register your company prior to submitting a bid or offer. Failure to register will result in your bid or offer being found non-responsive and rejected. All vendors must register in both the eVA and the Ariba Commerce Services Network Vendor Registration Systems.

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 Renewal of Contract

The term of this contract is three years with three one-year renewal options. For the one-year renewal options, the contract may renew annually subject to the following.

- 8.2.1 The Contractor shall advise the Department in writing no later than 2:00 PM on the last business day before February 15 that the insurer is willing to renew the contract on the same terms and conditions as currently in force or as modified pursuant to a request from the Department. This advice shall be in the form of a letter of intent to renew the contract.
- 8.2.2 All Contractors require a finding by the Department that the Contractor's performance has been satisfactory. Such findings are within the sole discretion of the Department but will be based on materially important issues including, but not limited to as employee satisfaction, adherence to the Department's administrative requirements and timeliness of deliverables.

8.3 Termination, Suspension and Cancellation of Contract

Either party may terminate this contract for its sole convenience effective July 1 of any year by delivery of written notice no later than the previous February 15.

The Department reserves the right to terminate the contract if average monthly enrollment falls below 200 enrolled employees as referenced in Section 3.7.

Furthermore, in the event of emergency requirements or significant changes in the Contractor's financial or organizational status which could not have reasonably been foreseen, the Department reserves the right to cancel and terminate this contract, in part or in whole without penalty, upon 60 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 and Interest

- 8.4.1 The Department will provide a premium payment sufficient to pay for the coverage of persons determined to be eligible by the Department made to the contractor no later than the tenth business day of the month for which coverage is effective. The premium payment will reflect

appropriate retroactive adjustments. TRICARE eligibility notwithstanding, the Contractor will pay claims or provide services only for persons determined to be eligible by the Department.

8.4.2 The standard form of payment utilized by the Commonwealth is by EDI (See Appendix 4 for description). Unless a different method is agreed upon through negotiations, each Contractor must complete the EDI agreements required by the Department of Accounts.

8.4.3 Retroactive Adjustments

Where the Department discovers an error in enrollment for which the Contractor has no responsibility, Contractor agrees to correct such an error retroactively up to a period of 60 days from the date on which the error is discovered.

8.4.4 COBRA Eligibles and Non-Medicare Retirees

For all state employee groups, contractor agrees to track eligibility and bill Extended Coverage (COBRA) enrollees designated by the Department for premiums. Insured plans shall submit a listing of any status changes to these enrollees during each month to the Department by the 15th of the following month reflecting changes by date and identified by social security number.

Contractor will administer COBRA for Non-Medicare Retirees and will also direct-bill any Non-Medicare Retirees whose pension payment cannot support a premium deduction for voluntary TRICARE supplemental health program coverage.

8.4.5 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. Payment will be made by the Department within 30 days of receipt of an approved invoice by the Commonwealth's EDI payment method.

8.5 Premiums

The Offerors shall propose premiums using the format referenced in paragraphs 4.1. All rate projections should include a surcharge of 2% to recognize the cost of the Department's administration of the program.

8.5.1 Insured plans shall establish premiums in accordance with their own procedures. Notice of any change in premiums shall be accomplished using the format referenced in subparagraph 1 of paragraph 4.1. Premiums cannot be changed during the plan year.

All insured plans will be paid 98% of the agreed upon premium.

8.6 Audits

Some standards of performance under this contract may be measured by audits.

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.

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.

8.7 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.

The Contractor shall provide the full name and address of their contract representative including telephone and fax number. In the event of a change in contract representatives, an official written notice shall be provided within 15 days of the change.

8.8 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.

8.9 Confidentiality of Information

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.

8.10 Commissions and Brokerage Fees

The Contractor agrees that, in the performance of this contract, no payments shall be made to brokers or sales persons who are not employees of the Contractor.

8.11 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.

8.12 Eligibility

The Department shall determine who is eligible for the state employee health benefits program. Only employees, non-Medicare retirees and their dependents eligible for the state employee health benefits program will be eligible to elect the voluntary TRICARE supplemental health plan. Changes in coverage will be permitted in compliance with the Department's Section 125 cafeteria plan at annual open enrollment or due to a qualifying mid-year event (QME).

The Contractor shall, on its own, determine that the TRICARE supplement's eligibility matches the eligibility requirements of the state plan. Contractor will immediately notify the Department of any employees, non-Medicare retirees and/or dependents who do not meet eligibility criteria of the TRICARE supplement or the state health program.

8.13 Employer Contributions Toward Premiums

By law, there will be no employer contribution for TRICARE supplemental health coverage on behalf of employees who elect such coverage.

8.14 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.

8.15 Internet Site

Contractor agrees to maintain an Internet site with a section or page devoted exclusively to Commonwealth of Virginia enrollees covered under the voluntary TRICARE supplement health plan. At a minimum, the site shall contain the following.

8.15.1 the data specified in paragraph 6.3.

8.15.1 an outline of coverage

8.15.2 other information about the plan

8.16 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.

8.17 Disputes

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 2.2-436411-70 of the Code of Virginia. The Contractor shall not be granted relief as a result of any delay in the Department's decision.

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

8.18 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, sub Contractor or

agents of the Contractor.

8.19 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.

8.20 Advertising

In the event a contract is awarded as a result of this RFP, the Contractor shall not advertise in writing or orally that the Commonwealth of Virginia, or any agency or institution of the Commonwealth, has purchased, or uses its products or services. Non-compliance with this provision shall be considered grounds for termination of the contract.

8.21 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.

8.22 Annual Enrollment

The Department will provide employees an annual opportunity to change health benefits plans or types of membership. Contractor agrees to follow all instructions of the Department with respect to the conduct of the annual enrollment, including and especially the form and content of information supplied to eligible persons. The Contractor agrees to supply to agencies sufficient quantities of benefits booklets and brochures for the orderly conduct of annual enrollment activities. Annual enrollment expenses are the responsibility of the Contractor and are to be absorbed in its administrative costs. There will be no special recognition of annual enrollment expenses without the prior agreement of the Department.

8.23 HIPAA Privacy Business Associates Agreement

The Contractor agrees to be bound by the HIPAA Privacy Business Associates Agreement. This agreement must be executed prior to any contract award. See Exhibit ONE.

8.25 Mailings and Notices

Contractor agrees to notify extended coverage enrollees and non-Medicare retirees annually in a form acceptable to the Department of changes in premiums and benefits or other contract amendments in a form acceptable to the Department. All notices shall be mailed first class. Contractor agrees to supply group administrators with all necessary forms and supplies.

Contractor will strictly limit the content and form of mailings and notices, other than premium bills and claims related transactions, to the benefits booklet and brochure cited in paragraphs 6.2 and 6.3 and an approved cover letter. Benefits booklets and brochures shall be printed in black ink on plain white paper, grade number 3, 50 pound offset, without any illustrations except graphs to illustrate HEDIS data. Under no circumstances will any communication of the contractor, written or verbal, compare its cost, benefits or performance with that of another plan in the employee health benefits program. The logo of the Department and the title of the document shall be featured prominently on the first page of each document.

Any and all communications to employees, non-Medicare retirees and and/or dependents, whether

written, oral or electronic, shall be approved by the Department prior to distribution or mailing.

8.26 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.

1. All personal information whether electronic or hard copy shall be stored in a manner that will prevent intrusion by unauthorized persons.
2. All intrusions or suspicion of intrusion into secured files containing personal information shall be reported to the Agency within 24 hours of detection.
3. All remedies suggested by the Contractor shall be approved by the Agency prior to being implemented.

Exhibit One

Group Health Plan Business Associate Agreement

This agreement ("Agreement") is effective as of _____ 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, 3003.

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: _____

Exhibit Two

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.virginia.gov (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: _____

Section B

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement

Small Business Name & Address DMBE Certificate #	Status if Small Business is also: Women (W), Minority (M)	Contact Person, Telephone & Email	Type of Goods and/or Services	Planned Involvement During Initial Period of the Contract	Planned Contract Dollars During Initial Period of the Contract
Totals \$					

List of Appendices

- Appendix 1 Current Standard Contract
- Appendix 2 Summary Description of All Commonwealth of Virginia Plans Offered
- Appendix 3 State Employee Membership and Billing System
- Appendix 4 EDI

Appendix 1

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

STANDARD CONTRACT

This contract is entered into _____, 2011, by _____, 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, inconsideration of the mutual covenants, promises and agreements herein contained, agree as follows:

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

PERIOD OF CONTRACT:

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; proposal submitted by the contractor dated _____, _____; the general conditions, special 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.

CONTRACTOR:

PURCHASING AGENCY:

BY: _____

By: _____

Print Name

Print Name

Title: _____

Title: _____

Date: _____

Date: _____

Appendix 2

Summary Description of All Commonwealth of Virginia Plans Offered

Please access the web addresses shown for summary benefit descriptions of plans

COVACare:

<http://www.dhrm.virginia.gov/hbenefits/cova/covacare.html>

COVA Connect:

<http://www.dhrm.virginia.gov/hbenefits/cova/covaconnect.html>

COVA HDHP:

<http://www.dhrm.virginia.gov/hbenefits/cova/hdhptoc.html>

click on “Plan Summary of Benefits”

Appendix 3

State Employee Membership and Billing System

A. Benefits Eligibility System

The Department maintains a central, sole source eligibility and enrollment database known as the Benefits Eligibility System (BES). BES contains records for State Program participants and their covered dependents. Participants include all employees, retirees, long-term disability participants, and survivors eligible for coverage under the State Program. Participant records are identified by a personal identification number which is not a social security number.

The Department provides the contractor with eligibility 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.html>). The 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. It is expected that the contractor comply with the Department's eligibility file processing requirements and update their database on a current basis to provide for accurate claims processing.

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 database and the contractor's database. The contractor reports discrepancies found in the comparison to the Department no later than the 20th of that month.

B. 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 (Section 4.0 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 employee and the TLC 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.

The 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.

C. Billing for Fully Insured Plans

The Department makes monthly premium payments to all fully insured carriers through a self-billing procedure based on the BES records as of the first day of each month of coverage. The self-billing process is run on the 5th working day of each month of coverage based on all first day eligibles and takes into consideration any retroactive changes. The self-billing file includes all eligibles for a contractor shown by agency and premiums due. The file is transferred electronically to the carrier and at the same time generates the request for payment. An EDI transfer around the 10th working day of each month makes payments. (See Appendix for a description of the Commonwealth's EDI payment system and forms required to be completed)

Appendix 4

Electronic Data Exchange (EDI)

All payments to Contractors will be made by EDI. The Financial Handbook and forms to be completed are found at the Web location below:

http://www.doa.virginia.gov/General_Accounting/EDI/tradingpartnerguide.pdf

ATTACHMENT 1

TECHNICAL QUESTIONNAIRE

Respond concisely but in detail to the questions below. Where ancillary materials are requested or provided, please so note in your response indicating where those materials may be found.

1. Please confirm that the plan you are offering is a fully insured plan and that there is no liability for claim payment or other charges on behalf of the Commonwealth of Virginia.
2. Please confirm that all employees, retirees and dependents determined to be eligible by the Department of Human Resource Management, and determined to be eligible under TRICARE criteria, will be covered with no waiting period or pre-existing provisions.
3. Please confirm that you understand that all premiums collected by the Commonwealth for active employees will be on a pre-tax basis, and non tax qualified dependents therefore may not be covered under the plan.
4. Please confirm that all employees are charged the same premium based on membership and there is not premium differential based on age, gender or health status.
5. Please confirm that all vendor administrative fees, including costs for Extended Coverage (COBRA) administration and direct-billing where required, are included in the employee premium.
6. Describe your process for administration of Extended Coverage (COBRA), including billing and eligibility requirements, required notices, termination of coverage, etc. This should include coverage provisions for individuals who are no longer eligible for either the state program or TRICARE.
7. Please confirm that the supplement you offer meets the requirements of creditable coverage under HIPAA and that you will send out Certificates of Credible Coverage as required under HIPAA upon a member's termination from the plan.
8. Describe how you will handle the differences between TRICARE and PPACA for eligibility for adult children to age 26.
9. Please confirm that the supplement you are offering is filed with the Commonwealth of Virginia Bureau of Insurance such that it permits you to restrict coverage to only those individuals determined to be eligible under the state employee health program.
10. Is the supplement you are offering offered to the general public on either a group or community rated basis? If so, describe.
11. Explain your relationship with any insurance underwriters. Describe the organizational structure, including employment relationships, contractual agreements, compensation, etc. between your organization and the insurance underwriter. Please include an organizational chart.

12. Please confirm that you will be responsible for all communication material, written, electronic and oral, used in marketing the plan. Provide examples.
13. Describe and provide examples of how aggregate claim information used to determine premiums will be provided.
14. Please confirm that you can accommodate a daily electronic 834 file placed in an FTP secure folder and that you can retrieve and upload that file to your claim system within 24 hours. Confirm that you can accommodate enrollment and disenrollment in a timely manner based on the Commonwealth's annual open enrollment and mid-year qualifying events.
15. Describe and provide examples of reports routinely provided for enrollment, disenrollment, coverage changes, audit, billing, COBRA administration, etc.
16. Do TRICARE supplemental providers submit claims on behalf of their patients?
17. Are members provided an Explanation of Benefits (EOB) upon adjudication and payment of a claim? Provide examples. Are EOBs, if provided, available on an electronic basis?
18. Describe your organization's internal processes to receive, date and control a claim within 24 hours of the date received. If not handled within 24 hours, provide a timeline for claim handling.
19. Describe your claim payment process, including processes and guidelines for payment to providers and payment to members.
20. Please confirm that you have a fully equipped and operational customer service unit. Describe such unit, including an organizational chart.
21. Describe your organization's processes to respond correctly and timely to inquiries received by telephone, by mail, by email or in person, including response time for each.
22. Describe your organization's efforts to measure patient satisfaction with the program including samples of surveys, response rate and rating of overall satisfaction with the program.
23. Is there an appeals process for claim or eligibility denials? If so, describe. If not, why not?
24. Does your organization provide an internet site with a section or page devoted to enrollees covered under this program? If so, please describe in detail, and provide screen prints of such a site and pages.
25. Do you provide an on-line directory or hard-copy directory of providers to employees interested in enrolling in the plan?

26. Describe your organization's process to participate as requested by the Department in benefits fairs and wellness activities coordinated through CommonHealth or through the Department.

27. Given the initial contract period of September 1, 2011 through June 30, 2014 what is the total value of your contract proposal?