

**PLEASE PRINT CLEARLY OR TYPE**

STATE OF NORTH CAROLINA

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS

COUNTY OF (1) DURHAM

(2) Blue Cross and Blue Shield of North Carolina )  
 )  
 )  
(your name) PETITIONER, )  
 )  
 )  
 )  
 )  
(3) North Carolina State Health Plan for Teachers and State Employees )  
 )  
 )  
 )  
 )  
 )  
 )  
 )  
(The State agency or board about which you are complaining) )

**PETITION  
FOR A  
CONTESTED CASE HEARING**

I hereby ask for a contested case hearing as provided for by North Carolina General Statute § 150B-23 because the Respondent has:

(Briefly state facts showing how you believe you have been harmed by the State agency or board.)

Please see Attachment A.

(4) Amount in controversy \$                                  (if applicable)  
(If more space is needed, attach additional pages.)

(5) Because of these facts, the State agency or board has: (check at least one from each column)

<u>      </u> deprived me of property;	<u>      </u> exceeded its authority or jurisdiction;
<u>      </u> ordered me to pay a fine or civil penalty; or	<u>  x  </u> acted erroneously;
<u>  x  </u> otherwise substantially prejudiced my rights;	<u>  x  </u> failed to use proper procedure;
<b>AND</b>	<u>  x  </u> acted arbitrarily or capriciously; or
	<u>  x  </u> failed to act as required by law or rule.

(6) Date: February 16, 2023 (7) Your phone number: ( 919 ) 239-2600

(8) Print your full address: Robinson, Bradshaw & Hinson, P.A., 434 Fayetteville Street, Suite 1600, Raleigh, North Carolina 27601

(street address/p.o. box) (city) (state) (zip)

(9) Print your name: Stephen D. Feldman

(10) Your signature: Feldman, Stephen

Digitally signed by Stephen D. Feldman  
DN: cn = Stephen D. Feldman, email = SFeldman@adnh.ncdohearing.com, o = ADNHearings, Employees  
Date: 2023.02.16 09:01:01 -04'00'

**You must** mail or deliver a **COPY** of this Petition to the State agency or board named on line (3) of this form. You should contact the agency or board to determine the name of the person to be served.

**CERTIFICATE OF SERVICE**

I certify that this Petition has been served on the State agency or board named below by depositing a copy of it with the United States Postal Service with sufficient postage affixed **OR** by delivering it to the named agency or board:

(11) <u>J. Benjamin Garner, Esq., designated agent for service of process</u> (name of person served)	(12) <u>North Carolina State Health Plan for Teachers and State Employees</u> (State agency or board listed on line 3)
(13) <u>3200 Atlantic Avenue</u> (street address/p.o. box)	<u>Raleigh North Carolina 27601</u> (city) (state) (zip code)

(14) This the 16th day of February, 2023.

(15) /s/ Stephen D. Feldman  
(your signature)

When you have completed this form, you **MUST** mail or deliver the **ORIGINAL** to the Office of Administrative Hearings, 1711 New Hope Church Road, Raleigh, NC 27609.

**This box for OAH use only.**

Amount Paid \$\_\_\_\_\_

☐ Cash – receipt number \_\_\_\_\_

☐ Money Order ☐ Certified Check ☐ Attorney Trust Account

Check number \_\_\_\_\_

☐ Indigent (must complete form HOI )

☐ Mandated federal cause of action

**Received by:** \_\_\_\_\_

# **ATTACHMENT A**

STATE OF NORTH CAROLINA  
DURHAM COUNTY

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
23 INS \_\_\_\_\_

BLUE CROSS AND BLUE SHIELD )  
OF NORTH CAROLINA, )  
 )  
Petitioner, )  
 )  
v. )  
 )  
NORTH CAROLINA STATE )  
HEALTH PLAN FOR )  
TEACHERS AND STATE )  
EMPLOYEES )  
 )  
Respondent. )

PETITION FOR  
CONTESTED-CASE  
HEARING

Pursuant to N.C. Gen. Stat. § 150B-23, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) requests a contested-case hearing on the decision of the North Carolina State Health Plan for Teachers and State Employees (the Plan) to award Aetna Life Insurance Company (Aetna) the Plan's 2025-2027 contract for third-party-administrator (TPA) services.

Blue Cross NC made the lowest-cost proposal for this contract. It also offered the Plan's members the most comprehensive network of providers. Despite those facts, the Plan awarded the contract to Aetna instead of Blue Cross NC. The Plan made that award by applying arbitrary criteria, by failing to gather and consider critical information, and by using a distorted scoring system. Because of those flaws, the process that led to this award was an improper procedure, and the Plan's award to Aetna was erroneous, arbitrary, and capricious. Blue Cross NC was substantially prejudiced as a result.

Blue Cross NC submits this petition based on the limited information available to it now. Blue Cross NC reserves the right to amend this petition after it receives further information.

In support of its petition, Blue Cross NC states as follows:

1. Blue Cross NC is a fully taxed, not-for-profit North Carolina corporation. Its mission is to support health care in North Carolina. Its principal place of business is in Durham, and it employs nearly 5,000 North Carolinians. Blue Cross NC has served as the Plan's TPA for about 35 years.
2. The Plan is an agency created by N.C. Gen. Stat. § 135-48.2 and governed by article 3B of chapter 135 of the North Carolina General Statutes. It provides health care coverage to hundreds of thousands of North Carolina teachers, state employees, retirees, and their dependents.
3. This petition is timely. *See* N.C. Gen. Stat. § 150B-23(f). After the Plan told Blue Cross NC that the Plan had awarded the RFP to Aetna, Blue Cross NC exhausted its administrative remedy—a remedy provided expressly in the Plan's Request for Proposal (RFP)—by making a written request for a protest meeting with the Plan within 30 days of the award. The Plan denied Blue Cross NC's request on January 20, 2023.
4. Blue Cross NC is a person aggrieved under N.C. Gen. Stat. § 150B-2(6) because it has been directly and substantially affected by the conduct alleged in this petition. Blue Cross NC is therefore entitled to commence this contested case under article 3 of chapter 150B.

5. The proper venue for this contested case is Durham County, Blue Cross NC's principal place of business. *See* N.C. Gen. Stat. § 150B-24(a)(1).

### **BACKGROUND**

6. The Plan issued the RFP on August 30, 2022. *See* Exhibit 1. The RFP sought proposals for a contract to administer the Plan's health insurance program by assembling a network of providers, negotiating discounts with those providers, processing claims, and administering other services.

7. The RFP set a deadline of September 26, 2022, for responses to certain minimum requirements. These included minimum requirements for the network of health care providers that each vendor would make available to Plan members.

8. Except for applying this minimum requirement, the Plan did not evaluate any vendor's provider network. It did not, for example, evaluate how many providers in the Plan's current Blue Cross NC network would not be included in Aetna's network. Nor did the Plan evaluate how many members would be forced to change providers because of differences in the networks offered by Blue Cross NC and Aetna.

9. Three vendors met the RFP's minimum requirements: Blue Cross NC, Aetna, and a unit of United Healthcare. Each of these vendors then submitted a proposal on November 7, 2022, that answered more questions posed in the RFP.

10. The Plan divided those further questions into two categories: (1) cost and (2) technical requirements. The RFP stated that each vendor's final score would weight these two categories equally.

### **Cost Proposal**

11. On cost, the RFP required each vendor to submit information in three areas.

12. First, the RFP asked each vendor to reprice a set of claims data that the Plan provided. That data represented actual medical claims paid on behalf of the Plan's members during one calendar year. Each vendor was asked to calculate the total cost of those claims for the 2025-2027 period, using the vendor's negotiated prices with providers.

13. Second, the RFP asked each vendor for a proposal on the administrative fees that the vendor would charge the Plan.

14. Third, the RFP asked each vendor for a proposal on network-pricing guarantees. This proposal had multiple components:

- a. Each vendor had to state a percentage discount (from providers' undiscounted prices) that the vendor would guarantee it would achieve in the aggregate for each year of the contract.
- b. Each vendor had to state a "trend" percentage (a measure of health care price inflation) that the vendor would guarantee not to exceed in the later years of the contract.
- c. Each vendor had to state maximum percentages by which its network prices (in various categories) would exceed the rates that the federal government would set in the future for similar services to Medicare recipients.

- d. For each of the above guarantees, each vendor had to say how much money it would refund to the Plan if the vendor did not meet that guarantee for a given year.

15. The RFP stated that the Plan would decide the “value” of each vendor’s guarantee proposal “based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.”

16. The RFP assigned points for each of the three cost components (network pricing, administrative fees, and network-pricing guarantees).

17. On network pricing, the RFP stated that the proposal that offered the lowest network pricing would be ranked highest and would receive six points. Other proposals would receive points based on how close they were to the lowest-priced proposal. The RFP stated:

*All other proposals will be ranked and will receive points based on the following criteria: within 0.5% of the first ranked proposal = 6 points; within 1.0% = 5 points; within 1.5% = 4 points; within 2.0% = 3 points; within 2.5% = 2 points; within 3.0% = 1 point, greater than 3.0% = 0 points.*

18. On administrative fees, the RFP stated that the lowest-cost proposal would receive two points. The remaining proposals would receive zero or one point:

*All other proposals will be ranked and may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals.*

19. The RFP did not state any criteria for deciding whether a vendor that did not quote the lowest administrative fees would get one point or zero points.



20. On network-pricing guarantees, the RFP stated that the vendor that offered network-pricing guarantees “with the greatest value” would receive two points. The remaining proposals would receive zero or one point:

*All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.*

21. As with administrative fees, the RFP did not state any criteria for deciding whether a vendor that did not offer the network-pricing guarantees “with the greatest value” would get one point or zero points.

### **Cost-Proposal Scoring Results**

22. The Plan determined that Blue Cross NC’s and Aetna’s network-pricing proposals were the lowest proposals and were within 0.5% of each other, so the Plan gave Blue Cross NC and Aetna six points each for the repricing exercise.

23. Blue Cross NC bid the lowest administrative fees, so it received two points for this cost element.

24. By the Plan’s own calculations, Blue Cross NC offered the lowest-cost proposal of any vendor. The Plan’s records show the following combination of the vendors’ network pricing and administrative fees for the three-year term of the contract:

<b>Total Costs Proposed for 2025-2027 (rounded to the nearest \$100,000)</b>					
	<b>2025</b>	<b>2026</b>	<b>2027</b>	<b>Total</b>	<b>Difference from low bid</b>
<b>Blue Cross NC</b>	\$3,102,600,000	\$3,298,700,000	\$3,486,800,000	\$9,888,100,000	Low bid
<b>Aetna</b>	\$3,133,100,000	\$3,307,800,000	\$3,491,900,000	\$9,932,800,000	\$44,700,000
<b>United</b>	\$3,172,300,000	\$3,363,200,000	\$3,550,200,000	\$10,085,700,000	\$197,600,000

25. As shown above, Blue Cross NC’s total cost proposal was \$44.7 million lower than Aetna’s total cost proposal over the three-year term of the contract.

26. Despite the fact that Blue Cross NC bid the lowest overall cost to the Plan, it received the same total cost score as Aetna. As shown below, that tie score resulted from the RFP’s flawed scoring method for network-pricing guarantees.

27. The Plan awarded Blue Cross NC zero points for its network-pricing-guarantee proposal. Blue Cross NC therefore received a total cost score of eight points: six points on network pricing, two points on administrative fees, and zero points on network-pricing guarantees.

28. In addition to the six points Aetna received for its network-pricing proposal, Aetna received one point for its administrative fees and one point for its

network-pricing guarantees. Aetna therefore received a total cost score of eight points, tied with Blue Cross NC.

29. United received five points for its network-pricing proposal, zero points for its administrative-fee proposal, and two points for its network-pricing-guarantee proposal. United therefore received a total cost score of seven points.

### **Technical Proposal**

30. On technical matters, the RFP required each vendor to give a yes-or-no answer on each of 310 requirements.

31. The Plan explicitly refused to receive any additional information that a vendor had on any technical requirement. The Plan did not allow any explanations, clarifications, or context on any vendor's capabilities or limitations. Each vendor could only answer "confirm" or "does not confirm."

32. The Plan's refusal to gather any explanation of each vendor's technical capabilities departed from the Plan's most recent RFP (in 2019) for TPA services. It also departed from every other RFP that the Plan has issued for these services in the past.

33. The RFP used a point system to score technical proposals. Under that scoring system, a vendor received one point for each yes ("confirm") answer and zero points for each no ("does not confirm") answer.

34. That scoring system meant that the Plan weighed each technical requirement the same, even though the requirements varied significantly in their importance to the Plan and its members.

35. Blue Cross NC said yes (“confirm”) to 303 of the 310 technical requirements.

36. Blue Cross NC had good reasons for not confirming the remaining seven requirements. Blue Cross NC studied the wording of these seven technical requirements and, for each, concluded that the requirement as phrased was technically impossible or not in the Plan’s best interest for any vendor to provide. Paragraphs 85 through 106 below discuss the problems with these seven technical requirements.

37. Aetna and United received 310 points each for their technical proposals. Blue Cross NC received 303 points.

#### **Blue Cross NC’s Request for a Bid-Protest Meeting**

38. The RFP contained an administrative remedy: If a losing vendor wanted to protest the award, that vendor had to make a written request for a protest meeting with the Plan. The RFP set a deadline for that written request: 30 calendar days from the date that the Plan issued its award.

39. The Plan awarded the TPA contract to Aetna on December 14, 2022.

40. On January 12, 2023, Blue Cross NC submitted to the Plan a timely and detailed written request for a protest meeting.

41. On January 20, 2023, the Plan sent Blue Cross NC a letter denying the meeting request. The letter asserted that “a meeting to further discuss [Blue Cross NC’s] protest of the award would serve no purpose.”

42. Blue Cross NC is filing this petition for a contested-case hearing within 60 days of the Plan's decision to deny Blue Cross NC's request for a protest meeting. This petition is therefore timely. *See* N.C. Gen. Stat. § 150B-23(f).

### **CONTESTED ACTIONS OF THE PLAN**

43. Blue Cross NC challenges the Plan's award of the TPA contract to Aetna. The Plan made that award based on an improper procedure, including arbitrary and capricious criteria and scoring. Those flaws, described below, produced an award that was erroneous, arbitrary, and capricious. The RFP process slighted the central interest of the Plan's members: broad access to high-quality health care. It also slighted the Plan's interest in securing that care at the lowest cost.

44. Blue Cross NC again notes that it is asserting the grounds listed in this petition based on the limited information now available to it. Blue Cross NC reserves its right to assert additional grounds, and to amend this petition, based on its pending public-records requests to the Plan, discovery in this contested case, and other developments.

### **Failure to Score Each Vendor's Network**

45. For Plan members, a critical feature of the Plan is its network of health care providers. The Plan's TPA creates that network. If the network does not have enough high-quality providers, the Plan's members will wait longer and pay more for needed health care services.

46. Despite how important the Plan’s provider network is to members, the RFP’s scoring system did not score the vendors’ provider networks. By treating the networks as only a minimum requirement, the RFP judged the networks on only a pass-fail basis.

47. Through that pass-fail approach, the RFP treated Blue Cross NC’s and Aetna’s networks as equivalent when, in fact, they are not equivalent at all. On information and belief, Blue Cross NC has significantly more provider locations than Aetna has in North Carolina overall. It also has more providers than Aetna has in almost every county in North Carolina.

48. The Plan admits that it did not compare the provider networks offered by Blue Cross NC and Aetna during the RFP process. In a document released on February 7, 2023, the Plan stated that Aetna “has 18 months to sign up willing and capable providers.”

49. Instead of comparing Blue Cross NC’s and Aetna’s networks during the RFP process, the Plan is relying on the mere hope that Aetna can improve its network before it takes over as the Plan’s TPA.

50. The RFP’s scoring system also assigned no points to whether the Plan’s choice of a vendor would cause disruption to Plan members—for example, by forcing them to change providers.

51. By failing to assign any points to this crucial factor, the Plan contradicted the RFP, which stated that the Plan sought a vendor that provided “a broad provider network with the least disruption.” Those words rang hollow: The

scoring system did not score the vendors' networks or measure disruption to the Plan's members.

52. Issuing the award to Aetna without scoring the vendors' networks of providers, and without accounting for the disruption that the award would cause, was erroneous, arbitrary, and capricious.

### **Failure to Validate Network-Pricing Proposals**

53. Even when the RFP's scoring process did assign scores, it assigned those scores in a flawed way.

54. As alleged above, on cost proposals, the Plan assigned points to vendors in three areas: network pricing, administrative fees, and network-pricing guarantees.

55. For network pricing, the RFP gave each vendor a data file with the same set of claims data. That claims data covered one calendar year. Each vendor then had to tell the Plan how much the Plan (and, through cost sharing, its members) would pay for the health care services described in the claims data. For these network-pricing proposals, vendors were instructed as follows:

*Using the repricing file referenced above, Vendors are to provide the contracted allowed amount for each service in the file. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.*

56. During the evaluation of each vendor's network-pricing proposal, the Plan did not test the accuracy of any vendor's self-reported pricing or discounts. For

example, the Plan could have cross-checked the self-reported discounts against market data. The Plan did not do so.

57. That choice had significant consequences. On information and belief, available data shows that Aetna's network pricing in North Carolina is higher than Blue Cross NC's pricing.

58. Because the Plan did not validate the accuracy of Aetna's network-pricing proposal, the Plan made a significant scoring error: It gave Aetna and Blue Cross NC the same number of points—six—on network pricing.

59. On information and belief, if the Plan had tested the accuracy of the pricing proposals, it would have awarded Blue Cross NC more points than Aetna in the network-pricing category.

### **Scoring of Administrative Fees and Network-Pricing Guarantees**

60. The RFP's weights and scoring methods for the other two cost-proposal sections—administrative fees and network-pricing guarantees—were equally infirm.

61. For example, the RFP assigned the same scoring weight to the proposals for administrative fees and network-pricing-guarantees. Each of these proposals could earn up to two points.

62. That equal weighting was irrational, arbitrary, and capricious. Administrative fees are actual costs to the Plan. Network-pricing guarantees, in contrast, are conditional rebates of part of a TPA vendor's administrative fees—rebates that would be made only if a vendor did not meet its pricing commitments.



63. There is no rational basis for the RFP to assign the same number of points to partial, conditional rebates (network-pricing guarantees) that it assigns to actual costs (administrative fees). A network-pricing guarantee is relevant only if the Plan's TPA does not meet its promised pricing. Under the existing TPA contract between Blue Cross NC and the Plan, Blue Cross NC has consistently met its contracted discount levels.

64. Had the administrative-fee element received more weight than the network-pricing-guarantee element, Blue Cross NC's overall cost proposal would have been ranked highest of any vendor. Blue Cross NC was the only vendor to receive the full number of points available for administrative fees, but Blue Cross NC and Aetna received the same total cost points. Thus, if the RFP had weighted administrative fees more heavily than network-pricing guarantees, Blue Cross NC would have received more total cost points than any other vendor.

65. The RFP compounded the problems from its illogical scoring method by using vague standards to score the administrative-fee proposals and network-pricing guarantees.

66. On administrative fees, the RFP stated that the proposals that did not rank the highest "may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals." The RFP did not explain how the Plan would decide whether to award one or zero points to a given proposal.

67. On network-pricing guarantees, the RFP stated that the “proposal that offers the network pricing guarantee with the greatest value will be ranked the highest” and will receive two points.

68. In this statement, the crucial term “greatest value” is undefined.

69. The RFP also stated that a vendor that does not provide the “greatest value” through its network-pricing guarantee “may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.”

70. This statement is even vaguer than the prior statement. The term “value” remains undefined. And the RFP again does not say how the Plan would decide whether to award one or zero points to a given proposal.

71. These vague standards had pivotal consequences.

72. The Plan awarded Blue Cross NC zero points for its network-pricing guarantees. That score was pivotal. Blue Cross NC received the highest possible score for its network pricing and its administrative fees. Thus, if the Plan had awarded Blue Cross NC even one point on network-pricing guarantees, Blue Cross NC’s overall cost proposal would have been ranked the highest.

73. As these points show, the RFP’s weights and scoring methods for administrative fees and network-pricing guarantees were an improper procedure. Those weights and scoring methods led to an arbitrary, capricious, and erroneous award.

### **Scoring of Technical Proposals**

74. The RFP’s scoring of technical proposals is at least as flawed as its scoring of cost proposals.

75. The scoring system for technical requirements presumed that all of the 310 technical requirements deserve equal weight. They do not.

76. Technical requirements central to the proper functioning of the Plan’s TPA—such as a vendor’s experience with care models designed to reduce costs, or a vendor’s ability to provide services to members who have an urgent medical need while traveling—are far more important than minor administrative matters, such as a vendor’s ability to display the name of a member’s employer in the vendor’s online portal or a vendor’s provision of online chat groups. Despite these differences in importance, the RFP’s scoring method assigned equal weight to these issues and all others.

77. In addition, the RFP did not ask any vendor about its capabilities, ideas, conditions, or limitations on any technical issue. The RFP stated that “[u]nder no circumstances will narrative or text from Vendor be accepted as a response.”

78. The Plan compounded the lack of technical information from vendors by declining to meet with any vendor to discuss the details of its proposal, even though the RFP allowed the Plan to do so.

79. The Plan scored the vendors’ technical proposals by assigning one point to each “yes” answer and assigning zero points to each “no” answer.

80. Through this scoring method, the RFP prioritized rote adherence to the Plan's demands, even if those demands were impossible or counterproductive. Rote adherence is what the Plan got in response: Aetna and United "confirmed" their ability to meet each requirement as stated. On information and belief, they did so even if there were limits on their ability to satisfy some of those requirements in the future.

81. The Plan made no effort to validate or confirm whether any vendor actually had the ability to meet the technical requirements. Instead, it relied solely on untested "yes" responses. When it rejected Blue Cross NC's request for a protest meeting, the Plan stated that "[i]f Aetna was untruthful when it confirmed its ability to meet all the Plan's requirements, then the Plan will discover this during the next two years of implementation and during the term of the third-party services contract." Through this statement, the Plan has conceded that it was willing to accept "yes" answers on faith and to sort out implementation issues and failures down the road, after the contract has already been awarded.

82. When Blue Cross NC made its technical proposal, it paid careful attention to the wording of each technical requirement. Blue Cross NC truthfully did not confirm the seven requirements that it could not confirm without additional discussion.

83. The RFP penalized this attention to detail. Blue Cross NC received zero points for these seven responses. During a debriefing meeting two days after

the award to Aetna was announced, Plan officials told Blue Cross NC that it did not win the award because of those seven responses.

84. That scoring and decision-making method has no sound basis. By refusing to consider any explanation for Blue Cross NC's responses, the Plan made an uninformed decision—one at odds with the due diligence required in a decision of this magnitude.

85. Had the RFP allowed Blue Cross NC to submit narrative explanations with its answers, those explanations would have shown the legitimate reasons why Blue Cross NC did not confirm seven technical requirements.

86. For example, Requirement 5.2.3.2(b)(iii) of the RFP asked vendors to confirm the following: "Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States."

87. Blue Cross NC did not confirm this condition for good reason. On rare occasions, out-of-state providers provide care to Plan members without first getting prior authorization for that care. Under the terms of contracts between affiliates of Blue Cross NC and these out-of-state providers, the provider is not charged a penalty for providing this care. Blue Cross NC therefore could not accurately state that the exact same utilization-management and payment rules would apply to every single provider across the country.

88. In addition, requiring mechanical sameness across all providers is not in the best interest of the Plan or its members. Rigid enforcement of a prior-

authorization requirement could prevent Plan members from receiving necessary medical care.

89. That rigid enforcement also would not produce any cost savings or other benefits for the Plan, for several reasons.

90. First, the waiver of these penalties is rare. In over 99% of cases, these out-of-state providers get prior authorization. Even so, the absolute phrasing of this requirement, combined with the yes-or-no format of the RFP, prevented Blue Cross NC from confirming this requirement as stated.

91. Second, in virtually all cases, the provider that cares for a Plan member without prior authorization would have received that authorization had it sought it. Thus, mechanically enforcing a requirement of prior authorization would deny treatment to Plan members over a technicality that has no ultimate effect on Plan or member costs.

92. Third, this lack of absolute sameness across the country is a necessary result of having out-of-state providers in the Blue Cross Blue Shield network that Blue Cross NC makes available—a network that provides significant benefits to Plan members.

93. Fourth, on information and belief, the out-of-state providers at issue demand similar penalty waivers from all TPAs, including Aetna. It is therefore unlikely that Aetna can comply with the absolute-sameness requirement stated in the RFP.

94. Requirement 5.2.7.2(b)(xxiv) of the RFP asked vendors to confirm the following: “Vendor’s member portal will accept and display Member-specific information from the other systems and Vendor’s health team, including . . . Electronic medical and health records, Disease Management Nurse notes, Case Management notes, [and] Health Coach notes . . . .”

95. These requirements—four of the seven technical requirements not confirmed by Blue Cross NC—are not technically feasible or not in the best interest of the Plan’s members.

96. Blue Cross NC’s member portal does not allow it to display electronic medical records (EMRs) from a provider. Providers have different and widely varying EMR systems, so displaying EMRs on a member’s portal would require a universal platform that is compatible with each provider’s system. Blue Cross NC is not aware of any TPA that can offer this feature.

97. In addition, the three categories of notes discussed in this technical requirement are notes made for the TPA’s own internal use, not notes meant for members’ review. At times, the notes contain candid comments on whether a patient is following a provider’s recommended course of treatment.

98. The Plan has not once raised the question of access to these internal notes during Blue Cross NC’s long history as the Plan’s TPA. Even so, because of the scoring method that the Plan used to evaluate proposals here, this issue was given the same weight as far more important requirements.

99. Requirement 5.2.8.2(b)(v) of the RFP asked vendors to confirm the following: “Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.”

100. Blue Cross NC does not allow assignment of benefits to providers for out-of-network claims. This policy exists for the benefit of the Plan and its members. If an out-of-network provider can count on receiving payment directly from Blue Cross NC, that provider will have little incentive to join the Blue Cross NC network. The lack of such an incentive would undermine Blue Cross NC’s ability to negotiate discounts for the Plan and its members. Thus, treating assignment of benefits to out-of-network providers as a preferred feature of a vendor is not in the interest of the Plan or its members.

101. By itself, moreover, assignment of benefits would have little benefit to Plan members. If this requirement is meant to streamline billing for out-of-network services and therefore reduce the burden on Plan members, it will not be enough to meet that objective. Any streamlining of billing would occur only when an out-of-network payment made by the Plan’s TPA under an assignment of benefits is accepted as payment in full. If the assignment-of-benefits requirement is motivated by a concern that a large benefits payout to a member might be retained by the member and not remitted to the provider, Blue Cross NC has implemented safeguards to prevent that outcome. The Plan is aware of these safeguards.

102. Requirement 5.2.6.2(b)(xvi) of the RFP asked vendors to confirm the following: “Vendor will use the unique Member ID number provided by the [Plan’s



eligibility and enrollment] vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the [eligibility and enrollment] vendor will be the sole Member ID on the ID Card.”

103. Blue Cross NC had good reasons for not confirming this requirement as well. This requirement is technically infeasible and would cause needless headaches for Plan members. Each of the Plan’s vendors has its own form of member ID. Each vendor’s form of ID is designed to be compatible with that vendor’s systems. Blue Cross NC, for example, has a sixteen-character form of ID that includes a particular prefix. When a Plan member visits a provider, that provider is familiar with and expects to see a sixteen-character form of ID and is prepared to use that form of ID in its billing systems.

104. Because of providers’ expectations, enforcing a “single ID number” requirement would be counterproductive for the Plan’s members. It would cause confusion and disruption with providers.

105. During its tenure as the Plan’s TPA, Blue Cross NC has discussed this issue with the Plan and has proposed several alternatives to meet the Plan’s goals. In each case, the Plan has declined to accept any approach that does not involve Blue Cross NC actually processing claims based on a single ID number—a demand that is technically and operationally impossible. On information and belief, any vendor, including Aetna, would find it impossible to use a single ID number as absolutely as the Plan envisions.

106. In sum, Blue Cross NC had good reasons for not confirming seven out of the 310 technical requirements in the RFP. If the Plan had allowed Blue Cross NC to explain these points, Blue Cross NC would have done so. Then the Plan would have been able to assess each vendor's capabilities on these points based on complete information.

107. The Plan's decision to prohibit Blue Cross NC from providing this information prevented the Plan from fully evaluating Blue Cross NC as a vendor and rendered the Plan's decision erroneous, arbitrary, and capricious.

#### **The RFP's Overall Method for Ranking and Scoring Proposals**

108. Finally, the formula that the Plan used to calculate each vendor's overall score and rank was unsound, arbitrary, and capricious.

109. Under the terms of the RFP, the Plan assigned a final cost score of three to the vendor with the cost proposal that received the highest overall score on the cost elements of the RFP. The second-place vendor received a final score of two, and the last-place vendor received a final score of one. Under the Plan's scoring method, Blue Cross NC and Aetna tied and received a final cost score of three. As the vendor with the lowest-ranked cost proposal, United received a final cost score of one.

110. The RFP used the same method for assigning a final score to each vendor's technical proposal. The technical proposal that received the most points was assigned a final technical score of three, the second-place vendor received a final technical score of two, and the lowest-ranked vendor received a technical score

of one. Because Aetna and United confirmed each of the 310 technical requirements, each of them received a final technical score of three. Blue Cross NC received a final technical score of one.

111. On the combination of the cost and technical scores, Aetna received a final score of six, while Blue Cross NC and United received final scores of four.

112. This scoring system has no rational basis, was an improper procedure, and was arbitrary and capricious.

113. Under this scoring system, a vendor whose cost proposal would save the Plan tens of millions of dollars compared to the next-lowest-cost proposal could receive a lower overall score simply because it did not confirm a handful of minor technical requirements. That is exactly what happened here.

114. A scoring system that assigns more weight to minor technical features than it assigns to the cost of providing medical care to hundreds of thousands of Plan members is illogical and unsound.

115. For the foregoing reasons, the Plan acted erroneously, and substantially prejudiced Blue Cross NC's rights, when it awarded the contract for TPA services in 2025-2027 to Aetna rather than Blue Cross NC.

116. For the foregoing reasons, the Plan failed to use proper procedure, and substantially prejudiced Blue Cross NC's rights, when it awarded the contract for TPA services in 2025-2027 to Aetna rather than Blue Cross NC.

117. For the foregoing reasons, the Plan acted arbitrarily and capriciously, and substantially prejudiced Blue Cross NC's rights, when it awarded the contract for TPA services in 2025-2027 to Aetna rather than Blue Cross NC.

118. For the foregoing reasons, the Plan failed to act as required by law or rule, and substantially prejudiced Blue Cross NC's rights, when it awarded the contract for TPA services in 2025-2027 to Aetna rather than Blue Cross NC.

### **REQUEST FOR RELIEF**

WHEREFORE, Blue Cross NC respectfully requests the following relief:

1. That this Tribunal order that the Plan's contract for TPA services for 2025-2027 be awarded to Blue Cross NC;
2. In the alternative, that this Tribunal vacate the contract award to Aetna and order the Plan to conduct a proper RFP process;
3. That this Tribunal award reasonable attorney fees and witness fees to Blue Cross NC, pursuant to N.C. Gen. Stat. § 150B-33(b)(11); and
4. That this Tribunal grant any other relief that it deems appropriate.

This 16th day of February, 2023.

ROBINSON, BRADSHAW & HINSON, P.A.

/s/ Stephen D. Feldman  
Matthew W. Sawchak  
N.C. State Bar No. 17059  
msawchak@robinsonbradshaw.com

Stephen D. Feldman  
N.C. State Bar No. 34940  
sfeldman@robinsonbradshaw.com

434 Fayetteville Street, Suite 1600  
Raleigh, North Carolina 27601  
Telephone: (919) 239-2600  
Facsimile: (919) 328-8790

Nathan C. Chase, Jr.  
N.C. State Bar No. 39314  
nchase@robinsonbradshaw.com

101 N. Tryon Street, Suite 1900  
Charlotte, North Carolina 28246  
Telephone: (704) 377-2536  
Facsimile: (704) 378-4000

Counsel for Blue Cross and Blue Shield of  
North Carolina

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing petition has been served on the respondent by certified mail, return receipt requested, addressed to:

J. Benjamin Garner, Esq., designated agent for service of process  
North Carolina State Health Plan for Teachers and State Employees  
3200 Atlantic Avenue  
Raleigh, NC 27604

The undersigned also certifies that a copy of the foregoing petition has been served on all parties of record to the Request for Proposal proceedings by certified mail, return receipt requested, addressed to:

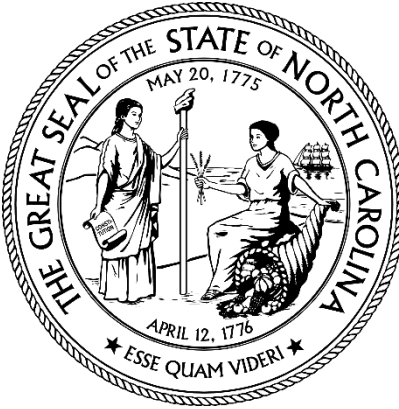
Aetna Life Insurance Company  
c/o CT Corporation System, registered agent for service of process  
160 Mine Lake Court, Suite 200  
Raleigh, North Carolina 27615

UMR, Inc.  
c/o CT Corporation System, registered agent for service of process  
160 Mine Lake Court, Suite 200  
Raleigh, North Carolina 27615

This 16th day of February, 2023.

/s/ Stephen D. Feldman  
Stephen D. Feldman

**EXHIBIT 1**  
**TO**  
**ATTACHMENT A**



**STATE OF NORTH CAROLINA**  
**THE NORTH CAROLINA STATE HEALTH PLAN**  
**FOR TEACHERS AND STATE EMPLOYEES**  
**REQUEST FOR PROPOSAL #: 270-20220830TPAS**  
**THIRD PARTY ADMINISTRATIVE SERVICES**

**Date of Issue: August 30, 2022**

**Proposal Opening Date: November 7, 2022**

**At 10:00 AM ET**

**Direct all inquiries concerning this RFP to:**

Vanessa Davison  
Contracting Agent

Email: [Vanessa Davison @nctreasurer.com](mailto:Vanessa.Davison@nctreasurer.com)  
[SHPCcontracting@nctreasurer.com](mailto:SHPCcontracting@nctreasurer.com)

Phone: 919-814-4421

*Sealed, mailed responses ONLY will be accepted for this solicitation.*



## STATE OF NORTH CAROLINA

### Request for Proposal # 270-20220830TPAS

\_\_\_\_\_


For internal State agency processing in the Interactive Purchasing System (IPS), please provide your company's Federal Employer Identification Number or alternate identification number (e.g., Social Security Number). Pursuant to N.C.G.S. § 132-1.10(b) this identification number shall not be released to the public. **This page will be removed and shredded, or otherwise kept confidential**, before the procurement file is made available for public inspection.

**This page is to be filled out and returned with your proposal.  
Failure to do so may subject your proposal to rejection.**

**ID Number:**

\_\_\_\_\_  
Federal ID Number or Social Security Number

\_\_\_\_\_  
Vendor Name

 <div style="text-align: center;"> <b>STATE OF NORTH CAROLINA</b>  <b>North Carolina Department of State Treasurer</b> </div>	
Refer <u><b>ALL</b></u> Inquiries regarding this RFP to:  <b>Vanessa Davison, Contracting Agent</b>  <u><b>vanessa.davison@nctreasurer.com</b></u> <u><b>with a copy to</b></u> <u><b>SHPCContracting@nctreasurer.com</b></u>	Request for Proposal # 270-20220830TPAS
	Proposals will be publicly opened: November 7, 2022, 10:00 a.m. ET
	Contract Type: Open Market
	Commodity No. and Description: 851017 – Health Administrative Services
	Using Agency: The North Carolina State Health Plan for Teachers and State Employees
	Requisition No.: 270-2022083TPAS

***Sealed, mailed responses ONLY will be accepted for this solicitation.***

#### **EXECUTION**

In compliance with this Request for Proposals (RFP), and subject to all the conditions herein, the undersigned Vendor offers and agrees to furnish and deliver any or all items upon which prices are bid, at the prices set opposite each item within the time specified herein. By executing this proposal, the undersigned Vendor certifies that this proposal is submitted competitively and without collusion, that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the North Carolina General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934. Furthermore, by executing this proposal, the undersigned certifies to the best of Vendor's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency. The undersigned Vendor certifies that it, and each of its Subcontractors for any Contract awarded as a result of this RFP, complies with the requirements of Article 2 of Chapter 64 of the North Carolina General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system. N.C.G.S. § 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By execution of this response to the RFP, the undersigned certifies, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

**Failure to execute/sign proposal prior to submittal shall render proposal invalid and it WILL BE REJECTED. Late proposals cannot be accepted.**

VENDOR:		
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:

PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE (SEE INSTRUCTIONS TO VENDORS ITEM #10):		
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF VENDOR:		FAX NUMBER:
VENDOR'S AUTHORIZED SIGNATURE:	DATE:	EMAIL:

Offer valid for at least 180 days from date of proposal opening, unless otherwise stated here: \_\_\_\_\_ days.

### **ACCEPTANCE OF PROPOSAL**

If any or all parts of this proposal are accepted by the State of North Carolina, an authorized representative of the NC Department of State Treasurer, State Health Plan Division shall affix his/her signature hereto and this document and all provisions of this Request For Proposal along with Vendor proposal response and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

<b><u>FOR STATE USE ONLY:</u></b>
Offer accepted and Contract awarded this _____ day of _____, 20_____, as indicated on the attached certification, by
_____ (Authorized Representatives of the NC Department of State Treasurer and State Health Plan Division).

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## **1.0 VISION AND OVERVIEW OF THE STATE HEALTH PLAN**

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### **1.1 VISION**

The North Carolina State Health Plan for Teachers and State Employees (Plan) seeks a Vendor that will provide superior third party administrative (TPA) services. Vendor must be willing to work with the Plan in meeting the mission and priorities set by the Treasurer and the Board of Trustees (Board). The Plan intends to be a leader in North Carolina known for providing cost-effective, quality health care programs for its membership.

To this end, several years ago, the Plan rolled out an initiative called the Clear Pricing Project (CPP) to promote affordable, quality care and increase transparency, predictability, and value for Plan Members. In the first phase of this project, the Plan developed a network of North Carolina providers, with reimbursement rates referenced to Medicare rates. The CPP providers were integrated with the TPA's network to form a hybrid network called the North Carolina State Health Plan network. While this initiative was very successful, the Plan intends to reset and expand efforts to achieve the CPP objectives. While reference-based pricing continues to be a focus area, the Plan is also interested in incorporating alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation.

The Plan's focus will continue to be on the key principles of transparent pricing, high quality care and service, and effective vendor partnerships. The Plan expects all Plan vendors to work in concert with Plan staff to fulfill its mission and vision while serving its Members. The Plan seeks a Vendor that will be:

- Flexible and Adaptable
- Collaborative with all CPP Initiatives
- Transparent
- Confident and Committed
- Responsive and Capable of Providing Superior Administrative and Technical Services

Vendor must demonstrate a dedication to providing a superior Customer Experience for all the services provided under the RFP which may require integration with other Plan vendors. Each Member touch point should be designed to be easily accessible and understandable. Vendor must have sufficient resources who are well educated on the Plan's unique benefits and services to respond to Member, Employing Unit, and Plan inquiries in a timely fashion.

Finally, Vendor must provide quality services. Providing accurate information, processing claims with a high degree of accuracy, and delivering accurate reports and data files are all examples of the kind of dedication to quality that the Plan requires of its vendors. To demonstrate this dedication to excellence, Vendor must provide skilled project management and ongoing resources, deploy appropriate operational controls, maintain a strong program governance, conduct frequent audits, and accept appropriate performance guarantees to measure the success of these services.

## 1.2 OVERVIEW OF THE STATE HEALTH PLAN

### State Health Plan

The Plan provides health care coverage to more than 742,000 teachers and school personnel, State employees, retirees, current and former lawmakers, State university and community college personnel, and eligible dependents. The services outlined in this RFP are focused on the approximately 582,000 self-funded Members. The mission of the State Health Plan is to improve the health and health care of North Carolina teachers, State employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

### Governance

The Treasurer, Executive Administrator, and the Board are designated as fiduciaries for the Plan. The powers and duties of the Treasurer are set forth in statute at N.C.G.S. § 135-48.30(a) and include setting benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums subject to approval of the Board. The Board's powers and duties are set forth at N.C.G.S. § 135-22 and include approving large contracts, approving premium rates, copays and deductibles proposed by the Treasurer, and developing and maintaining a strategic plan. The North Carolina General Assembly determines member eligibility rules and provides State funding for the Plan.

The Board is required to be composed of at least one (1) of the following: an employee of a State department, agency, or institution; a teacher employed by a North Carolina public school system; a retired employee of a State department, agency, or institution; and a retired teacher from a North Carolina public school system. The Board must also include individuals with the following expertise: actuarial science, health economics, health benefits and administration, and health law and policy. The State Treasurer is an ex officio member of the Board and serves as its Chair, but only votes in the event of a tie. The Director of the Office of State Budget and Management serves as an ex officio nonvoting member. Two (2) members are appointed by the Governor. Two (2) members are appointed by the State Treasurer. Two (2) members are appointed by the North Carolina General Assembly upon the recommendation of the Speaker of the House of Representatives. Two (2) members are appointed by the North Carolina General Assembly upon the recommendation of the President Pro Tempore of the Senate.

### Membership Statistics

The total membership as of April 30, 2022, is broken out as follows:

- 489,155 active employees and their dependents.
- 1,635 Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) participants and their dependents. COBRA requires most employers with group health plans to offer employees the opportunity to continue their group health care coverage temporarily under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status. COBRA rules apply to the State Health Plan pursuant to Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300bb-1 through 300bb-8.
- 248,977 Medicare and non-Medicare retirees and disabled members and their dependents.
- 3,093 Members and their dependents who are eligible for the Plan on a fully contributory basis who are invoiced for their premiums (direct bill members and surviving dependents) on a monthly basis.

The Plan offers two (2) Preferred Provider Organization (PPO) plans to its active employees and Non-Medicare retirees, described below, using the North Carolina State Health Plan Network for services incurred in North Carolina. Members who seek services outside of North Carolina have access to Blue Cross North Carolina's Blue Card network.

- The Enhanced PPO Plan (80/20) has higher premiums in exchange for lower copays, coinsurance, and deductibles. This plan includes the ability for the Subscriber to lower monthly Subscriber premium by attesting to being a non-tobacco user or a tobacco user willing to complete a tobacco cessation program.



- The Base PPO Plan (70/30) has lower premiums in exchange for higher copays, coinsurance, and deductibles. Like the Enhanced PPO Plan (80/20), the Base PPO Plan (70/30) includes the ability for the Subscriber to lower the monthly Subscriber premium by attesting to being a non-tobacco user or a tobacco user willing to complete a tobacco cessation program.

In 2022, the Plan offers three (3) health plan options for Medicare primary Members. These plans include the Base PPO Plan (70/30), which is also offered to Non-Medicare primary Members and administered through Blue Cross North Carolina, and two (2) Group Medicare Advantage (PPO) Plan options — offered through Humana— which include benefits and services such as access to the SilverSneakers® Fitness Program, a nurse help line and disease and case management services.

- Humana Group Medicare Advantage PPO Base Plan – 143,197
- Humana Group Medicare Advantage PPO Enhanced Plan – 17,977
- Base PPO Plan (70/30) – 35,987

The Plan offers a High Deductible Health Plan (HDHP) to employees determined by their Employing Units to be full-time employees in accordance with Section 4980H of the Internal Revenue Code and the employee does not qualify for coverage under subdivision (1), (5), (6), (7), (8), (9), or (10) of N.C.G.S. § 135-48.40(b). Eligibility is also subject to N.C.G.S. § 135-48.43.

- 572 HDHP Members

### Plan Vendors

The Plan contracts with a number of vendors to provide third party administrative, pharmacy benefit management and other related services:

- Blue Cross and Blue Shield of North Carolina (BCBSNC) is the contracted TPA for Claims and Related Services for three (3) of the Plan's self-funded plan options.
- The two (2) fully insured Medicare Advantage Plan designs are provided by Humana.
- CVS Health provides Pharmacy Benefit Management Services (PBM).
- Benefitfocus is the Plan's eligibility and enrollment services (EES) vendor.
- iTEDIUM provides COBRA administration and billing services.

A listing of the Plan's contracted vendors is available at [www.shpnc.org](http://www.shpnc.org), bottom of the page in the footer section, "SHP Contracted Vendors."

## 2.0 GENERAL INFORMATION

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### 2.1 REQUEST FOR PROPOSAL DOCUMENT

The RFP is comprised of the base RFP document, any attachments, and any addenda released before Contract award. All attachments and addenda released for this RFP in advance of any Contract award are incorporated herein by reference.

### 2.2 E-PROCUREMENT SOLICITATION

**ATTENTION:** This is NOT an E-Procurement solicitation. Paragraph #16 of ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS, paragraphs b), c), and d) do not apply to this solicitation.

### 2.3 NOTICE TO VENDORS REGARDING RFP TERMS AND CONDITIONS

It shall be Vendor's responsibility to read the Instructions, the State's terms and conditions, all relevant exhibits and attachments, and any other components made a part of this RFP and comply with all requirements and

specifications herein. Vendors also are responsible for obtaining and complying with all addenda and other changes that may be issued in connection with this RFP.

If Vendors have questions, issues, or exceptions regarding any term, condition, or other component within this RFP, those must be submitted as questions in accordance with the instructions in Section 2.5 PROPOSAL QUESTIONS. If the State determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an Addendum. The State may also elect to leave open the possibility for later negotiation and amendment of specific provisions of the Contract that have been addressed during the question-and-answer period. Other than through this process, the State rejects and will not be required to evaluate or consider any additional or modified terms and conditions submitted with Vendor's proposal. This applies to any language appearing in or attached to the document as part of Vendor's proposal that purports to vary any terms and conditions or Vendors' instructions herein or to render the proposal non-binding or subject to further negotiation. Vendor's proposal shall constitute a firm offer. **By execution and delivery of this RFP Response, Vendor agrees that any additional or modified terms and conditions, whether submitted purposely or inadvertently, shall have no force or effect, and will be disregarded. Any bid that contains language that indicates the bid is non-binding or subject to further negotiation before a contractual document may be signed shall be rejected. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject Vendor's proposal as nonresponsive.**

If a Vendor desires modification of the terms and conditions of this solicitation, it is urged and cautioned to inquire during the question period, in accordance with the instructions in this RFP, about whether specific language proposed as a modification is acceptable to or will be considered by the State. Identification of objections or exceptions to the State's terms and conditions in the proposal itself shall not be allowed and shall be disregarded or the proposal rejected.

Contact with anyone working for or with the State regarding this RFP other than the State Contract Manager named on the face page of this RFP in the manner specified by this RFP shall constitute grounds for rejection of said Vendor's offer, at the State's election.

## 2.4 RFP SCHEDULE

The table below shows the *intended* schedule for this RFP. The State will make every effort to adhere to this schedule.

Event	Responsibility	Date and Time
Issue RFP	Plan	August 30, 2022
Phone call with potential Offerors	Plan	September 1, 2022, 10:00 a.m. ET  To join the phone call with potential Offerors, dial 984-275-3153, Conference ID: 844 589 624#
Vendor Deadline for Submission of Written Minimum Requirements Questions	Vendor	September 12, 2022, 12:00 p.m. ET
Plan Responds to Minimum Requirements Questions	Plan	September 16, 2022
Deadline to Submit Minimum Requirements Responses	Vendor	September 26, 2022, 10:00 a.m. ET  The public bid opening for this solicitation will be conducted via conference call.  To hear the bid opening for this RFP,

		dial 877-810-9415, Access Code: 4542246#
Evaluation of Minimum Requirement Responses	Plan	September 27 – 29, 2022
Notify Vendors if Minimum Requirements Met. If met, Vendors will be provided information regarding access to claims information.	Plan	September 29, 2022
Issue Vendor's designated recipient, a link to Secure File Transfer Protocol (SFTP) system for attachments and data files	Plan	September 29 – 30, 2022
Vendor Deadline for Submission of All Written Questions	Vendor	October 10, 2022, 12:00 p.m. ET
Plan Responds to Questions (Addendum Posted on Ariba landing page.)	Plan	October 14, 2022
Opening of Proposals by Plan (Bid Closes)	Vendor	November 7, 2022, 10:00 a.m. ET
Evaluation of Proposals	Plan	November 8 – 16, 2022
Best and Final Offer (BAFO)	Plan	November 17 – 30, 2022
Plan Seek Approval from the Attorney General's Office	Plan	December 1 – 7, 2022
Present award recommendation to the Board	Plan	December, 2022
Award of the Contract	Plan & Vendor	December, 2022
Implementation Period	Plan & Vendor	January 1, 2023 – December 31, 2024
Services Begin	Vendor	January 1, 2025

## 2.5 PROPOSAL QUESTIONS

Upon review of the RFP documents, Vendors may have questions to clarify or interpret the RFP in order to submit the best proposals possible. To accommodate the Proposal Questions process, Vendors shall submit any such questions by the above due dates. Questions received after these dates will not receive a response.

Written questions shall be emailed to [Vanessa.Davison@nctreasurer.com](mailto:Vanessa.Davison@nctreasurer.com) with a copy to [SHPCContracting@nctreasurer.com](mailto:SHPCContracting@nctreasurer.com) by the date and time specified above. When submitting Minimum Requirements questions, Vendors should enter "RFP # 270-20220830TPAS: Minimum Requirements Questions" as the subject for the email. When submitting all other questions, Vendors should enter "RFP # 270-20220830TPAS Questions." Question submittals should include a reference to the applicable RFP section and be submitted in the format shown below in sequential order:

Question #	Reference	Vendor Question
1.	RFP Section, Page Number	Vendor question ...?

Questions received prior to the submission deadline dates in Section 2.4, the State's response, and any additional terms deemed necessary by the State will be posted in the form of an Addendum to this RFP on the Ariba landing page and can be accessed at the following link: <http://discovery.ariba.com/rfx/13956411>. No information, instruction, or advice provided orally or informally by any State personnel, whether made in response to a question or otherwise in connection with this RFP, shall be considered authoritative or binding. Vendors shall rely *only* on written material contained in an Addendum to this RFP.

## 2.6 PROPOSAL SUBMITTAL

### 2.6.1 RFP Phases for Submission

- a) This RFP requires that Vendors meet certain Minimum Requirements in order for technical and cost responses to be evaluated for possible Contract award (See Section 5.1). Therefore, submission of responses are divided into two (2) phases:
  - i. Minimum Requirements Submission
  - ii. Technical and Cost Proposal Submission
- b) Vendors that meet the Minimum Requirements will be notified and may provide Technical and Cost Proposals in response to the RFP. Vendors that do not meet the Minimum Requirements will be disqualified from further consideration.
- c) Vendors that meet the Minimum Requirements and submit the signed ATTACHMENT I: NONDISCLOSURE AGREEMENT, will be provided a de-identified medical claims file for repricing, census data and all other exhibits listed in ATTACHMENT A: PRICING. The files will be provided via SFTP. The instructions for accessing the data files are as follows:
  - i. The Plan will provide its Actuarial/Analytical and Health Benefits Consulting vendor Segal a listing of Vendors that meet the Minimum Requirements and copies of the NDA that identifies each Vendor's designated recipient and email address.
  - ii. Segal will send each Vendor's designated recipient a link to the SFTP system with all the data and exhibits identified above and in ATTACHMENT A: PRICING.
  - iii. The designated recipient may access the SFTP system and download each of the files.
- d) Sealed proposals, subject to the conditions made a part hereof and the receipt requirements described below, shall be received at the address indicated in the table below, for furnishing and delivering those items or Services as described herein.

Mailing and Office address for delivery of proposal via US Postal Service, special delivery, overnight, or any other carrier
PROPOSAL NUMBER: 270-20220830TPAS NC Department of State Treasurer State Health Plan Division 3200 Atlantic Avenue Raleigh, NC 27604  Attention: Vanessa Davison, Contracting Agent

**IMPORTANT NOTE:** All proposals shall be physically delivered to the office address listed above on or before the proposal deadline in order to be considered timely, regardless of the method of delivery. **This is an absolute requirement.** All risk of late arrival due to unanticipated delay—whether delivered by hand, U.S. Postal Service, courier, or other delivery service is entirely on Vendor. It is the sole responsibility of Vendor to have the proposal physically in this office by the specified time and date of opening. The time of delivery will

be marked on each proposal when received, and any proposal received after the proposal submission deadline will be rejected. Sealed proposals, subject to the conditions made a part hereof, will be received at the address indicated in the table in this Section, for furnishing and delivering the commodity as described herein.

All Vendors are urged to take the possibility of delay of the U.S. Postal Service into account when submitting the Minimum Requirements Proposal and the Technical and Cost Proposals. **Attempts to submit a proposal via facsimile (FAX) machine, telephone, or electronic means, including but not limited to email, in response to this RFP shall NOT be accepted.**

**All Vendors shall follow the instructions below when submitting the Minimum Requirements Proposal and the Technical and Cost Proposals.**

### **2.6.2 Minimum Requirements Proposal Submission**

- a) Submit **two (2) signed, original executed** Minimum Requirements Proposal responses, fifteen (15) photocopies, one (1) photocopy of the Minimum Requirements Proposal redacted in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act, two (2) un-redacted electronic copies on flash drives and, if required, one (1) redacted copy in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act, on flash drive of your proposal simultaneously to the address identified in the table above. Redacted copies shall exclude any proprietary information in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act. All redactions shall be made in black so that the redactions are easily identifiable by the Plan.
- b) Submit your Minimum Requirements Proposal in a sealed package. Clearly mark each package with: (1) Vendor name; (2) the RFP number; (3) "Minimum Requirements Proposal"; and (4) the due date. Address the package(s) for delivery as shown in the table above.
- c) The electronic copies of your proposal must be provided on separate read-only flash drives. The files on the flash drives **shall NOT** be password protected, shall be in .PDF or .XLS format, and shall be capable of being copied to other media including readable in Microsoft Word and/or Microsoft Excel.
- d) Flash Drive One must contain the entire Minimum Requirements Proposal including any proprietary information and have the following label affixed to the flash drive: 1) Vendor name; (2) the RFP number; (3) the due date; and (4) the words "Minimum Requirements Proposal Non-Redacted."
- e) Flash Drive Two, if required for confidentiality, must contain the Minimum Requirements Proposal excluding any information identified as confidential and proprietary in accordance with ATTACHMENT B, Paragraph 14 of the Instructions to Vendors. The Plan in responding to public records requests, will release the information on this flash drive. It is the sole responsibility of Vendor to ensure that this flash drive complies with the requirements of ATTACHMENT B, Paragraph 14 of the Instructions to Vendors. The following label must be affixed to the flash drive: (1) Vendor name; (2) the RFP number; (3) the due date; and (4) the words "Minimum Requirements Proposal Redacted."

### **2.6.3 Technical and Cost Proposal Submission**

- a) Submit **two (2) signed, original executed** Technical and Cost Proposal responses, thirteen (13) photocopies, one (1) photocopy of the Technical and Cost Proposal redacted in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act, two (2) un-redacted electronic copies on flash drives and, if required, one (1) redacted copy in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act, on flash drive of your proposal simultaneously to the address identified in the table above. Redacted copies shall exclude any proprietary information in accordance with Chapter 132 of the North Carolina General Statutes, the Public Records Act. All redactions shall be made in black so that the redactions are easily identifiable by the Plan.

Individual attachments, exhibits, and/or supporting documentation **greater than 50 pages** in length may be submitted in electronic copy only on flash drives. The original and photocopy technical responses must

specifically identify the file names and location of the individual attachments, exhibits, and/or supporting documentation.

- b) Submit your technical and costs proposals in two (2) separate sealed packages. Clearly mark each package with: (1) Vendor name; (2) the RFP number; (3) "Technical or Cost Proposal"; and (4) the due date. Address the package(s) for delivery as shown in the table above.
- c) For delivery purposes, separate sealed envelopes from a single Vendor may be included in the same outer package. Proposals are subject to rejection unless submitted with the information above included on the outside of the sealed proposal package.
- d) The electronic copies of your proposal must be provided on separate read-only flash drives. The files on the flash drives **shall NOT** be password protected, shall be in .PDF or .XLS format, and shall be capable of being copied to other media including readable in Microsoft Word and/or Microsoft Excel.
- e) Flash Drive One must contain the entire Technical and Cost Proposal including any proprietary information and have the following label affixed to the flash drive: 1) Vendor name; (2) the RFP number; (3) the due date; and (4) the words "Technical and Cost Proposal Non-Redacted."
- f) Flash Drive Two, if required for confidentiality, must contain the Technical and Cost Proposal excluding any information identified as confidential and proprietary in accordance with ATTACHMENT B, Paragraph 14 of the Instructions to Vendors. The Plan in responding to public records requests, will release the information on this flash drive. It is the sole responsibility of Vendor to ensure that this flash drive complies with the requirements of ATTACHMENT B, Paragraph 14 of the Instructions to Vendors. The following label must be affixed to the flash drive: (1) Vendor name; (2) the RFP number; (3) the due date; and (4) the words "Technical and Cost Proposal Redacted."

## **2.7 PROPOSAL CONTENTS**

Vendor proposal responses shall:

- a) Match the order of the RFP.
- b) Include the RFP section and requirement or specification numbers.
- c) Include a Table of Contents.
- d) Include tabs indexing each section.
- e) Be submitted in multiple three (3) ring binders no larger than three (3) inches each.
- f) Include at a minimum the following information: RFP number, RFP title, Proposal title, and the submitting Vendor's name on the front and side of each binder.

### **2.7.1 Minimum Requirements Proposal Contents**

Vendors shall populate RFP attachments indicated below that require Vendor to provide information and include an authorized signature where requested. Vendors' Minimum Requirements Proposal responses shall include the following items and those attachments should be arranged in the following order:

- a) Completed and signed ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION.
- b) Third Party Administrative Services Minimum Requirements Proposal (RFP Section 5.1 TPA Minimum Requirements Table).
- c) Completed ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE.
- d) ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS.
- e) Completed version of ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR.
- f) Completed and signed version of ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION.
- g) Completed and signed version of ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT.
- h) Completed and signed version of ATTACHMENT H: HIPAA QUESTIONNAIRE.
- i) Completed and signed version of ATTACHMENT I: NONDISCLOSURE AGREEMENT.

## 2.7.2 Technical and Cost Proposal Contents

Vendors shall populate all attachments of this RFP that require Vendor to provide information and include an authorized signature where requested. Vendors' Technical and Cost Proposal responses shall include the following items and those attachments should be arranged in the following order:

- a) Completed and signed version of EXECUTION PAGES along with the body of the RFP, and signed receipt pages of any addenda released in conjunction with this RFP (if required to be returned).
- b) Completed Response to RFP Section 4.10 "Administrators for the Contract and HIPAA Privacy Officer."
- c) Completed ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE.
- d) Completed version of ATTACHMENT A: PRICING.
- e) ATTACHMENT B: INSTRUCTIONS TO VENDORS.
- f) Completed version of ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION.

## 2.8 DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

- a) **ADDENDUM:** Written clarification or revision to this RFP during the procurement process and prior to the close of bids.
- b) **ADMINISTRATIVE DECISION MEMO (ADM):** Document that outlines the Plan's business rules and/or requirements and the processes used by Vendor to support the Plan. The ADM must be signed by the Plan's Contract Administrator regarding day-to-day activities, and/or his/her delegate and Vendor's Contract Administrator regarding day-to-day activities, and/or his/her delegate.
- c) **AUDIT FILES:** A Full File that provides all records/transactions required to successfully validate vendor or partner data including, but not limited to, enrollment (i.e., demographics, Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
- d) **BAFO:** Best and Final Offer, submitted by a Vendor to alter its initial offer, made in response to a request by the State.
- e) **BEACON – (Building Enterprise Access for NC's Core Operation Needs):** State system that integrates employee benefit enrollment with HR and Payroll SAP software. It also supports related payroll processes, reporting, and other related services. Currently, enrollment data from BEACON is sent via daily EDI files to the Plan's eligibility and enrollment services vendor.
- f) **BENEFIT EFFECTIVE DATE:** The date Vendor is obligated to start processing claims.
- g) **BENEFIT YEAR:** The fiscal 12-month period which begins every January 1st and ends every December 31st during which yearly plan design features such as the copayments and co-insurance and specific benefit maximums accumulate.
- h) **BOARD OF TRUSTEES (BOARD):** The governing board whose members are appointed by the Governor, the North Carolina General Assembly, and the State Treasurer and who act as fiduciaries for the Plan in carrying out their duties and responsibilities as set forth in law.
- i) **BUSINESS REQUIREMENTS:** Customer (Plan) needs and expectations that will be memorialized in a Business Requirements Document.
- j) **BUSINESS REQUIREMENTS DOCUMENT (BRD):** Document that outlines the Business Requirements, for a benefit, program, or process and may include requirements for multiple Plan vendors.
- k) **CHANGE FILE:** An EDI file that provides records/transactions, including retroactivity, that have changed or are new since the last EDI file. Change Files are often desirable as they are smaller in size and are quicker to process than Full Files. With Change Files, successive files will contain only data that has changed since the preceding Change File or Full File.

- l) **CLARIFICATION:** A written response from a Vendor that provides an answer or explanation to a question posed by the State about that Vendor's proposal. Clarifications are incorporated into Vendor's proposal response.
- m) **CLOSE-OUT DOCUMENT:** A document developed by Vendor to tie up any loose ends from a project and officially deliver the project to the operations and/or business teams.
- n) **CMS:** Federal Centers for Medicare and Medicaid Services.
- o) **COBRA:** Consolidated Omnibus Budget Reconciliation Act of 1986, 29 U.S.C. §. 1161-1168 as applicable to the North Carolina State Health Plan pursuant to Title XXII of the Public Health Service Act, U.S.C. §§ 300bb-1 through 300bb-8. Provides certain former employees, retirees, spouses, former spouses, and Dependent children the right to temporary continuation of health coverage at group rates. The coverage, however, is only available when coverage is lost for specific qualifying events.
- p) **CONFLICT OF INTEREST:** Situations or circumstances through which Vendor, or entities or individuals closely affiliated with Vendor, will derive, or reasonably may be perceived as deriving, direct financial or other pecuniary benefit from its performance of this Contract other than through the compensation received according to the Contract for performance of the Contract, or that might impair, or reasonably be perceived as impairing, Vendor's ability to perform this Contract in the best interests of the State.
- q) **CONTRACT ADMINISTRATOR:** Representative of the Plan who will administer this Contract for the State.
- r) **CONTRACTING AGENT:** Representative of the Plan who corresponds with potential Vendors regarding this RFP.
- s) **COVERAGE TIER:** The type of coverage (employee only, employee + spouse, employee + child(ren), and employee + family) the Subscriber has elected.
- t) **CUSTOMER EXPERIENCE:** The service experience of customers.
- u) **DATA CENTER:** A facility that performs one or more of the following functions:
  - a. Physically houses various equipment, such as computers, servers (e.g., web servers, application servers, database servers), switches routers, data storage devices, load balances, wire cages or closets, vaults, racks, and related equipment;
  - b. Stores, manages, processes, and exchanges digital data and information;
  - c. Provides application services or management for various data processing, such as web hosting internet, intranet, and telecommunication and information technology.
- v) **DATA WAREHOUSE:** A Data Warehouse is a merged repository that stores data from multiple sources from an enterprise's various operational systems, that is constructed with predefined schemas designed for data analytics and reporting, for current and historical decision support information of raw data, whether structured or unstructured, from multiple sources, and its schema is undefined.
- w) **DELIVERABLE:** Refers to any service, duty, performance, or other contractual obligation of Vendor.
- x) **DEPENDENT:** An eligible Plan Member other than the Subscriber.
- y) **DEPLOYMENT PLAN:** A document developed by Vendor to outline the sequence of operations or steps that must be carried out to deploy new functionality or processes.



- z) **ELECTRONIC DATA INTERFACE (EDI):** Standard format for exchanging business data.
- aa) **EMPLOYING UNIT:** A North Carolina local education agency; community college; State department, agency, or institution; or association or examining board or commission, whose employees are eligible for membership in a State of North Carolina-supported retirement system as defined in Article 3B of Chapter 135 of the North Carolina General Statutes as may be amended from time to time. An Employing Unit also shall mean a charter school in accordance with Part 6A of Chapter 115C of the North Carolina General Statutes whose board of directors elects to become a participating employer in the Plan under N.C.G.S. § 135-39.17. Bona fide fire departments, rescue or emergency medical service squads, and National Guard units are deemed to be Employing Units for the purpose of providing benefits under this Article. An Employing Unit shall also mean an employer, as defined for local government employers by N.C.G.S. § 128-21(11) who has received legislative authority to and has elected to participate in the Plan.
- bb) **END-TO-END TESTING:** Testing that begins at the first step of the process and concludes with the last step. In this Contract, End-to-End Testing includes testing the process from the beginning step to the last step which includes testing with every Plan vendor involved in the item to be tested.
- cc) **ENTITY:** For the purposes of this Contract, Entity refers to a distinct grouping of Employing Units. They include, but are not limited to:
- a. **BEACON Groups** – Employing Units utilizing the BEACON payroll system.
  - b. **Universities** – Employing Units that are part of the North Carolina University System.
  - c. **Community Colleges** – Employing Units that are part of the North Carolina Community College System.
  - d. **Public Schools** – Employing Units that are part of the North Carolina Public Schools or Local Education Associations (LEAs).
  - e. **Charter Schools** – North Carolina Charter Schools that have elected to participate in the Plan.
  - f. **Local Governments** – Local Governments that have elected to participate in the Plan.
- dd) **E-PROCUREMENT SERVICES:** The program, system, and associated Services through which the State conducts electronic procurement.
- ee) **FOCUS AUDITS:** Audits performed on an as-needed basis at the Plan's discretion throughout the Plan Year. The North Carolina Office of the State Auditor may initiate an audit at any time.
- ff) **FULL FILE:** EDI file that provides all records/transactions between a date range or a complete historical dump of data. Full Files can also contain termination and future transactions based on the requirements. Full Files are larger in size and take longer to process. With Full Files, successive files will contain more and more and take longer and longer to process. For example, if Full Files are created each month, every Full File created will contain all records/transactions from the previous Full File and any additional records/transactions created during the current month. Examples of standard Full Files include but are not limited to:
- a. **Audit Files** – A Full File that provides all records/transactions required to successfully validate vendor or Partner data including, but not limited to enrollment (i.e., demographics and Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
  - b. **Seed File** – A Full File that provides all records/transactions required to successfully “seed” or baseline Plan data with a vendor, Partner, or the Plan. This data includes, but is not limited to enrollment (i.e., demographics Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group).
  - c. **Annual or Open Enrollment File** – A Full File that provides all records/transactions required to successfully validate vendor or Partner data for the subsequent Plan Year, including but not limited to enrollment (i.e., demographics and Member categories) and coverage periods (i.e., effective and expiration dates, plan, and Group). Vendors and Partners may request that an annual enrollment Full File is broken up into several files due to file size processing limitations.

- gg) **GO-LIVE:** The first time a system or service can be used after all tests have been completed and the functionality has been implemented. There shall be a Go-Live date in every Implementation Plan.
- hh) **GROUP:** The entity through which Members are “grouped” to enroll and be invoiced (i.e., Employing Units, Retirement Systems, direct bill, and COBRA).
- ii) **HEALTH BENEFIT REPRESENTATIVE (HBR):** The employee designated by the Employing Unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The North Carolina Retirement Systems is the HBR for retired state employees.
- jj) **HEALTH ASSESSMENT:** Individual health questionnaires that provide a systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease.
- kk) **HIPAA:** The Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.§. 1301 et seq. The law provides uniform federal privacy protection standards for consumers across the country. The standards protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Federal Department of Health and Human Services, these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. The term HIPAA also includes all amendments and implementing regulations including specifically the HITECH Act of 2009, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 11-5.
- ll) **IMPLEMENTATION PLAN:** Documentation of the agreed upon target dates for meeting milestones and Deliverables that must be completed for the provision of services to Go-Live. Implementation Plans shall be utilized for the initial implementation and Go-Live of the Contract and for any subsequent Amendments or activities that require Vendor system development or Plan vendor integration. Implementation Plans shall include a description of the co-dependencies and tasks, identification of business, and/or deliverable owner(s).
- mm) **INTERACTIVE VOICE RESPONSE (IVR):** A technology that allows a computer to interact with humans through the use of voice and keypad inputs.
- nn) **LOAD RATE:** The number of enrollment transactions that successfully pass the EDI edits and load automatically into Vendor's system without manual intervention. The enrollment transaction should be counted at the Contract or family level.
- oo) **Mapped or Mapped Member:** The Plan's EES vendor “maps” Members into a specific plan design and/or premium for the start of each year's open enrollment. If Members take no action, they remain in that plan and premium for which they were “Mapped” for the following year. Example: All Plan members enrolled in the Enhanced PPO Plan (80/20) for the current benefit year are mapped to the Base PPO Plan (70/30) without the tobacco credit for the following year. The Subscriber has the opportunity to change that Mapped enrollment during open enrollment.
- pp) **MAY:** Denotes that which is permissible, not mandatory
- qq) **MEDICAL MANAGEMENT:** A general term applied to practices of utilization management (UM), case management (CM), and disease management (DM), alone or in combination with each other.
- rr) **MEMBER:** Any Subscriber enrolled in the North Carolina State Health Plan for Teachers and state employees, or a Dependent currently enrolled in the health benefit plan for which a premium is paid.
- ss) **N.C.G.S.:** North Carolina General Statutes.

- tt) **PARTIES TO THE CONTRACT:** The Parties (Parties) to this Contract are the Plan and Vendor(s) selected through the RFP process.
- uu) **PARTNER:** State sister agencies or other governmental units including BEACON, the State Retirement Systems, the University system, community college system, and public school systems.
- vv) **PERFORMANCE GUARANTEE:** A contractual obligation or performance standard Vendor must comply with or be subject to contractual fee reductions, payments to the Plan, or legal remedies.
- ww) **PLAN YEAR:** A twelve-month period which runs from January 1 through December 31.
- xx) **PLAN'S AUDITORS:** Includes external audit Vendors engaged by the Plan, internal Plan auditors, and Certified Public Accountants.
- yy) **PLAN DESIGN:** Each version of the Health benefit Product is known as the Plan Design. For example, the Plan currently has three (3) PPO Plan Designs for Active Members: Enhanced PPO Plan (80/20), Base PPO Plan (70/30), and the HDHP.
- zz) **PRODUCT:** Health benefit Products are generally differentiated by the network and provider reimbursement methodology but may have other differentiating characteristics. The Plan currently offers two (2) different Products: Preferred Provider Organizations (PPO) and Medicare Advantage Plans.
- aaa) **PROTECTED HEALTH INFORMATION (PHI):** Shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information created or received by the Business Associate from or on behalf of the Covered Entity.
- bbb) **QUALIFIED PROPOSAL:** A responsive proposal submitted by a responsible Vendor.
- ccc) **REBATES:** The amounts paid to Vendor (a) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (b) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescription drugs by Members. Rebates include all revenue received by Vendor from outside sources related to the Plan's utilization or enrollment in programs. These would include, but are not limited to access fees, market share fees, rebates, formulary access fees, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers, and data warehouse vendors.
- ddd) **REDACT:** For purposes of this RFP, to edit a document by obscuring or removing information that is considered confidential or proprietary as defined by N.C.G.S. § 132-1.2. Any redactions must be done in black.
- eee) **REQUEST FOR PROPOSAL (RFP):** The document which establishes the bidding and contract requirements and solicits bid proposals to meet the purchase needs of the State as identified herein.
- fff) **SECURE FILE TRANSFER PROTOCOL (SFTP):** SFTP in which a standard network protocol is used to exchange files over a Transmission Control Protocol/Internet Protocol based network.
- ggg) **SERVICE PERIOD:** The initial service period begins upon the Plan's acceptance of all implementation Deliverables for which all TPA services are in effect. The Service Periods for this Contract equate to the Plan Year.
- hhh) **SERVICES:** The tasks and duties undertaken by Vendor to fulfill the requirements and specifications of this RFP.
- iii) **SHALL OR MUST:** Denotes that which is a mandatory requirement.
- jjj) **SHOULD:** Denotes that which is recommended or preferred, but not mandatory.

kkk) **SPLIT CONTRACT:** Retiree who is Medicare primary with one or more Dependents that are non-Medicare primary or vice versa.

lll) **STANDARD AUDITS:** Audits performed on an ongoing quarterly basis by the Plan's Auditors and/or the North Carolina Office of the State Auditor. Standard Audits are used to measure claims accuracy, generally, and associated with Performance Guarantees and identify overpayments

mmm) **STATE:** The State of North Carolina, including any of its sub-units recognized under North Carolina law.

nnn) **STATE AGENCY:** Any of the more than 30 employing units within the executive branch of the State, including its departments, boards, commissions, institutions of higher education, and other institutions.

ooo) **STATE BUSINESS DAY:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, except for North Carolina state holidays as defined by the Office of State Human Resources: <http://www.osp.state.nc.us/holsched.htm>.

ppp) **SUBCONTRACTOR:** An entity having an arrangement with a Plan vendor, where the Plan vendor uses the Products and/or services of that entity to fulfill some of its obligations under its contract with the Plan, while retaining full responsibility for the performance of all of its (Vendor's) obligations under the contract, including payment to the Subcontractor. The Subcontractor has no contractual relationship with the Plan, only with Vendor.

qqq) **SUBSCRIBER:** The primary health benefit plan contract holder.

rrr) **TEST PLAN:** The document or tool developed by Vendor to manage, organize, and track test cases.

sss) **TIER 1 PROVIDER:** In-network provider that meets the established high quality and low cost criteria.

ttt) **TIER 2 PROVIDER:** In-network provider that does not meet the Tier 1 provider quality and/or cost criteria.

uuu) **THIRD PARTY ADMINISTRATOR (TPA):** A Vendor that provides administrative services and assumes responsibility for administering health benefit plans including claims processing without assuming financial risk for claims payments.

vvv) **THIRD PARTY ADMINISTRATIVE (TPA) SERVICES:** Services provided by the Third Party Administrator.

www) **UNIT TESTING:** Testing performed in isolation of interdependencies.

xxx) **VENDOR:** Supplier, bidder, proposer, company, firm, corporation, partnership, individual, or other entity submitting a response to this RFP.

yyy) **VENDOR AUDIT SCHEDULE:** Schedule that outlines the dates and turnaround times for each step of the monthly enrollment audits between Plan Vendors.

## 3.0 METHOD OF AWARD AND PROPOSAL EVALUATION PROCESS

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### 3.1 METHOD OF AWARD

Pursuant to N.C.G.S. § 135-48.34, this solicitation is not subject to the requirements of Article 3 of Chapter 143 of the North Carolina General Statutes. Contracts will be awarded in accordance with N.C.G.S. § 135-

48.33 and the evaluation criteria set out in this solicitation. Prospective Vendors shall not be discriminated against on the basis of any prohibited grounds as defined by applicable Federal and State law.

All qualified proposals will be evaluated, and awards will be made to Vendor(s) meeting the RFP requirements and achieving the highest and best final evaluation based on the criteria described below.

While the intent of this RFP is to award a Contract(s) to a single Vendor, the State reserves the right to make separate awards to different Vendors for one or more line items, to not award one or more line items, or to cancel this RFP in its entirety without awarding a Contract if it is considered to be most advantageous to the State to do so.

The status of a Vendor's E-Procurement Services account(s) shall be considered a relevant factor in determining whether to approve the award of a contract under this RFP. Any Vendor with an E-Procurement Services account that is in arrears by 91 days or more at the time of proposal opening may, at the State's discretion, be disqualified from further evaluation or consideration.

The State reserves the right to waive any minor informality or technicality in proposals received.

### **3.2 CONFIDENTIALITY AND PROHIBITED COMMUNICATIONS DURING EVALUATION**

During the evaluation period—from the date proposals are opened through the date the contract is awarded—each Vendor submitting a proposal (including its representatives, Subcontractors, and/or suppliers) is prohibited from having any communications with any person inside or outside the using agency, issuing agency, other government agency office, or body (including the purchaser named above, department secretary, agency head, members of the general assembly and/or governor's office), or private entity, if the communication refers to the content of Vendor's proposal or qualifications, the contents of another Vendor's proposal, another Vendor's qualifications or ability to perform the contract, and/or the transmittal of any other communication of information that could be reasonably considered to have the effect of directly or indirectly influencing the evaluation of proposals and/or the award of the contract. A Vendor not in compliance with this provision shall be disqualified from contract award, unless it is determined in the State's discretion that the communication was harmless, that it was made without intent to influence and that the best interest of the State would not be served by the disqualification. A Vendor's proposal may be disqualified if its Subcontractor and supplier engage in any of the foregoing communications during the time that the procurement is active (i.e., the issuance date of the procurement to the date of contract award). Only those discussions, communications or transmittals of information authorized or initiated by the issuing agency for this RFP or general inquiries directed to the purchaser regarding requirements of the RFP (prior to proposal submission) or the status of the contract award (after submission) are excepted from this provision.

### **3.3 PROPOSAL EVALUATION PROCESS**

The State shall review all Vendor responses to this RFP to confirm that they meet the specifications and requirements of the RFP.

#### **a) The State will conduct a One-Step evaluation of Proposals:**

Proposals will be received from each responsive Vendor in a sealed envelope or package.

All proposals must be received by the State no later than the date and time specified on the cover sheet of this RFP. At that date and time, the package containing the proposals from each responding Vendor will be opened publicly and the name of Vendor will be announced.

At their option, the evaluators may request oral presentations or discussion with any or all Vendors for the purpose of clarification or to amplify the materials presented in any part of the proposal. Vendors are cautioned, however, that the evaluators are not required to request presentations or other clarifications—and often do not. Therefore, all proposals should be complete and reflect the most favorable terms available from Vendor.

Only information which is received in response to this RFP will be evaluated; reference to information previously submitted or available elsewhere shall not be evaluated or considered.

The State shall conduct a comprehensive, fair, and impartial evaluation of the proposals received in response to this request. Proposals will be evaluated according to completeness, content, and experience with similar work, the ability of Vendor and its staff, and cost(s). Specific evaluation criteria are listed in Section 3.4 EVALUATION CRITERIA, below.

Vendors are cautioned that this is a request for offers, not an offer or request to contract, and the State reserves the unqualified right to reject any and all offers at any time if such rejection is deemed to be in the best interest of the State.

The State reserves the right to reject all original offers and request one or more of Vendors submitting proposals within a competitive range to submit a best and final offer (BAFO), based on discussions and negotiations with the State, if the initial responses to the RFP have been evaluated and determined to be unsatisfactory.

Upon completion of the evaluation process, the State will make Award(s) based on the evaluation and post the award(s) to IPS under the RFP number for this solicitation. Award of a Contract to one Vendor does not mean that the other proposals lacked merit, but that, all factors considered, the selected proposal was deemed most advantageous and represented the best value to the State.

#### **b) Evaluation Committee**

An Evaluation Committee (Committee) will be established to review each proposal and recommend a Vendor. The Plan may engage the professional services of Plan vendors to assist in the evaluation process. The Plan reserves the right to alter the composition of the Committee or to designate other staff to assist in the process. Other designated staff and senior management from the Department of State Treasurer may attend meetings, discussions, and/or presentations during the evaluation process. However, all decisions regarding scoring and the final recommendation will be made solely by Committee members.

The Committee will review and evaluate all proposals submitted by the deadline specified in this RFP. This Committee will be responsible for the entire evaluation process. Committee participants are obligated to keep information identified as trade secret and proprietary confidential.

Technical Proposals meeting the Minimum Requirements described in Section 5.1 will be considered and evaluated as follows:

##### **1: Evaluation of Technical Proposal**

##### **2: Evaluation of Cost Proposal**

##### **3: Determination of Successful Proposal Based on the Combination of Technical & Cost**

#### **c) Approval for Contract Award**

Upon completion of the evaluation, the Committee will present their findings and recommendations to the Board. The Board, with the guidance of the Committee, will make the final award recommendation. The Plan's Executive Administrator will award the Contract after approval by the Plan's Board and Attorney General's Office. A Contract is not binding until the Plan's Executive Administrator and State Treasurer have signed the Acceptance of Proposal.

### **3.4 EVALUATION CRITERIA**

#### **a) Overall Scoring Weights:**

Each Vendor's proposal will be evaluated and scored on several factors. The Technical Proposal includes the written proposal and oral presentation, if applicable. The Technical Proposal and the Cost Proposal will be scored separately based on the overall point scale described below.

*The total points scale will reflect the following weights:*

Technical Proposal	50%
Cost Proposal	50%
<b>Total:</b>	<b>100%</b>

**b) Technical Requirements & Specifications:**

Scoring points for the Technical Proposal will be allocated as follows:

<b>TECHNICAL AREAS</b>	<b>MAXIMUM POINTS</b>
Section 5.2.1 Account Management	20
Section 5.2.2 Finance and Banking	19
Section 5.2.3 Network Management	28
Section 5.2.4 Product and Plan Design Management	4
Section 5.2.5 Medical Management	18
Section 5.2.6 Enrollment, EDI, and Data Management	40
Section 5.2.7 Customer Experience	52
Section 5.2.8 Claims Processing and Appeals Management	16
Section 5.2.9 Claims Audit, Recovery, and Investigation	25
Section 5.2.10 Initial Implementation and Ongoing Testing	3
Section 5.2.11 Reporting	48
<b>Total</b>	<b>310</b>

The Vendors will be ranked in descending order based on the total points earned. The Vendor earning the least points out of the total 310 will receive the rank of one (1). The bids will fall in line according to total scored points, with the Vendor earning the most points out of the total 310 receiving the highest rank. Should two (2) Vendors earn the same score in the technical points, they will be given equal rank.

**c) Cost Proposal:**

Cost Proposals will be scored based upon the Vendor's response to ATTACHMENT A. The maximum number of total points will be awarded to Vendor offering the most competitive cost proposal with others receiving points proportionately.

Vendor responses to the cost specifications in ATTACHMENT A will be evaluated in three (3) categories representing 10 total points.

- 1) Network Pricing – six (6) points

- a) Projected claim costs will be calculated for each Vendor based on their response to the cost specifications.
  - b) The highest ranked (or lowest network pricing) proposal will receive the full six (6) points allocated to this section.
  - c) All other proposals will be ranked and will receive points based on the following criteria: within 0.5% of the first ranked proposal = 6 points; within 1.0% = 5 points; within 1.5% = 4 points, within 2.0% = 3 points, within 2.5% = 2 points, within 3.0% = 1 point, greater than 3.0% = 0 points.
- 2) Administrative Fees – two (2) points
- a) Projected administrative fees will be calculated for each Vendor based on their response to the cost specifications.
  - b) The highest ranked (or lowest administrative fees) proposal will receive the full two (2) points allocated to this section.
  - c) All other proposals will be ranked and may receive one (1) or zero (0) points based on their administrative fees in comparison to the lowest administrative fee proposal and the other proposals.
- 3) Network Pricing Guarantees – two (2) points
- a) Proposals will be evaluated and ranked based on their proposed network pricing guarantees. The value of the pricing guarantees will be based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.
  - b) The proposal that offers the network pricing guarantees with the greatest value will be ranked the highest and will receive the full two (2) points allocated to this section.
  - c) All other proposals will be ranked and may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.

The Vendors will be ranked in descending order based on the total cost proposal points earned. The Vendor earning the least cost proposal points out of the total 10 will receive the rank of one (1). The bids will fall in line according to total cost proposal points, with the Vendor earning the most points out of the total 10 receiving the highest rank. Should two Vendors earn the same score in the cost proposals, they will be given equal rank.

### 3.5 PERFORMANCE OUTSIDE THE UNITED STATES

Vendor shall complete ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR. In addition to any other evaluation criteria identified in this RFP, the State may also consider, for purposes of evaluating proposed or actual contract performance outside of the United States, how that performance may affect the following factors to ensure that any award will be in the best interest of the State:

- a) Total cost to the State
- b) Level of quality provided by Vendor
- c) Process and performance capability across multiple jurisdictions
- d) Protection of the State's information and intellectual property
- e) Availability of pertinent skills
- f) Ability to understand the State's business requirements and internal operational culture
- g) Particular risk factors such as the security of the State's information technology
- h) Relations with citizens and employees
- i) Contract enforcement jurisdictional issues



### 3.6 INTERPRETATION OF TERMS AND PHRASES

This RFP serves two (2) functions: (1) to advise potential Vendors of the parameters of the solution being sought by the State; and (2) to provide (together with other specified documents) the terms of the Contract resulting from this procurement. As such, all terms in the RFP shall be enforceable as contract terms in accordance with ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS. The use of phrases “shall,” “must,” and “requirements” are intended to create enforceable contract obligations. “Shall” or “must” denote that which is a mandatory requirement. “Should” denotes that which is recommended or preferred, but not mandatory. “May” denotes that which is permissible, not mandatory.

In determining whether proposals should be evaluated or rejected, the State will take into consideration the degree to which Vendors have proposed or failed to propose responses that will satisfy the State’s needs as described in the RFP. Except as specifically stated in the RFP, no one requirement shall automatically disqualify a Vendor from consideration. However, failure to comply with any single requirement may result in the State exercising its discretion to reject a proposal in its entirety.

## 4.0 REQUIREMENTS

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This Section lists the requirements related to this RFP. By submitting a proposal, Vendor agrees to meet all stated requirements in this Section as well as any other specifications, requirements, and terms and conditions stated in this RFP. If a Vendor is unclear about a requirement or specification or believes a change to a requirement would allow for the State to receive a better proposal, Vendor is urged and cautioned to submit these items in the form of a question during the question and answer period in accordance with Section 2.5. Vendors must provide a response to Section 4.10 in accordance with Section 2.7.2.

### 4.1 CONTRACT TERM

The Contract shall have an initial term of 60 months, including 24 months for implementation, beginning January 1, 2023, through December 31, 2024. Vendor shall begin providing services on January 1, 2025, through December 31, 2027.

At the end of the Contract’s current term, the State shall have the option, in its sole discretion, to extend the Contract on the same terms and conditions for up to two (2) additional one-year terms beginning January 1, 2028, through December 31, 2028, and January 1, 2029, through December 31, 2029. The State will give Vendor written notice of its intent to exercise each extension option no later than thirty (30) days before the end of the Contract’s then-current term. In addition, the State reserves the right to extend a contract term for a period of up to 180 days in 90-day-or-less increments.

### 4.2 PRICING

Proposal price shall constitute the total cost to the State for complete performance in accordance with the requirements and specifications herein. Vendor shall not invoice for any amounts not specifically allowed for in this RFP. Vendor shall be responsible for all travel expenses, including travel mileage, meals, lodging, and other travel expenses incurred in the performance of this Contract. Complete ATTACHMENT A: PRICING and include in Proposal.

### 4.3 INVOICES

#### 4.3.1 Administrative Fees

- a) Vendor shall submit a completed and signed “STATE OF NORTH CAROLINA SUBSTITUTE W-9 FORM, Request for Taxpayer Identification Number” to the Plan’s Contracting Section within 15 days of execution of the Contract. This form can be accessed at the following link: <https://www.osc.nc.gov/vendor-resources>.

- b) Vendor shall invoice the Plan for administrative fees for services rendered in accordance with the Scope of Work and provisions of this Contract, and in compliance with the cost proposed in ATTACHMENT A.
- c) All invoices shall be submitted electronically to SHPNCFinance@nctreasurer.com to ensure timely receipt and payment.
- d) All invoices shall include an authorized signature and a certification stating, "As an authorized representative of Vendor, I hereby certify that the units and amounts billed to the North Carolina State Health Plan (Plan) on this invoice are accurate and true and comply with all laws, regulations, and contractual provisions that are conditions of payment pursuant to the relationship between Vendor and the Plan."
- e) Vendor shall submit an invoice by the 20th day of each month, unless another date is approved by the Plan, reflecting all billable administrative activity for the previous month.
- f) Any services invoiced on a Per Member Per Month (PMPM) or Per Subscriber Per Month (PSPM) basis shall be based on actual membership provided by the Plan's EES vendor. The membership report will be provided electronically to Vendor by the Plan or the Plan's EES vendor by the 10th State Business day of the month. Vendor agrees that membership is to be based on this membership report without exception.
- g) The Parties shall mutually agree to an invoicing and reimbursement schedule for any one-time fees charged in accordance with ATTACHMENT A, except the Plan shall not make payment for any one-time fees prior to the date services for the applicable component of the Scope of Work are fully implemented.
- h) The Plan, at its sole discretion, shall determine if the services on each invoice have been satisfactorily completed. The Plan may withhold payment for incomplete, unsatisfactory, or untimely Deliverables.
- i) The Plan reserves the right to validate any invoice submitted for payment and shall have access to Vendor's or Subcontractors' supporting documentation necessary to validate the invoice.
- j) Payment of fees will be made within 30 calendar days of receipt of the invoice, provided that the Plan has determined satisfactory completion of a particular service or Deliverable. If the Plan determines an invoice contains an error, Vendor shall be required to submit a corrected invoice, in which case payment shall be made within 30 calendar days of receipt of the corrected invoice.
- k) Vendor is responsible for any and all payments to Subcontractors.
- l) Payment of the invoice by the Plan does not constitute a waiver or otherwise prejudice the Plan's right to object to or question any invoice or matter in relation thereto. Such payment shall not be construed as acceptance of any part of the work or service provided or as an approval of any of the amount invoiced therein.

#### **4.3.2 Claims and other Disbursements**

- a) Vendor shall batch claims and/or other disbursements for payment from the Plan's bank account on a weekly basis according to the disbursement schedule established by the Plan.
- b) Vendor shall submit a weekly reporting package of disbursements as required in Section 5.2.2 et seq., no later than 9:30 a.m. ET on the first State Business Day of each week. Vendor shall hold checks and processing of electronic funds transfers (EFTs) for all disbursements until funding is authorized and requisitioned by the Plan. The Plan shall notify Vendor of funding availability no later than 4:00 p.m. ET on the day the request is received.

- c) The Plan reserves the right to validate any reporting package of disbursements submitted for funding and shall have access to Vendor's or Subcontractors' supporting documentation as necessary to validate the funding request.
- d) Funding of weekly disbursements by the Plan shall not constitute a waiver or otherwise prejudice the Plan's right to object to or question any disbursement or matter in relation thereto. Such funding shall not be construed as acceptance of any part of the work or service provided or as an approval of any of the amount funded therein.

#### 4.4 PAYMENT TERMS

Vendor will be compensated at the rates quoted in Vendor's Cost Proposal.

#### 4.5 FINANCIAL STABILITY

Each Vendor shall certify it is financially stable by completing ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION. The State is requiring this certification to minimize potential issues from Contracting with a Vendor that is financially unstable. From the date of the Certification to the expiration of the Contract, Vendor shall notify the State within 30 days of any occurrence or condition that materially alters the truth of any statement made in this Certification.

#### 4.6 RESERVED

#### 4.7 BACKGROUND CHECKS

Vendor and its personnel are required to provide or undergo background checks at Vendor's expense prior to beginning work with the State. As part of this process, the details below must be provided to the State:

- a) Any **criminal felony conviction**, or conviction of any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception, of Vendor, its officers or directors, or any of its employees or other personnel to provide Services on this project, of which Vendor has knowledge or a statement that it is aware of none;
- b) Any **criminal investigation** for any felony or offense involving moral turpitude, including, but not limited to fraud, misappropriation, falsification, or deception pending against Vendor, its officers or directors, or any of its employees or other personnel to provide Services on this project, of which Vendor has knowledge or a statement it is aware of none;
- c) Any **regulatory sanctions** levied against Vendor or any of its officers, directors or its professional employees expected to provide Services on this project by any state or federal regulatory agencies within the past three years or a statement that there are none. As used herein, the term "regulatory sanctions" includes the revocation or suspension of any license or certification, the levying of any monetary penalties or fines, and the issuance of any written warnings;
- d) Any **regulatory investigations** pending against Vendor or any of its officers, directors or its professional employees expected to provide Services on this project by any state or federal regulatory agencies of which Vendor has knowledge or a statement that there are none.
- e) Any **civil litigation**, arbitration, proceeding, or judgments pending against Vendor during the three (3) years preceding submission of its proposal herein or a statement that there are none.

Vendor's responses to these requests shall be considered to be continuing representations, and Vendor's failure to notify the State within 30 days of any criminal litigation, investigation, or proceeding involving Vendor or its then current officers, directors, or persons providing Services under this Contract during its term shall constitute a material breach of contract. The provisions of this paragraph shall also apply to any Subcontractor utilized by Vendor to perform Services under this Contract.

#### 4.8 PERSONNEL

Vendor shall not substitute key personnel assigned to the performance of this Contract without prior written approval by the Plan's Contract Administrator regarding day-to-day activities. Vendor shall notify the Plan's Contract Administrator regarding day-to-day activities of any desired substitution, including the name(s) and references of Vendor's recommended substitute personnel. The State will approve or disapprove the requested substitution in a timely manner. The State may, in its sole discretion, terminate the services of any person providing services under this Contract. Upon such termination, the State may request acceptable substitute personnel or terminate the contract services provided by such personnel.

#### 4.9 VENDOR'S REPRESENTATIONS

- a) Vendor warrants that qualified personnel shall provide Services under this Contract in a professional manner. "Professional manner" means that the personnel performing the Services will possess the skill and competence consistent with the prevailing business standards in the industry. Vendor agrees that it will not enter any agreement with a third party that may abridge any rights of the State under this Contract. Vendor will serve as the prime vendor under this Contract and shall be responsible for the performance and payment of all Subcontractor(s) that may be approved by the State. Names of any third-party vendors or Subcontractors of Vendor may appear for purposes of convenience in Contract documents; and shall not limit Vendor's obligations hereunder. Vendor will retain executive representation for functional and technical expertise as needed in order to incorporate any work by third party Subcontractor(s).
- b) If any Services, deliverables, functions, or responsibilities not specifically described in this Contract are required for Vendor's proper performance, provision and delivery of the service and deliverables under this Contract, or are an inherent part of or necessary sub-task included within such service, they will be deemed to be implied by and included within the scope of the Contract to the same extent and in the same manner as if specifically described in the Contract. Unless otherwise expressly provided herein, Vendor will furnish all of its own necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies, and materials necessary for Vendor to provide and deliver the Services and Deliverables.
- c) Vendor warrants that it has the financial capacity to perform and to continue perform its obligations under the Contract; that Vendor has no constructive or actual knowledge of an actual or potential legal proceeding being brought against Vendor that could materially adversely affect performance of this Contract; and that entering into this Contract is not prohibited by any contract, or order by any court of competent jurisdiction.

#### 4.10 ADMINISTRATORS FOR THE CONTRACT AND HIPAA PRIVACY OFFICER

The contract administrators are the persons to whom notices provided for in this Contract shall be given and to whom matters relating to administration or interpretation of this Contract shall be addressed. Either party may change its administrator or his or her address and telephone number by written notice to the other party.

- a) **The Plan's Contract Administrator for day to day activities, Contract Administrator for all contractual issues, and HIPAA and Contract Compliance Coordinator are listed below:**

North Carolina State Health Plan Contract Administrator regarding day-to-day activities herein:

Caroline Smart, Senior Director of Plan Integration  
North Carolina State Health Plan for Teachers and State Employees  
3200 Atlantic Avenue  
Raleigh, NC 27604  
Phone: (919) 814-4454  
Email: [Caroline.Smart@nctreasurer.com](mailto:Caroline.Smart@nctreasurer.com)

North Carolina State Health Plan Contract Administrator for all contractual issues listed herein:

Vanessa Davison, Contracting Agent  
North Carolina State Health Plan for Teachers and State Employees  
3200 Atlantic Avenue  
Raleigh, NC 27604  
Phone (919) 814-4421  
Email: [Vanessa.Davison@nctreasurer.com](mailto:Vanessa.Davison@nctreasurer.com)

North Carolina State Health Plan HIPAA and Contract Compliance Coordinator for all privacy related matters herein:

Chris Almberg, HIPAA Privacy Officer  
North Carolina State Health Plan for Teachers and State Employees  
3200 Atlantic Avenue  
Raleigh, NC 27604  
Phone (919) 814-4428  
Email: [Chris.Almberg@nctreasurer.com](mailto:Chris.Almberg@nctreasurer.com)

North Carolina Department of State Treasurer Information Security Officer for all data security related matters herein:

Renee Bourget, Information Security Manager  
North Carolina Information Technology Division  
3200 Atlantic Avenue  
Raleigh, NC 27604  
Phone (919) 266-3925  
Email: [Renee.Bourget@nctreasurer.com](mailto:Renee.Bourget@nctreasurer.com)

**b) Vendor's contract administrator for day to day activities, contract administrator for all contractual issues, and HIPAA and Contract Compliance coordinator are listed below:**

Vendor's contract administrator regarding day-to-day activities herein:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Vendor's contract administrator for all contractual issues listed herein:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Vendor's HIPAA Privacy or Compliance Officer for all privacy related matters herein:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

Vendor's Information Security Officer for all data security related matters herein:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

#### **4.11 CONFIDENTIALITY AND PROTECTION OF PROPRIETARY INFORMATION**

Pursuant to N.C.G.S. §§ 135-48.10, 132-1.2, 132-1.10, and 75-65 and in accordance with other applicable state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), Vendor shall maintain the confidentiality of all Plan Member information, in whatever form, and however it is obtained. Vendor further agrees that if it receives, stores, processes, has access to, maintains, or otherwise deals with "patient identifying information" or "records" as defined in 42 C.F.R. § 2.11 from a substance use disorder "program," as defined in 42 C.F.R. § 2.11, that is federally assisted in a manner described in 42 C.F.R. § 2.12(b), then it is fully bound by the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, with respect to such information and records, including but not limited to the provisions related to use, disclosure and re-disclosure thereof. For any security breach by Vendor or its Subcontractors or agents as described in Article 2A of Chapter 75 of the North Carolina General Statutes, the Plan has a right to require Vendor to provide notice required by N.C.G.S. § 75-65 and to offer credit monitoring for affected Members, all at Vendor's sole expense.

##### **a) Confidentiality Agreements**

Within 10 calendar days of the Contract execution date, Vendor must begin the process of executing Confidentiality Agreements with Plan vendors as determined by the Plan. Vendor must complete the execution of Confidentiality Agreements within 45 calendar days of the Contract execution date. The Plan will provide Vendor with contact information for these Plan vendors upon announcement of the winning Vendor.

#### **4.12 ADMINISTRATIVE DECISION MEMOS (ADM)**

Administrative Decision Memos (ADM) will be used to document processes or initiate changes related to the performance of this Contract. The Plan will initiate the ADM for response by Vendor. If requested by the Plan, Vendor shall submit an ADM after consulting with the Plan for approval. Upon written approval by the Plan's Contract Administrator regarding day-to-day activities, the ADM will be incorporated into the Contract. Updates and revisions to an ADM shall follow this procedure.

#### **4.13 CONTRACT DOCUMENTS**

The Contract consists of the following documents, incorporated herein by reference:

- a) The Addenda to this RFP, if any; and
- b) This RFP, which includes all Exhibits, Attachments, and Appendices; and
- c) Vendor's Minimum Requirements Proposal including clarifications and supplemental documentation;
- d) Vendor's Technical and Cost Proposal including clarifications, supplemental documentation, and,

- e) Any ADM, Business Requirements Document (BRD), or Implementation Plans (developed or modified as described in ATTACHMENT C. 24. Amendments).

#### **4.14 DATA OWNERSHIP**

Vendor understands and agrees that all data and documents provided by the Plan or by Plan vendors are and shall be owned by the Plan or its vendors and shall be used by Vendor solely for the purposes described in this Contract. Under no circumstances shall Vendor share the data with any other entity without the Plan's prior written authorization except as otherwise authorized by this Contract.

#### **4.15 CONFLICT OF INTEREST**

By signing the Execution Page, Vendor certifies that it shall not take any action or acquire any interest, either directly or indirectly, that will create a Conflict of Interest, as defined herein, in any manner or degree with the performance of its services during the term of the Contract.

**Vendor shall:**

- a) Disclose any relationship to any business or associate with whom Vendor is currently doing business that creates or may give the appearance of a Conflict of Interest related to this RFP.
- b) Disclose prior to employment or engagement by Vendor, any firm principal, staff member or subcontractor, known by Vendor to have a Conflict of Interest or potential Conflict of Interest related to this RFP.
- c) Disclose any affiliation, business relationship or other association with any Plan vendor. A full list of Plan vendors is available at:  
[https://shp.nctreasurer.com/AboutSHP/oversight/Pages/SHP\\_contracted\\_vendors.aspx](https://shp.nctreasurer.com/AboutSHP/oversight/Pages/SHP_contracted_vendors.aspx), bottom of the page in the footer section.
- d) Provide written notice to the Plan of any actual or imminent legal matters or regulatory compliance actions involving Vendor and federal, state, or local government entities. Without limitation, notice shall be provided for investigations and legal actions or matters subject to arbitration involving Vendor and/or its subcontractors, including key management or executive staff, or any major stakeholder (five percent (5%) or more), brought by a government agency (federal or state) on matters relating to payments from government entities. In providing the notice, Vendor shall provide the date of initiation, the subject matter, and the parties to the matter, and the resolution if resolved at the time of the notice. Notice must include settlement agreements or corporate integrity agreements, unless otherwise confidential.
- e) Specify any lawsuits or regulatory compliance actions with which Vendor has been involved within the past five (5) years. If any, please provide a detailed explanation.
- f) Notify the Plan in writing within 15 calendar days of any material changes in disclosures or certifications made under this section for the duration of the contract.

#### **4.16 VENDOR'S REPRESENTATIVE**

**Vendor shall:**

- a) Provide to the Plan in ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION a list of individuals with authority to bind the firm in connection with this Contract, including answering questions, providing clarifications concerning Vendor's proposal, and executing future contractual documents.
- b) Notify the Plan in writing within 15 calendar days of any changes in those individuals identified as having authority to bind the firm.

#### **4.17 DEBARRED, SUSPENDED OR EXCLUDED VENDORS**

**Vendor shall:**

- a) Notify the Plan in writing within 15 calendar days if any of its principals, Subcontractors or Subcontractors' principals become debarred, suspended, or in any way excluded from State or Federal procurements as reported to the System for Award Management (SAM) or appears as an excluded provider on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
- b) If information contrary to this certification or notification subsequently becomes available, such evidence may be grounds for non-award, or breach of contract should Vendor be a recipient of the contract award.

#### **4.18 REGISTRATION AND CERTIFICATION**

**Vendor shall comply with the following:**

- a) As a condition of contract award, any Vendor that is a corporation, limited-liability company, or limited-liability partnership shall have received, and shall maintain throughout the term of the Contract, a Certificate of Authority to Transact Business in North Carolina from the North Carolina Secretary of State, as required by North Carolina law.
- b) Vendor shall notify the Plan in writing within 15 calendar days of any changes in certifications made in response to this RFP for the duration of the Contract.

#### **4.19 TRANSITION OF CONTRACT SERVICES AND RELATED ACTIVITIES**

**Vendor shall:**

- a) Upon award of the Contract, cooperate fully with the incumbent, as required by the Plan, in the transition of contract services and related activities.
- b) Upon expiration or termination of the Contract, cooperate fully in the transition of contract services and related activities to the successor TPA vendor or other vendors for a period up to 18 months which includes, but is not limited to sending data files during the testing and transition phase, as requested by the Plan and formalized in the Implementation Plan with the new TPA vendor.
- c) During the 18-month runout of the Contract, continue the services required to support claims processing which include, but are not limited to claims processing, eligibility, customer service, appeals and grievances, Medical Management, escheats, and recoveries.

#### **4.20 PERFORMANCE GUARANTEES**

By signing the Execution Page, Vendor certifies its agreement to adhere to the Performance Guarantees in Section 6.3.

### **5.0 TECHNICAL & COST PROPOSAL REQUIREMENTS & SPECIFICATIONS**

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#### **5.1 MINIMUM REQUIREMENTS**

This procurement is open to qualifying Vendors that satisfy the Minimum Requirements described in this section.

When completing the TPA Minimum Requirements Table below and ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE, Vendors must confirm or not confirm, and only when requested, provide



information for all Minimum Requirements. Only those Vendors that meet 100% of the Minimum Requirements will be provided (via SFTP) a de-identified medical claims file for repricing, census data and all other exhibits listed in ATTACHMENT A: PRICING. These files are needed to submit technical and cost proposals for consideration and possible Contract award.

The Plan reserves the right to reject proposals deemed incomplete or non-compliance with these Minimum Requirements.

Vendors shall duplicate the TPA Minimum Requirements Table below and provide the page number reference to the location within Vendor's proposal where the minimum requirement has been satisfied.

TPA MINIMUM REQUIREMENTS TABLE		
	Requirement	RFP Section Number and Page Number of Response
1	Vendor shall provide a description of the company, its operations and ownership.	
2	Vendor shall provide the city and state for each office where the operational and account management resources dedicated to the Plan will be primarily located.	
3	<p>a) Vendor shall have provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives.</p> <p>b) If confirmed, provide contact information for one (1) such client so the Plan can complete a reference call related to the services in this RFP.</p>	
4	<p>a) Vendor shall certify without exception the sufficiency of its security standards, tools, technologies, and procedures in providing Services under this Contract.</p> <p>b) All Vendor and/or third-party Data Centers and Information Technology Systems used under this proposed Contract for the purpose of collecting, storing, transmitting, or exchanging Plan Data shall have and maintain, valid, favorable third-party security certification(s) on all related security controls that are consistent with, and can be cross-walked to, the data classification level and security controls appropriate for moderate information system(s) per the National Institute of Standards and Technology ("NIST") SP 800-53 Rev. 5 or the most recent revision. To satisfy this requirement, reports must have been issued within twelve (12) months prior to the anticipated Contract award date or be supplemented by bridge letters covering no more than two (2) years subsequent to the initial report issuance date. Vendor shall provide a crosswalk document along with full copies of the third-party security certification or assessment report(s), and any necessary bridge letters. Vendor shall also identify which specific system(s) covered by the third-party security certifications or attestations will be used to provide the Services under this Contract. Opinion letters or security certification attestation letters will not be submitted in lieu of full report(s).</p> <p>c) Vendor shall agree that the Plan has the right to independently evaluate, audit, and verify such requirements as part of its evaluation and during the life of the Contract, including requesting the performance of a penetration test with satisfactory results. The State will verify any such</p>	

	<p>third-party security certification or assessment report yearly during the life of the Contract, and Vendor will be required to provide an updated report or bridge letter verifying that there have been no material changes in the controls reported since the issuance of the last report. Bridge letters will only be accepted for two (2) years after the date of the initial report to satisfy this requirement.</p> <p>d) Vendor shall agree that the Plan has the right to, based upon its evaluation, require that Vendor maintain cyber breach liability insurance coverage in an amount specified by the Plan, and/or commit to obtaining a favorable third-party security certification or assessment report no later than six months prior to the date that Services under this Contract begin as a condition of Contract award. Vendor shall provide documentation of the amount of cyber breach liability insurance that it currently carries for all Vendor and/or third-party Data Centers and Information Technology Systems used to provide the Services under this Contract that will contain Plan Data. If Vendor is currently undergoing a third-party NIST SP 800-53 Rev. 5 (or most recent revision) compliant security assessment of such Data Centers or Information Technology Systems, Vendor shall provide proof of purchase or a copy of its contract with the third-party retained to perform the audit, and the expected date for completion.</p> <p>e) Vendor shall accept, and the Plan understands, that security certification and assessment reports and security information provided to the State for the purpose of this Contract may contain confidential information and/or trade secrets. Refer to Section 14 "Confidential Information" of ATTACHMENT B: INSTRUCTIONS TO VENDORS for information regarding the treatment of Confidential Information.</p>	
5	<p>Vendor must demonstrate financial stability. Vendor shall provide audited or reviewed financial statements prepared by an independent Certified Public Accountant (CPA) for the two (2) most recent fiscal years that shall include, at a minimum, a balance sheet, income statement (i.e., profit/loss statement), and cash flow statement and, if the most recent audited or reviewed financial statement was prepared more than six (6) months prior to the issuance of this RFP, the Vendor shall also submit its most recent internal financial statements (balance sheet, income statement, and cash flow statement or budget), with entries reflecting revenues and expenditures from the date of the audited or reviewed financial statement, to the end of the most recent financial reporting period (i.e., the quarter or month preceding the issuance date of this RFP). Vendor is encouraged to explain any negative financial information in its financial statement and is encouraged to provide documentation supporting those explanations.</p> <p>Consolidated financial statement of the Vendor's parent or related corporation/business entity shall not be considered, unless: 1) the Vendor's actual financial performance for the designated period is separately identified in and/or attached to the consolidated statements; 2) the parent or related corporation/business entity provides the State with a document wherein the parent or related corporation/business entity will be financially responsible for the Vendor's performance of the contract and the consolidated statement demonstrates the parent or related corporation's/business entity's financial ability to perform the contract, financial stability, and/or such other financial considerations identified in the evaluation criteria; and/or 3) Vendor provides its own internally prepared</p>	

	financial statements and such other evidence of its own financial stability identified above.	
6	Vendor shall confirm it agrees to ATTACHMENT C: NORTH CAROLINA GENERAL TERMS AND CONDITIONS without exception.	
7	Vendor shall complete and submit ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR.	
8	Vendor shall be financially stable; and complete, sign and submit without exception, ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION.	
9	Vendor shall complete, sign, and submit ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT.	
10	Vendor shall provide sufficient documentation and demonstrate HIPAA compliance through completing, signing, and submitting ATTACHMENT H: HIPAA QUESTIONNAIRE. If Vendor maintains that any information in documents submitted to demonstrate HIPAA compliance is proprietary or otherwise confidential, Vendor may Redact those portions in black.	
11	Vendor shall complete, sign, and submit ATTACHMENT I: NONDISCLOSURE AGREEMENT.	
12	Vendor shall complete, sign, and submit ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION form.	
13	Vendor shall submit two (2) completed and signed originals of Execution Page.	
14	Vendor shall confirm it agreed to all performance guarantees as described in Section 6.3 and Schedules I and II.	

Vendor shall complete ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE which addresses the Minimum Requirements below. Only responses submitted on ATTACHMENT K will be valid and considered by the Committee. Vendor is strongly encouraged to adhere to the instructions in completing the form. Vendor shall not alter, amend, or qualify any of terms as written by the Plan. Within ATTACHMENT K, Vendor shall confirm the following:

#### 5.1.1 Account Management Minimum Requirements

- a. Vendor has one (1) or more current or former administrative services only (ASO) clients with more than 25,000 Medicare primary members.
- b. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.
- c. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.
- d. Vendor has a “firewall” between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.

### 5.1.2 Finance and Banking Minimum Requirements

- a. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.
- b. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website:  
<https://www.nctreasurer.com/media/3791/open>
- c. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.
- d. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.
- e. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:
  - i. State banking: <https://www.nctreasurer.com/media/3791/open>
  - ii. Cash management: <https://www.osc.nc.gov/state-agency-resources/statewide-cash-management>
  - iii. Escheats: <https://www.nccash.com/holder-information-and-reporting>
  - iv. High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."
- f. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.

### 5.1.3 Network Management Minimum Requirements

- a. Vendor agrees the Plan is a government payor.
- b. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.
- c. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.
- d. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
- e. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.
- f. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.
- g. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.
- h. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.

- i. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.
- j. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.
- k. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.
- l. Vendor will administer other reference-based pricing models, if requested by the Plan.

#### **5.1.4 Product and Plan Design Management Minimum Requirements**

- a. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.
  - i. Enhanced PPO Plan (80/20): <https://www.shpnc.org/media/2583/download?attachment>
  - ii. Base PPO Plan (70/30): <https://www.shpnc.org/media/2582/download?attachment>
  - iii. HDHP: <https://www.shpnc.org/media/2584/open>
- b. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the Primary Care Provider (PCP) listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.
- c. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.
- d. Vendor will integrate real-time or near real-time deductible and/or out-of-pocket (OOP) accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.
- e. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.
- f. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.
- g. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

#### **5.1.5 Medical Management Programs Minimum Requirements**

- a. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
- b. Vendor will carve-out PBM services from this Contract.
- c. Vendor will customize any of the Medical Management programs, if requested by the Plan.

#### **5.1.6 Enrollment, EDI, and Data Management Minimum Requirements**

- a. Vendor will support the Plan's Group set-up structure which includes establishing, maintaining, and reporting on more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. A list of the Plan's current Group structure, which includes Group and Entity identifiers, can be found in Exhibit 3, "Group Structure."

- b. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.
- c. Vendor will have the capability to accept at least 500,000 transactions in a single file transmission.
- d. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.
- e. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.
- f. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."
- g. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.
- h. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.
- i. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.
- j. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer  
Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

- k. Vendor will serve as the Plan's Responsible Reporting Entity (RRE) under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Expanded Reporting Option.
- l. As an Expanded Reporter, Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to obtain Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare rules, to determine which Plan Members' Medicare information requires updating.
- m. Vendor will update Vendor's system with the necessary updates from the Medicare audit and send Members' updated Medicare information to the Plan's EES vendor.
- n. Vendor will store and utilize the Medicare Beneficiary Identifier (MBI), in addition to other Member identification numbers, such as Social Security Number (SSN).
- o. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.
- p. Vendor will maintain Medicare primacy effective and termination dates.
- q. Vendor will maintain multiple Medicare entitlement reasons.

- r. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.
- s. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).
- t. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.
- u. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.
- v. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.
- w. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a new PCP. The final workflows will be defined during Contract implementation. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP synchronization requirements.
- x. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)
  - i. Plan's logo.
  - ii. Plan's messaging.
  - iii. Plan's network (if applicable).
  - iv. Out-of-NC network.
  - v. Member out-of-pockets.
  - vi. Plan's Rx BIN and PBM information.
  - vii. Group Name (e.g., Wake County Schools, University of North Carolina, Department of Transportation).
  - viii. Member's unique ID number.
  - ix. Member's selected PCP.
- y. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of Certificates of Creditable Coverage (CCC) and reporting needs under sections 6055 and 6056 of the IRS code.
- z. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- aa. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- bb. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.

- cc. Vendor will implement a process with the Plan to respond to data quality (DQ) issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.
- dd. Vendor will release data to the Plan as described in state and federal law.
- ee. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.

#### **5.1.7 Customer Experience Minimum Requirements**

- a. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.
- b. Vendor will have a dedicated toll-free number for Plan Members.
- c. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.
- d. Vendor will customize its interactive voice response (IVR) script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
- e. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.
- f. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
- g. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and Explanation of Benefits (EOB) mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."
- h. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.
- i. Vendor will co-brand letters or other materials Vendor sends to Members.
- j. Vendor will customize the portal with the Plan's branding (logo).
- k. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.

#### **5.1.8 Claims Processing and Appeals Management Minimum Requirements**

- a. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.
- b. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
- c. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.



- d. Vendor will customize any appeals letters, as requested by the Plan.
- e. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.
- f. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan - Medicare Part B."
- g. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.
- h. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."

### 5.1.9 Claims Audit, Recovery, and Investigation Minimum Requirements

- a. Vendor will support ongoing quarterly claims accuracy audits, or Standard Audits, performed on a statistically valid random claims sample selected by the Plan's audit vendor which will be used to measure claims accuracy for Performance Guarantees on a quarterly basis. Vendor will share provider contracts and system pricing with the Plan's auditors for review and audit. The audit will also include a targeted sample selected from a comprehensive analysis of all claims by the Plan's audit vendor.

An audit plan will be provided prior to the initial quarterly audit that will define the ongoing Standard Audit timelines. Both the random claims sample and the targeted sample will be used to identify overpayments owed to the Plan. For purposes of Standard Audits, claims accuracy will be measured based on the following criteria:

- i. Financial Accuracy: Total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute values of the dollars processed in error from the total dollars processed. Underpayments and overpayments are not offset by one another.
- ii. Payment Accuracy: The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
- iii. Processing Accuracy: The number of claims processed with no procedural errors divided by the total number of claims processed.

For purposes of the above definitions, if Vendor has identified and recovered an overpayment or processed an underpayment prior to the audit, it is not an error. If Vendor has identified but not recovered the overpayment or processed the underpayment, it is an error.

- b. Vendor will, in addition to supporting ongoing quarterly claims accuracy audits, support Focus Audits, such as, but not limited to, coordination of benefits (COB) audits, duplicate claims audits, eligibility audits, and comprehensive electronic audits conducted by the Plan's auditor vendor on an as needed basis. All the rules outlined in Section 5.1.9.a above will apply to these audits.
- c. Vendor's recovery processes will follow all deposit and financial reporting requirements outlined in Section 5.2.2, Finance and Banking.
- d. Vendor will recover any overpayments to Providers by offsetting future payments or by demand without any limitation as to time since the Plan as a government payor is not subject to the two-year limitation established in N.C.G.S. § 58-3-225(h).
- e. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (North Carolina General Statutes, Chapter 105A, Article 1), the Retirement/Disability Offset Program (N.C.G.S. §§ 135-

9(b), 128-31, 120-4.29), Wage Garnishment (N.C.G.S. § 135-48.37A), and Credit Card Intercepts (N.C.G.S. § 1- 359) and implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 10, "State Health Plan Recovery Workflows."

- f. Vendor will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, mental health parity, disclosures, reporting, etc.).
- g. Vendor has an investigation or similar unit to investigate possible fraud and abuse and will share details about specific investigations that impact the Plan, including the names of the providers involved.

#### **5.1.10 Initial Implementation and Ongoing Testing Minimum Requirements**

- a. Vendor will have a fully assembled implementation team that includes the appropriate subject matter experts, ready to begin work within two (2) weeks of contract award. The team shall include an overall implementation manager and separate implementation resources for, at a minimum, each of the following work streams:
  - i. Group Set-Up & Enrollment
  - ii. Plan Vendor Integration & EDI, which includes:
    - 1) EES vendor Integration. (EDI, PCP Tool, SSOs, Audits)
    - 2) PBM vendor Integration. (Data files, SSOs, Accumulators)
    - 3) Billing vendor Integration. (Claims hold, Audits)
    - 4) Plan Data Warehouse Integration. (Data files)
  - iii. Network Evaluation

Other workstreams will kick-off throughout 2023.

- b. Vendor will have the depository bank account(s) setup and tested at least 45 days prior to January 1, 2025.
- c. If applicable, Vendor will have the disbursement account(s) setup and tested at least 30 days prior to January 1, 2025.
- d. Vendor will have all services, including custom programs, operational by January 1, 2025.
- e. Vendor will work with the Plan to document in an ADM all custom processes developed to meet the Plan's unique requirements. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
- f. Vendor will work with the Plan to finalize Vendor Audit Schedule for 2025 and subsequent years. This Audit Schedule will be updated via ADM. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
- g. For all technical components of the initial implementation as well as any implementations throughout the lifetime of the Contract, Vendor will develop functional requirements documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation derived from the Plan's Business Requirements. These documents must be mutually agreed upon by Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.
- h. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live of any initiative. To support testing, Vendor must not only have the resources, but also the test environments, necessary to support multiple work streams at one time. As mentioned above, the Test Plan will be mutually agreed upon by Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.

- i. Vendor will support the 2025 Open Enrollment, which is currently scheduled for October 2024 but may be rescheduled to a different time at the Plan's sole discretion. Vendor must have the group set-up complete, the call center open, any required SSOs in place, the PCP selection tool integrated with the Plan's EES vendor and be able to accept EDI from Plan vendors during the month Open Enrollment occurs.

#### 5.1.11 Reporting Minimum Requirement

- a. Vendor will agree to delivering the Standard Reports as described in Section 5.2.11.2.b.viii.2) – xvii.3), and based on the delivery schedule in Exhibit 11, "Standard Reports."

### 5.2 TECHNICAL PROPOSAL REQUIREMENTS AND SPECIFICATIONS

Vendor shall complete ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE which addresses the technical requirements below.

#### 5.2.1 Account Management

##### 5.2.1.1 Overview and Expectations

The Plan seeks to partner with a Vendor that has the experience, knowledge, and resources to support all the services outlined in this RFP. Vendor must be transparent when partnering with the Plan on initiatives or providing internal processes, data, or other information, as requested by the Plan. Vendor must also show a willingness to develop custom networks and Product solutions to support the Plan. Finally, Vendor must be responsive and have the resources to support Plan operations, implementations, and ongoing data needs.

##### 5.2.1.2 Resources

- a. Vendor addressed the following in the Minimum Requirements Table or ATTACHMENT K:
  - i. Vendor has provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives. Vendor shall provide the Plan with contact information for one (1) such client to complete a reference call related to the services in this RFP.
  - ii. Vendor has one (1) or more current or former ASO clients with more than 25,000 Medicare primary members.
  - iii. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.
  - iv. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.
  - v. Vendor has a "firewall" between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.
- b. Vendor shall confirm it will provide a dedicated resource for each of the following roles:
  - i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to Plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.
  - ii. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment and Group Set-Up.
  - iii. **Member Services Manager** – Responsible for all customer service functions and reporting.

- iv. **Claims Services Manager** – Responsible for claims payments and recoveries.
  - v. **Enrollment and Group Set-Up**– Responsible for all enrollment, enrollment files, and reconciliation services.
  - vi. **Data Manager** – Responsible for providing expertise in data analytics and modeling as well as coordinating data requests, data testing, and data exchanges, including any data files to Plan vendors, Plan partners, and the Plan.
  - vii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process and must continue to support the Plan for a minimum of 90 days after the implementation date of January 1, 2025, if requested by the Plan. Such support includes, but is not limited to, weekly calls with the Plan and the designated account management team; maintenance of issue tracking logs; and issue resolution.
- c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed. Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:
- i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.). This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic initiatives.
  - ii. **Director of Network Management** – Responsible for overall management of Vendor's network including provider contracting, network development, and/or provider relations functions. This resource will work with the Plan to develop, implement, and maintain custom provider reimbursement models or other provider initiatives as requested by the Plan.
  - iii. **Actuary** - Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating Return on Investment (ROI) in order to measure financial effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) as well as alternate payment models (Accountable Care Organizations, Clinically Integrated Networks, etc.). Will be required, upon request, to provide sufficient data and documentation to the Plan to independently verify calculations. The Actuary shall be a Fellow of the Society of Actuaries with a primary focus in Health Benefit Systems.
  - iv. **Privacy Officer** - Responsible for ensuring compliance with all applicable laws and regulations, including, but not limited to, HIPAA, Patient Protection and Affordable Care Act (PPACA), and the Employee Retirement Income Security Act of 1974 (ERISA). Responsible for maintaining internal controls to protect Protected Health Information (PHI) and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.
  - v. **Attorney** - Responsible for communicating program and policy updates to the Plan and coordinating as necessary with the Plan's internal counsel and staff. Responsible for promptly reviewing materials for Vendor and providing appropriate, legally justifiable, feedback to the Plan. This person must be well-versed in Chapter 135 of the North Carolina General Statutes and Chapter 58 of the North Carolina General Statutes, to the extent that North Carolina Department of Insurance (DOI) regulations apply to the Plan.

#### 5.2.1.3 The Plan requires a Vendor that is both responsive and transparent

- a. Vendor shall confirm each of the following:

- i. Vendor will meet with the Plan within two (2) weeks of a new request or initiative and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan. Meeting topics could include, but would not be limited to, data requests, network and/or Product development, pilots, and other initiatives.
- ii. Once a project or initiative is underway, Vendor will meet with the Plan within one (1) week of the request and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan.
- iii. Vendor will respond to Plan inquiries regarding legal, financial, or operational matters within 48 hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.
- iv. Vendor will respond to Plan inquiries regarding customer and provider matters within 24 hours of the request, unless extended by the Plan.
- v. Vendor will work with the Plan and other Plan vendors as needed to resolve issues. This includes providing the specific Vendor resources and expertise needed to address the specific issue(s), not just the account management team; and multiple meetings per week prior to and after Go-Live before all services are normalized.
- vi. Vendor will keep the Plan informed of changing state and federal rules, mandates, or other requirements to ensure compliance.
- vii. Upon request, Vendor will provide written documents outlining internal processes and procedures and, when requested by the Plan, agree to alter internal processes to meet the needs of the Plan.
- viii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.

## **5.2.2 Finance and Banking**

### **5.2.2.1 Overview and Expectations**

The Plan seeks a Vendor that can provide a full range of best in class financial and accounting services in support of TPA services. These services include, but are not limited to, claims processing, provider payments, and recoveries. Vendor must be able to process and deposit receipts each day as well as batch claims and other disbursements on a weekly basis as required by the Plan. Vendor must be able to implement processes for all financial transactions that are compliant with State banking guidelines, including the policies and regulations of the Office of State Controller and the Department of State Treasurer, and provide timely documentation and reporting to support the Plan's financial reporting. As a State Agency, the Plan may have unique limitations or special requirements around funding claims and handling deposits and other financial transactions.

#### **5.2.2.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.
  - ii. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website:  
<https://www.nctreasurer.com/media/3791/open>.

- iii. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.
  - iv. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.
  - v. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:
    - 1) State banking: <https://www.nctreasurer.com/media/3791/open>
    - 2) Cash management: <https://www.osc.nc.gov/state-agency-resources/statewide-cash-management>
    - 3) Escheats: <https://www.nccash.com/holder-information-and-reporting>
    - 4) High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."
  - vi. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.
  - ii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer.
  - iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable.
  - iv. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.
  - v. Vendor will provide access to up to three (3) years of historical receipts and claims funding data.
  - vi. Vendor will provide electronic submission of deposit reports and disbursement funding as well as detailed backup documentation to support the transactions.
  - vii. Vendor will provide historical check register detail and receipts as well as claims funding data.
  - viii. Vendor has internal quality control programs and audits that will ensure the accuracy of all financial reporting to the Plan.
  - ix. Vendor will batch claims and other disbursements for payment via check or automatic clearing house (ACH) from the Plan's bank account on a weekly basis as determined by the Plan.
  - x. Vendor will hold payment of weekly claims and other disbursements until funding is authorized and requisitioned by the Plan.
  - xi. Vendor will limit the aggregate dollar amount of claims paid each week if requested by the Plan to manage cash flow.
  - xii. Vendor will deposit checks received into the Plan's bank account within 24 hours of receipt to comply with the State's banking and cash management requirements.

- xiii. Vendor will provide a daily reporting package of deposited receipts as required by the Plan (see Reporting Section 5.2.11).
- xiv. Vendor will provide a weekly reporting package of claims and other disbursement as required by the Plan (see Reporting Section 5.2.11).
- xv. Vendor will customize the reporting of any deposits, disbursements, or other financial transactions as required by the Plan.
- xvi. Vendor will notify and report on all warrants/checks to be escheated prior to the submitting state filings, and if required by the Plan, adhere to a prior approval process for escheats.
- xvii. Vendor will recommend uncollectible accounts for write-off and adhere to a prior approval process.
- xviii. Vendor will notify and consult with the Plan at least 60 days in advance, or as soon as practical, of any system or business process change as it relates to handling, processing, or reporting of the Plan's financial transactions.
- xix. Vendor will process ad hoc check requests, such as a settlement check to a Member, as requested by the Plan.

### **5.2.3 Network Management**

#### **5.2.3.1 Overview and Expectations**

The Plan requires a Vendor that will provide a strong network in all 100 counties of North Carolina and throughout the United States. This Vendor must also partner with the Plan on network initiatives that provide affordable, quality care and increase transparency, predictability, and value for Plan Members. For example, the Plan's most recent network initiative was the implementation of a network of independent North Carolina providers, and a few smaller hospitals that were reimbursed on a Medicare reference-based pricing model. The effort is known as the Clear Pricing Project. The network, the North Carolina State Health Plan Network, was managed and supplemented by the TPA. Through this effort, the Plan built some key provider partnerships and demonstrated the viability of the reference-based pricing reimbursement methodology. While reference-based pricing continues to be a strategy the Plan intends to pursue, the specific types of alternative payment models to be implemented at the Go-Live of the Contract will be determined during implementation. Regardless of the payment model, the Plan intends to find a way to continue the tiered network strategy that rewarded Plan Members, via lower cost-shares, for utilizing CPP providers. Therefore, selecting a TPA partner that will support this type of custom provider reimbursement arrangement, or any other custom network, is essential to the Plan's provider strategy.

#### **5.2.3.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor agrees the Plan is a government payor.
  - ii. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.
  - iii. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.
  - iv. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

- v. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.
  - vi. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.
  - vii. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.
  - viii. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.
  - ix. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.
  - x. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if requested by the Plan.
  - xi. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.
  - xii. Vendor will administer other reference-based pricing models, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support transparency by allowing the Plan, at its request, to directly view any contracts associated with Vendor's network. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules. The Plan will take steps to protect Vendor's confidential data and proprietary information in accordance with applicable state and federal laws and regulations.
  - ii. Vendor will provide services to Members who travel outside the United States and have an urgent medical need.
  - iii. Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.
  - iv. Vendor will customize "hidden providers" (e.g., an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon) payment policies, as requested by the Plan.
  - v. Vendor will work with the Plan to ensure reimbursement rates for virtual visits with network providers are set appropriately.
  - vi. Vendor will provide transition of care services to assist Members when their provider is no longer in the network.
  - vii. Vendor offers a "narrow" network in North Carolina that may be utilized by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.
  - viii. Vendor has a network management team that will support the Plan on any custom or private label network solutions.



- ix. Vendor has a provider credentialing team that could be utilized to credential potential network providers if the Plan were to develop a network solution that may include providers that are not currently enrolled in Vendor's other networks.
- x. Vendor has the ability to communicate directly with providers and will communicate Plan specific information to providers, as requested by the Plan.
- xi. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for specific services such as, but not limited to, specialty pharmacy.
- xii. Vendor has experience with each of the following alternative models of care or clinically integrated systems and will work with the Plan to deploy Vendor's solution or develop a similar custom solution for the Plan. Vendor shall confirm it has experience with each alternative payment model listed below:
  - 1) Patient-Centered Medical Homes.
  - 2) Hospital At Home Programs.
  - 3) Accountable Care Organizations.
  - 4) Community Care Organizations.
  - 5) Integrated Delivery Networks.
  - 6) Shared Risk/Savings.
  - 7) Pay-for-Performance.
  - 8) Global Payment/Capitation.
  - 9) Primary Care Incentives.
- xiii. Vendor will support the integration and ongoing operations of any of the aforementioned alternative payment models or clinically integrated systems that may be designed and managed by other Plan vendors.
- xiv. Vendor has the system capability to support capitated payments.
- xv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.
- xvi. If the Plan deploys a custom network or reimbursement models, Vendor's provider portal will allow Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.
- xvii. If the Plan deploys a custom network, Vendor will administer Plan specific provider contract documents which may include, but is not limited to, network participation agreements (NPA), reimbursement exhibits, pricing policies, fee schedules, and pricing development and maintenance policies.
- xviii. Vendor acknowledges any NPA developed to support a custom network for the Plan is not subject to review by DOI since the Plan is self-funded and not subject to DOI regulations except for those specifically noted in Chapters 58 and 135 of the North Carolina General Statutes.
- xix. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support any custom alternative payment models or networks implemented for the Plan.
- xx. Vendor will provide a dedicated provider call center, with a Plan specific phone number and greeting if the Plan implements a full, custom provider network.

## **5.2.4 Product and Plan Design Management**

### **5.2.4.1 Overview and Expectations**

The Plan seeks a Vendor that offers innovation in both Product and Plan Designs. Vendor should have an efficient business rules-based claims system that can not only support state, federal, and other custom benefits

but also accommodate unique medical and claims processing policies. Vendor should be nimble in its approach to piloting new programs and demonstrate “speed to market” when rolling out new Products, Plan Designs, and benefit features to meet the challenges facing state government health plans.

#### 5.2.4.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

- i. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan’s current programs.
  - 1) Enhanced PPO Plan (80/20): <https://www.shpnc.org/media/2583/download?attachment>
  - 2) Base PPO Plan (70/30): <https://www.shpnc.org/media/2582/download?attachment>
  - 3) HDHP: <https://www.shpnc.org/media/2584/open>
- ii. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the PCP listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, “PCP Copay Incentive Scenarios,” for more detailed information about the current program.
- iii. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.
- iv. Vendor will integrate real-time or near real-time deductible and/or OOP accumulators with the Plan’s PBM to support a combined Medical/Rx deductible and OOP maximums.
- v. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.
- vi. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.
- vii. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

b. Vendor shall additionally confirm each of the following:

- i. Vendor’s systems will support each of the following Plan Design features. Vendor shall confirm each Plan design feature below:
  - 1) Applying a copay and a deductible to the same service.
  - 2) Applying a copay based on the providers network tier.
  - 3) Waiving the emergency room copay when the Member is admitted for an inpatient stay and/or an observation stay.
  - 4) Applying a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
    - a) PCP.
    - b) Specialist.
    - c) Urgent Care.
    - d) Emergency Room (ER).
    - e) Physical Therapy.
    - f) Occupational Therapy.
    - g) Speech and Hearing Therapy.
    - h) Outpatient Behavioral Health.

- i) Per Inpatient Confinement.
- 5) Setting benefit limits by age.
- 6) Setting benefit limits by frequency of service.
- 7) Setting benefit limits by confinement.
- 8) Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.
- ii. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.
- iii. Vendor will, upon request, administer a four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an out-of-area (OOA) benefit, and a non-network benefit.
- iv. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.
- v. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.
- vi. Vendor will administer member cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.
- vii. Vendor will implement incentive programs where Plan Members are given gift cards, or other incentives, for seeing certain providers and/or completing certain tasks.
- viii. Vendor will, upon request, integrate with other Plan vendors or Partners to deliver value-based and/or incentive benefits.
- ix. Vendor will, upon request, implement a Health Reimbursement Account (HRA) for Plan Members with each of the following features. Vendor shall confirm each HRA feature below:
  - 1) HRA annual balances based on the number of family Members enrolled.  
Example:  
Subscriber only = \$600 starting balance.  
Subscriber + one (1) Dependent = \$1200 starting balance.  
Subscriber + two (2) or more Dependents = \$1800 starting balance.
  - 2) Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.2.
  - 3) HRA account reconciliation services to support the Plan's banking and financial reporting requirements.
  - 4) Proration that reduces the starting HRA amount for Members who enroll after the beginning of the Benefit Year.
  - 5) Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.
  - 6) Automatic claims reimbursement functionality from the HRA.
  - 7) Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.
  - 8) Annual HRA rollover functionality.
  - 9) Ability to customize the HRA Member portal, as requested by the Plan.
  - 10) Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.
  - 11) HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.
  - 12) HRA Debit Card.
  - 13) Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.
  - 14) Ability to provide an HRA on a copay-based plan like the Enhanced PPO Plan (80/20).

15) Ability to customize HRA reports, as requested by the Plan.

- x. Vendor offers Health Savings Account (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.
- xi. Upon request, Vendor will administer a self-funded Group Medicare Supplement Plan.
- xii. Vendor will work with the Plan to implement benefits that may not be finalized and/or approved until close to the effective date. While it is the Plan's preference to have all benefits approved by the Board more than six (6) months in advance, there are dependencies, such as final budget approval by the North Carolina General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.

## **5.2.5 Medical Management Programs**

### **5.2.5.1 Overview and Expectations**

The Plan seeks a Vendor that demonstrates versatility and innovation in managing the complex medical environment. Vendor should provide high quality, evidence-based, member centric, cost-efficient clinical management programs that support Members with the most appropriate, effective, and high-value benefits to improve their health while fostering an optimum Member experience.

### **5.2.5.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.
  - ii. Vendor will carve-out PBM services from this Contract.
  - iii. Vendor will customize any of the Medical Management programs, if requested by the Plan.
- b. Vendor shall additionally confirm each of the following:
  - i. Vendor will customize any medical policy, if requested by the Plan.
  - ii. Vendor will provide comprehensive, holistic, evidence-based medical policies and Medical Management of Members' physical and behavioral health, including substance misuses, which focus on quality, positive Member outcomes, and cost efficiencies.
  - iii. Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation, if requested by the Plan.
  - iv. Vendor will keep the Plan apprised of disease trends within the population and provide reporting that summarizes overall Plan health.
  - v. Vendor will appropriately identify and engage Members in each of the following types of programs:
    - 1) Transition of Care (TOC) programs;
    - 2) High utilizer outreach and management programs; and,
    - 3) Complex case management programs.
  - vi. Vendor will provide "Hospital at Home" and/or other programs to promote transition from inpatient-hospital to home setting when appropriate.
  - vii. Vendor will offer wellness and prevention programs to support Plan Members.

- viii. Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members, if requested by the Plan.
- ix. Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, Vendor, and any other Plan vendors or Plan Partners involved in the program administration.
- x. Vendor will provide disease management Health Coaching Services.
- xi. Vendor will transition specific specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.
- xii. Vendor will provide claims and analytical data to support the transition of specific specialty medications to the Plan's PBM.
- xiii. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.
- xiv. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.
- xv. Vendor will meet with the Plan and the Plan's PBM to coordinate medical and pharmacy management programs.
- xvi. Vendor will perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.

## **5.2.6 Enrollment, EDI, and Data Management**

### **5.2.6.1 Overview and Expectations**

The Plan seeks a Vendor with a platform that can support the Plan's enrollment rules, as defined by North Carolina General Statutes Chapter 135, Article 3B. Vendor must also be able to support the Plan's Group set-up requirements which include setting up and maintaining over 400 Employing Units, the Retirement Group, and the other non-active Groups including the Direct Bill Group, the COBRA Group and the Sponsored Dependents Group. Vendor must also have extensive experience with Medicare eligibility as the Plan has both Medicare primary and Medicare secondary Members.

### **5.2.6.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will support the Plan's Group set-up structure which includes establishing, maintaining, and reporting on more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. A list of the Plan's current Group structure, which includes Group and Entity identifiers, can be found in Exhibit 3, "Group Structure."
  - ii. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.
  - iii. Vendor will have the capability to accept and at least 500,000 transactions in a single file transmission.
  - iv. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.

- v. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.
- vi. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."
- vii. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.
- viii. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.
- ix. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.
- x. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer  
Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

- xi. Vendor will serve as the Plan's RRE under Section 111 of MMSEA Expanded Reporting Option.
- xii. As an Expanded Reporter, Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to obtain Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare rules, to determine which Plan Members' Medicare information requires updating.
- xiii. Vendor will update Vendor's system with the necessary updates from the Medicare audit and send Members' updated Medicare information to the Plan's EES vendor.
- xiv. Vendor will store and utilize the MBI, in addition to other Member identification numbers, such as SSN.
- xv. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.
- xvi. Vendor will maintain Medicare primacy effective and termination dates.
- xvii. Vendor will maintain multiple Medicare entitlement reasons.
- xviii. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.
- xix. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).

- xx. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.
- xxi. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.
- xxii. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.
- xxiii. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a new PCP. The final workflows will be defined during Contract implementation. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP synchronization requirements.
- xxiv. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)
  - 1) Plan's logo.
  - 2) Plan's messaging.
  - 3) Plan's network (if applicable).
  - 4) Out-of-NC network.
  - 5) Member out-of-pockets.
  - 6) Plan's Rx BIN and PBM information.
  - 7) Group Name (e.g., Wake County Schools, University of North Carolina, Department of Transportation).
  - 8) Member's unique ID number.
  - 9) Member's selected PCP.
- xxv. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of CCC and reporting needs under sections 6055 and 6056 of the IRS code.
- xxvi. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- xxvii. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.
- xxviii. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.
- xxix. Vendor will implement a process with the Plan to respond to DQ issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.
- xxx. Vendor will release data to the Plan as described in state and federal law.
- xxxi. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.

## b. Vendor shall additionally confirm each of the following:

- i. Vendor will support Plan eligibility as defined by North Carolina General Statutes Chapter 135, Article 3B, Part 4.
- ii. Vendor will accept industry standard and/or custom data files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:
  - 1) ASC X12 EDI transaction sets.
  - 2) XML files.
  - 3) Flat/ Fixed Files.
  - 4) APIs.
- iii. Vendor will accept and process multiple data files within the same day.
- iv. Vendor will accept and process multiple concurrent file transmissions.
- v. Vendor will process “change” records as either terminated or added records.
- vi. Vendor will load and process “terminated” and “add” transactions for the same Members within the same day.
- vii. Vendor will exchange the enrollment and eligibility data using secure protocols.
- viii. Vendor will provide a copy of outbound files delivered to other Plan vendors to the Plan via SFTP or SharePoint based on instructions from the Plan.
- ix. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.
- x. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits. Thresholds will be determined during implementation.
- xi. Vendor will have a Load-Rate of at least 98% on accurate transactions received via EDI from the Plan’s EES vendor.
- xii. In addition to accepting and processing daily enrollment data file from the Plan’s EES vendor, Vendor will manually load any data that cannot be processed automatically within three (3) State Business Days.
- xiii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan’s EES vendor.
- xiv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Members.
- xv. Vendor will accept and store multiple Member ID numbers from the Plan’s EES vendor such as a unique member ID created by the EES vendor and MBI and/or the Member SSN.
- xvi. Vendor will use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card.
- xvii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors.



xviii. Vendor will accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years. Vendor will not receive enrollment effective dates prior to January 1, 2025.

Example: June 2026, Vendor receives enrollment with a February 1, 2025 effective date. Vendor updates Member with appropriate 2026 and 2025 coverage.

xix. Vendor will adjust enrollment effective or termination dates retroactively that may cross Plan Years.

xx. Vendor will meet with the Plan and other Plan vendors on a weekly basis, or as requested by the Plan.

xxi. Vendor will display the appropriate Group name on Member ID cards, the secure Member portal and reports. Examples of Group Names:

- 1) Department of State Treasurer
- 2) Charlotte Mecklenburg Schools
- 3) Retirement Systems

xxii. Vendor will store a Member's PCP election, including the PCP election effective and termination dates to facilitate the PCP copay incentives outlined in Section 5.2.4, Product and Plan Design Management.

xxiii. Vendor will notify providers that they have been selected as a Member's PCP.

xxiv. Vendor will support an Open Enrollment (OE) period that generally last two (2) to four (4) weeks and during a time period chosen by the Plan.

xxv. Vendor will support multiple OEs in one Plan year, if requested by the Plan.

xxvi. Vendor will vary the OE periods by Group and/or Product, if requested by the Plan.

xxvii. Vendor will, upon request, receive Member enrollments from the Plan's EES vendor prior to OE that have been "Mapped" to a specific Plan Design for the next Plan Year. The "Mapping" of Members will occur over several weeks prior to the beginning of OE. These "Mapped" Members may be included in the daily EDI Change Files received from the Plan's EES vendor or in a Full File, if chosen by the Plan.

xxviii. Vendor will receive and process Member elections from the Plan's EES vendor after OE using a Full File or via daily Change Files that come during OE. The type of file will be determined by the Plan during the initial implementation and will be re-evaluated annually as part of OE planning.

xxix. Vendor will produce and distribute ID cards for over 500,000 Members after OE so that Members receive their ID cards prior to the new Plan Year.

xxx. Vendor will produce and mail CCCs to Members whose coverage terminates, as required by law.

xxxi. Vendor will produce CCCs for Members who reside in states that require annual CCCs.

xxxii. Vendor will produce and mail or email CCCs on demand, for Members who request new copies of CCCs.

xxxiii. Vendor will produce and mail the 1095-B forms, if requested by the Plan.

xxxiv. Vendor will provide call center support to respond to both HBRs and Member inquiries about 1095-B forms, if requested by the Plan.

xxxv. Vendor will file 1094-B and 1095-B forms electronically, if requested by the Plan.

xxxvi. Vendor will continue filing 1095-B corrections to the IRS throughout the year, if requested by the Plan.

- xxxvii. Upon notification by the Plan's COBRA Administration and Billing (CABS) vendor, Vendor will hold claims for individual Groups that have not paid their premium bill.
- xxxviii. Vendor will confirm that the monthly, custom claims data file that will be provided to the Plan can be sent as a Full File or Change File. The specific requirements will be developed during the implementation.
- xxxix. Vendor will confirm that it will provide reference tables and data dictionaries, with thorough field descriptions, to support the monthly, custom claims data files and that the reference tables and data dictionaries will be updated as needed and sent to the Plan within three (3) State Business Days of any change.
- xxxx. Vendor will conduct a Medicare repricing exercise to benchmark Vendor's network rates against Medicare reimbursement rates. The details of the repricing exercise shall be formalized in an ADM and memorialized via an Amendment to the Contract, as needed.

## **5.2.7 Customer Experience**

### **5.2.7.1 Overview and Expectations**

A top priority for the Plan is ensuring a superior Customer Experience with all customer-facing resources and tools. Vendor must show a dedication to constant Customer Experience improvements and be an innovator in Member engagement. Engagement includes web based and mobile technology, transparency tools, and provider search functions that clearly identify low-cost, high-quality providers by specialty. If Plan-specific networks are utilized, these tools must display the Plan-specific information.

### **5.2.7.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.
  - ii. Vendor will have a dedicated toll-free number for Plan Members.
  - iii. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.
  - iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.
  - v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.
  - vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.
  - vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."
  - viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.
  - ix. Vendor will co-brand letters or other materials Vendor sends to Members.

- x. Vendor will customize the portal with the Plan's branding (logo).
  - xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will receive emails from Plan Members and respond to their inquiries.
  - ii. Upon request, Vendor will provide expanded hours of operation during the OE period at no additional cost to the Plan. The Plan's enrollment and eligibility call center is generally open on Saturdays during OE.
  - iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.
  - iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.
  - v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.
  - vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.
  - vii. Vendor will provide copies of call notes to Members upon request.
  - viii. Vendor will provide reports, based on call reason type, to the Plan upon request.
  - ix. Vendor will provide an escalation team to respond and resolve inquiries from the Plan.
  - x. When appropriate, Vendor will mail apology letters to Plan Members who have been impacted by a Vendor error.
  - xi. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.
  - xii. Vendor will support single sign-on to and from the Plan's PBM customer portal, the Plan's EES vendor and other Plan vendor sites, as requested by the Plan.
  - xiii. Vendor will customize the materials available to Plan Members via the secure Member portal.
  - xiv. In addition to displaying the Plan's branding, Vendor will display the name of the Member's Employing Unit (e.g., Department of State Treasurer, Retirement System, Wake County Schools, etc.) once the Member has logged into the secure member site.
  - xv. Vendor will, upon request, segregate and provide secure Member portal access to a Dependent, or a Dependent's designee, in a court-ordered scenario such as a Medical Support Notice.
  - xvi. Vendor's secure member portal will capture Plan Members' preferences for communication.
  - xvii. Vendor's secure portal will allow a Plan Member to print a temporary ID card that include the Plan's PBM information and custom ID card elements.
  - xviii. Vendor's mobile application and secure portal will allow Members to order a new ID card.

- xix. Vendor will provide a mobile application that includes a virtual ID card for Members who prefer to use mobile technology.
- xx. Vendor's portal will provide health/condition-specific resources to Members, such as educational videos, recipes, digital coaching modules, webinars, links to Plan approved/promoted websites, evidenced-based articles, and tools for self-management.
- xxi. Vendor's member portal will provide and moderate online forums and live chat groups.
- xxii. Vendor's member portal will receive and display timely data from various providers such as, but not limited to, lab results from large independent labs, prescriptions from pharmacies, and other data from physicians' offices. This information could be used by Plan Members to gather information necessary to complete annual Health Assessment or validate Member actions to earn incentives.
- xxiii. Vendor's member portal will allow Members to:
  - 1) View claims and claim payment status.
  - 2) View and print EOBs.
  - 3) View deductible and OOP accumulations.
  - 4) Single-Sign-On (SSO) to the HSA vendor, if applicable.
  - 5) View HRA claims, if applicable.
  - 6) View HRA Balances, if applicable, including, but not limited to:
    - a) Initial HRA Funding.
    - b) Rollover Funds.
    - c) Incentive Funds.
  - 7) Order new HRA or HSA debit cards, if applicable.
  - 8) Track incentive programs and benefit designs (e.g., cash rewards, health reimbursement account contributions) and administer the reward for participation, as defined by the Plan.
  - 9) Complete a Health Assessment that could be customized by the Plan.
- xxiv. Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:
  - 1) Electronic medical and health records.
  - 2) Disease Management Nurse notes.
  - 3) Case Management notes.
  - 4) Health Coach notes.
  - 5) Vendor analytical system alerts, such as gaps in care.
  - 6) Progress towards Incentives earned, if applicable.
- xxv. Vendor will provide the following services whether the Member is logged into the secure member portal or accessing Vendor's external site:
  - 1) Search for providers by specialty.
  - 2) Search for procedure/service cost.
- xxvi. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiative, upcoming Plan mailers and/or events, and develop and implement process improvements between the Plan vendors and Partners.
- xxvii. Vendor, if instructed by the Plan, will conduct an annual Member Satisfaction Survey for all Plan Members, including Members who are not enrolled in plans administered by Vendor. The Plan will be responsible for communicating the survey to Plan Members and may provide a link to the survey on the Plan's website. Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.
- xxviii. Vendor will conduct other surveys, as requested by the Plan.

- xxix. Vendor will attend Plan-hosted OE events to educate members on Plan options. The Plan representatives are generally on the road across the State or hosting online webinars during most of September and October promoting OE. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.
- xxx. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.
- xxxi. Vendor will attend Wellness Fairs and other promotional events around the State, as requested by the Plan.
- xxxii. Upon request, Vendor will provide resources to conduct biometric screenings at wellness events. If requested, Vendor shall have the ability to send the biometric results to the Members' PCPs.
- xxxiii. Vendor will provide language interpreters, including sign language, at events as requested by the Plan.
- xxxiv. Vendor will, upon request, provide Marketing and Communication resources to the Plan to develop materials.
- xxxv. Vendor will assist with the Plan's benefit booklet review and/or provide guidance regarding the Plan's benefit booklets which includes individual books for each plan offered.
- xxxvi. Vendor will develop and implement new letters and/or communication materials for Members and/or Providers to support any programs implemented for the Plan.
- xxxvii. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPACA.
- xxxviii. Vendor will suppress specific Member communications, upon request from the Plan.

## **5.2.8 Claims Processing and Appeals Management**

### **5.2.8.1 Overview and Expectations**

The Plan seeks a Vendor with an efficient business rules-based claims system that can support required state, federal, and other custom benefits.

### **5.2.8.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.
  - ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
  - iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.
  - iv. Vendor will customize any appeals letters, as requested by the Plan.

- v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.
  - vi. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan – Medicare Part B."
  - vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.
  - viii. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.
  - ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.
  - iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).
  - iv. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add edits at the Plan's request.
  - v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.
  - vi. Vendor will provide a weekly summary of any claims totaling  $\geq \$100,000.00$  to the Plan's Contract Administrator for day to day activities. The summary shall include the total charge, total allowed amount, Member cost share, and a short description of circumstance of the claim, including a status of the Member's condition.
  - vii. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.
  - viii. Vendor will coordinate benefits with other commercial payors.
  - ix. Vendor will support all future state and federal requirements at no additional cost to the Plan.
  - x. Vendor will produce EOBs that meet all Federal requirements.
  - xi. Vendor will prevent Subscribers from having access to the Dependents EOBs when the Subscriber does not have custodial rights.
  - xii. Vendor will mail EOBs directly to Dependents 18 years of age or older without a copy to the Subscriber.
  - xiii. Vendors will mail a Dependent's EOB to a different address if a different address exists in the Dependent's demographic record.
  - xiv. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.
  - xv. Vendor will provide a single, combined Medical and HRA EOB, as requested by the Plan.

xvi. Vendor will implement PCP “gate-keeper” rules, as requested by the Plan.

## 5.2.9 Claims Audit, Recovery, and Investigation

### 5.2.9.1 Overview and Expectations

The Plan seeks a Vendor that places great value on the accuracy of its deliverables. Vendor must be open to audits by the Plan’s Auditors as well as audits performed by and for the North Carolina Office of the State Auditor. The Plan expects Vendor to be time sensitive to all audit requests and be prepared to support multiple audits simultaneously. The Plan, at its discretion, may use its own vendors to seek recoveries; therefore, Vendor must support the Plan’s recovery vendors by providing claims data, adjusting claims, and posting payments. Vendor must also demonstrate a dedication to the detection and reduction of fraud, waste, and abuse. This includes the recovery of fraud dollars and a willingness to assist in the prosecution of those who commit fraud.

*Notice: The Plan is not assigning its right to pursue recoveries on its own behalf or through another vendor.*

### 5.2.9.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

- i. Vendor will support ongoing quarterly claims accuracy audits, or Standard Audits, performed on a statistically valid random claims sample selected by the Plan’s audit vendor which will be used to measure claims accuracy for Performance Guarantees on a quarterly basis. Vendor will share provider contracts and system pricing with the Plan’s auditors for review and audit. The audit will also include a targeted sample selected from a comprehensive analysis of all claims by the Plan’s audit vendor.

An audit plan will be provided prior to the initial quarterly audit that will define the ongoing Standard Audit timelines. Both the random claims sample and the targeted sample will be used to identify overpayments owed to the Plan. For purposes of Standard Audits, claims accuracy will be measured based on the following criteria:

- 1) Financial Accuracy: Total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute values of the dollars processed in error from the total dollars processed. Underpayments and overpayments are not offset by one another.
- 2) Payment Accuracy: The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
- 3) Processing Accuracy: The number of claims processed with no procedural errors divided by the total number of claims processed.

For purposes of the above definitions, if Vendor has identified and recovered an overpayment or processed an underpayment prior to the audit, it is not an error. If Vendor has identified but not recovered the overpayment or processed the underpayment, it is an error.

- ii. Vendor will, in addition to supporting ongoing quarterly claims accuracy audits, support Focus Audits, such as, but not limited to, COB audits, duplicate claims audits, eligibility audits, and comprehensive electronic Audits conducted by the Plan’s auditor vendor on an as needed basis. All the rules outlined in Section 5.2.9.2.a.i above will apply to these audits.
- iii. Vendor’s recovery processes will follow all deposit and financial reporting requirements outlined in Section 5.2.2, Finance and Banking.
- iv. Vendor will recover any overpayments to Providers by offsetting future payments or by demand without any limitation as to time since the Plan as a government payor is not subject to the two-year limitation established in N.C.G.S. § 58-3-225(h).

- v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (North Carolina General Statutes Chapter 105A, Article 1), the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29), Wage Garnishment (N.C.G.S. § 135-48.37A), and Credit Card Intercepts (N.C.G.S. § 1-359) and implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 10, "State Health Plan Recovery Workflows."
  - vi. Vendor will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, mental health parity, disclosures, reporting, etc.).
  - vii. Vendor has an investigation or similar unit to investigate possible fraud and abuse and will share details about specific investigations that impact the Plan, including the names of the providers involved.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will support any other audit requested by the NC OSA.
  - ii. Vendor will support multiple audits simultaneously. Although the Plan will work with Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.
  - iii. Vendor will provide the Plan's Auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits including remote, view only access to view the claims adjudication system used by Vendor to process the Plan's claims.
  - iv. Vendor will provide on-site office space at Vendor's facilities that are actually processing Plan claims, including system access for the Plan's Auditors, the Plan, or the NC OSA.
  - v. Vendor will customize any standard audit reports to meet the Plan's specific audit needs.
  - vi. Vendor will provide claims files to the Plan's Auditors on a monthly basis.
  - vii. Vendor will provide feedback on all site visit claims within two (2) weeks of the end of the on-site visit. Vendor will also respond to any findings in the draft audit report within two (2) weeks of receipt.
  - viii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within 30 days of the final report, or another timeframe as specified by the Plan.
  - ix. Vendor will provide full impact reports, and review and recover out-of-sample claims for any audit findings that reveal systemic or easily repeatable issues. These out-of-sample claim recoveries will not impact performance guarantee measures.
  - x. Vendor will not enter into a settlement on the Plan's behalf with a Provider, a Member, or anyone else, without first obtaining the Plan's approval.
  - xi. Vendor will support the Plan's third-party liability vendor, or any other recovery vendor the Plan may work with, by providing data, adjusting claims, and posting payments.
  - xii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.
  - xiii. Vendor will customize any recovery or investigation reports, if requested by the Plan.
  - xiv. Vendor will implement debt collections processes with a collection agency approved by the NC AGO. The list of approved collections agencies may change during the life of the Contract, as required by the NC AGO.



- xv. Vendor will adjust Member claims based on recoveries received on behalf of the Plan, including, but not limited to, those from the collection agency, Plan vendors, or Members within 30 days of notification. Plan vendors or State Collections Agencies that seek recoveries on behalf of the Plan, must work with Vendor to ensure the claims are appropriately adjusted and recoveries are deposited in the Plan's depository accounts.
- xvi. Vendor will, upon request from a Member covered through an Employing Unit, the Direct Bill Group, the Sponsored Dependent Group, or the COBRA Group, establish a payment plan; however, payment plans shall not exceed 12 months without the Plan's prior approval.
- xvii. Vendor will, upon request by a Member covered through the Retirement System, establish a payment plan. The payment plan shall not exceed six (6) months without the Plan's prior approval.
- xviii. Vendor will consider any Member or former Member to be in default who misses one (1) payment. If any Member or former Member sends in a partial payment, Member or former Member must be caught up in one (1) month or Member or former Member will be considered to be in default.
- xix. Vendor will allow the Plan to perform onsite reviews and validations of Vendor's internal processes.
- xx. Vendor will provide workflows, data, and other materials to review Vendor's processes within 30 days of request.
- xxi. Vendor will work with the Plan to develop process improvement plans.
- xxii. Vendor will provide monthly recovery reports and will customize those reports, if requested by the Plan.
- xxiii. Vendor will track and report actual cost savings dollars against targets, and if available, benchmarks.
- xxiv. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.
- xxv. Vendor will provide Plan specific investigation reports on a monthly basis and customize these reports, as requested by the Plan.

## **5.2.10 Initial Implementation and Ongoing Testing**

### **5.2.10.1 Overview and Expectations**

The Plan seeks to partner with a Vendor that has the resources to support on-time implementation of all programs and services included in this Contract. Vendor must provide dedicated resources and expertise to support simultaneous implementation of multiple work streams. In addition, the Plan will implement new benefits, services, and Plan vendors throughout the life of the Contract that will require Vendor to be nimble and efficient in terms of implementing new processes and/or integrating with new Plan vendors, or support changes to existing Plan vendors' requirements. When possible, the Plan will work with all parties to let the implementation schedule dictate the Go-Live date, but in some instances, such as the annual benefit changes or Plan vendor changes, the Go-Live date will be pre-determined. The Plan will notify Vendor as soon as possible about all proposed changes.

### **5.2.10.2 Services**

- a. Vendor confirmed the following in the Minimum Requirements:
  - i. Vendor will have a fully assembled implementation team that includes the appropriate subject matter experts, ready to begin work within two (2) weeks of contract award. The team shall include an overall implementation manager and separate implementation resources for, at a minimum, each of the following work streams:

- 1) Group Set-Up & Enrollment
- 2) Plan Vendor Integration & EDI, which includes:
  - a) EES vendor Integration. (EDI, PCP Tool, SSOs, Audits)
  - b) PBM vendor Integration. (Data files, SSOs, Accumulators)
  - c) Billing vendor Integration. (Claims hold, Audits)
  - d) Plan Data Warehouse Integration. (Data files)
- 3) Network Evaluation

Other workstreams will kick-off throughout 2023.

- ii. Vendor will have the depository bank account(s) setup and tested at least 45 days prior to January 1, 2025.
  - iii. If applicable, Vendor will have the disbursement account(s) setup and tested at least 30 days prior to January 1, 2025.
  - iv. Vendor will have all services, including custom programs, operational by January 1, 2025.
  - v. Vendor will work with the Plan to document in an ADM all custom processes developed to meet the Plan's unique requirements. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
  - vi. Vendor will work with the Plan to finalize Vendor Audit Schedule for 2025 and subsequent years. The Audit Schedule will be updated via ADM. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.
  - vii. For all technical components of the initial implementation as well as any implementations throughout the lifetime of the Contract, Vendor will develop functional requirements documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation derived from the Plan's Business Requirements. These documents must be mutually agreed upon by Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.
  - viii. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live of any initiative. To support testing, Vendor must not only have the resources, but also the test environments, necessary to support multiple work streams at one time. As mentioned above, the Test Plan will be mutually agreed upon by Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.
  - ix. Vendor will support the 2025 Open Enrollment, which is currently scheduled for October 2024, but may be rescheduled to a different time at the Plan's sole discretion. Vendor must have the group set-up complete, the call center open, any required SSOs in place, the PCP selection tool integrated with the Plan's EES vendor and be able to accept EDI from Plan vendors during the month Open Enrollment occurs.
- b. Vendor shall additionally confirm each of the following:
- i. Vendor will ensure there are no data latency issues that would delay initiating any audits with the Plan's Auditors after the first quarter, or any subsequent quarter, of operation.
  - ii. If during the implementation, a decision is made that Members will need welcome kits, Vendor will ensure that those kits are mailed prior to January 1, 2025.
  - iii. If requested by the Plan, Vendor will support a readiness review and/or implementation audit at least 60 days prior to January 1, 2025. Vendor shall participate in all readiness review and/or implementation audit activities conducted by the Plan or by Plan vendors to ensure Vendor's operational readiness.

## 5.2.11 Reporting

### 5.2.11.1 Overview and Expectations

The Plan seeks a partner that can support its custom reporting requirements which include reports that are sent to the Plan on a daily, weekly, monthly, quarterly, and annual basis. These reports must be accurate and received on the schedule defined by the Plan. The Plan will also have ongoing ad hoc report requirements; therefore, Vendor must have the resources and expertise to assist the Plan as needed.

### 5.2.11.2 Services

- a. Vendor confirmed the following Minimum Requirement:
  - i. Vendor will agree to delivering the Standard Reports as described in Section 5.2.11.2.b.viii.2) – xvii.3), and based on the delivery schedule in Exhibit 11, “Standard Reports.”
- b. Vendor shall additionally confirm each of the following. Note: Final individual report or reporting package format and content will be finalized during implementation and may be updated throughout the lifetime of the Contract via ADM:
  - i. Vendor will provide standard and ad hoc reports in any of the following formats, as requested by the Plan:
    - 1) Excel.
    - 2) PDF.
    - 3) Text.
    - 4) XML.
    - 5) HTML.
    - 6) CSV (raw format).
  - ii. Vendor will customize any report, as requested by the Plan.
  - iii. Vendor will combine claims and financial data in reporting.
  - iv. Vendor will email all standard reports, to the email addresses provided by the Plan. If PHI is included, the reports shall be sent via secure email.
  - v. Vendor will produce ad hoc reports within 10-15 days of a request to support the Plan’s responsibilities to the Board of Trustees and/or North Carolina General Assembly.
  - vi. Vendor will include Book of Business and other internal and/or external benchmarks in reports, when requested by the Plan.
  - vii. Vendor will provide other enterprise-level, executive reports as well as departmental and ad-hoc reporting, as requested by the Plan. Stratifications may include:
    - 1) Demographics.
      - a) Gender.
      - b) Age.
      - c) Race.
    - 2) Employing unit, work location.
    - 3) Geography.
      - a) Zip Code.
      - b) County.
      - c) Hospital Service Area.
      - d) Healthcare Referral Region (HRR).

- e) Out-Of-State.
  - 4) Subscriber versus Member.
  - 5) Active and Retiree (Pre and Post-65).
  - 6) Plan Type.
  - 7) Time period.
    - a) Calendar Year (CY).
    - b) Year-to-Date (YTD).
    - c) Month-to-Month.
    - d) Fiscal Year.
    - e) Quarterly.
    - f) Ad-hoc.
  - 8) Paid, incurred, capitated claims.
  - 9) Provider Level.
    - a) By NPI, DEA #, In/Out-of-Network, Vendor's unique provider number.
    - b) PCP, Specialist, Hospital.
  - 10) Network.
    - a) In/Out-of-Network.
    - b) Quality Outcomes.
  - 11) Utilization Trends.
    - a) High Cost Claimants.
    - b) High Volume Claims Utilizers.
  - 12) Disease Categories via ICD-10, DRG, MDC, or ad hoc criteria.
    - a) Chronic conditions.
    - b) Acute conditions.
    - c) Catastrophic (cost-driving outliers).
- viii. Vendor will provide each of the following enrollment reports or reporting packages. The method for providing the report will be determined during implementation.
- 1) Weekly membership reports that include, but are not limited to, the following information:
    - a) Group Number.
    - b) All internal and external member Identification numbers (i.e., EES assigned ID, SSN, MBI, Employer ID, etc.).
    - c) Subscriber number.
    - d) Hire date.
    - e) Coverage effective date.
    - f) Coverage expiration date.
    - g) Current benefit effective date.
    - h) Current benefit expiration date.
    - i) Member First Name.
    - j) Member Last Name.
    - k) Member SSN.
    - l) Member date of birth.
    - m) Member tier.
    - n) Member benefit identifier code(s).
    - o) Medicare primary flag.
    - p) Medicare Coverage.
      - Medicare A effective date
      - Medicare B effective date.
    - q) Medicare effective date.
    - r) Medicare expiration date.
  - 2) Monthly Member reporting package based on enrollment the last day of the previous month that includes each of the following:
    - a) Enrollment by Plan Design, Entity, Group, Tier, and Medicare Status.
    - b) In-state Member counts by county broken down by Plan Design, then totaled.
    - c) Out-of-state Member counts by state or country broken down by Plan Design, then totaled.
    - d) Enrollment by Group number broken down by Subscriber and Dependent, then totaled.

- e) Graphs (pie charts) that include:
  - All Members by Plan Design.
    - In-state Members by Plan Design.
    - Out-of-state Members by Plan Design.
  - All Members by Coverage Tier.
  - Top 10 Counties.
- 3) Monthly PCP Election report that includes, but is not limited to:
  - a) Total number of Members that have elected a PCP broken down by Plan Design.
  - b) Statistics about the Members who see the PCP on their card and those that see other PCPs.
  - c) Types of PCP elected (i.e., general practice, pediatrician, family medicine, etc.).
  - d) List of elected providers and number of Members who have elected them as their PCP.
- ix. Vendor will provide each of the following Banking and Finance reports or reporting packages. The method for providing the report will be determined during implementation.
  - 1) Monthly accounts receivable aging report that includes, but is not limited to:
    - a) The amount of recoveries due, but not received.
    - b) The amount of any unapplied receipts.
    - c) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days; and over 120 days.
    - d) Supporting documentation from which these amounts are derived.
  - 2) Quarterly report of any uncollectible accounts:
    - a) Recommended for debt write-off which includes, but is not limited to:
      - Account name.
      - Subscriber number, if applicable.
      - Description/justification of the reason for write-off.
      - The provider code, if applicable.
      - Dollar amount and date originally paid, if applicable.
      - Payee status.
      - Identifying number (e.g., invoice, claim, case).
      - Total amount proposed for write-off.
    - b) Recommended for exhausted debt (debt Vendor should stop tracking and pursuing when agreed upon recovery process has been completed) which includes, but is not limited to:
      - Account name.
      - Subscriber number, if applicable.
      - Description/justification of the reason for exhausted debt.
      - Provider code, if applicable.
      - Dollar amount and date originally paid, if applicable.
      - Payee status.
      - Identifying number (e.g., invoice, claim, case).
      - Total amount proposed for exhausted debt.
  - 3) Daily deposited receipts reporting package, reported separately by Product type, e.g., PPO, HSA, HRA, etc., including:
    - a) Summary report, which includes, but is not limited to:
      - Date of deposit.
      - Total amount received by check.
      - Total amount received by ACH.
      - Distinct identification of which amounts relate to claims and which amounts relate to other types of deposits.
      - Descriptive labeling of other deposits.
      - Grand total of the daily deposits.
    - b) Any documentation from the banking institution of the deposited amounts posted daily, e.g., bank deposit slips, electronic deposit report, lockbox report, etc.
    - c) Daily deposit supporting documentation report, which includes, but is not limited to:
      - Type of deposit, i.e., checks, ACH, and/or wire.
      - Amount of each individual deposit and a grand total per deposit type.
    - d) Ability to produce Member level detail when requested by the Plan.

- 4) Daily NSF report listing all NSF for the previous months which includes:
    - a) Subscriber number, if applicable.
    - b) Provider information, if applicable.
    - c) Date returned.
    - d) Dollar amount.
  - 5) Monthly misapplied deposits and/or collections report (e.g., applied deposit to wrong Member or wrong client) which includes date originally deposited and how they were corrected.
  - 6) Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:
    - a) Number of checks processed weekly.
    - b) Number of EFTs processed weekly.
    - c) Payment amount(s) by type e.g., claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.
    - d) Weekly total by type.
    - e) Month to date total by type.
    - f) Supporting documentation of all disbursements and an explanation of any adjustments and/or miscellaneous payments, e.g., check register, any system generated reports of check writes, etc.
  - 7) Monthly deposit reconciliation which includes, but is not limited to:
    - a) Date of each daily deposit.
    - b) Total amount of deposit for each day.
    - c) Breakdown of amount by type of deposit, i.e., checks, wires, ACH (drafts).
    - d) Monthly total of each type.
  - 8) Monthly reconciliation of claims and other disbursements which includes, but is not limited to:
    - a) Daily transactions listed individually with a daily total as well as a summary total.
    - b) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds, and other disbursements.
  - 9) As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:
    - a) Final due date to escheat the warrants/checks.
    - b) Name of state and dormancy period for each state.
    - c) Number of warrants for each state and dollar amount.
    - d) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all Product types.
    - e) Explanation of any special circumstances or issues.
  - 10) Monthly Summary of Billed Charges by State Fiscal Year which includes a summary of claims paid for the period which includes both medical and pharmacy claims.
  - 11) Monthly Statement of Account (SOA) which includes all charges including claims and administrative fees s paid. It is a full picture of all income/expenses for the month.
- x. Vendor will provide each of the following Financial Performance reports or reporting packages. The method for providing the report will be determined during implementation.
- 1) Performance Guarantees (PG), as outlined in Section 6.3, reports as follows:
    - a) Monthly PG status report.
    - b) Quarterly PG report cards.
    - c) Annual PG report cards that include summary data and year end PG results.
  - 2) Monthly Performance Matrix reports as outlined in Exhibit 12, "Matrix Reports," and listed below:
    - a) Reports 1 and 2: Charge Summary Paid and Incurred Reports.
    - b) Reports 3 and 4: Charge Summary Trend Paid and Incurred.
    - c) Reports 5 and 6: Coinsurance and Deductible, Full Population-Paid and Incurred.
    - d) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.
    - e) Reports 9 and 10: Copay-Incurred and Paid.
    - f) Report 11: Copay-Incurred (Claims Run out).
    - g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
    - h) Reports 14 and 15: Financial Summary-Paid and Incurred.
    - i) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.

- j) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.
  - 3) Monthly Triangulations reports with the following stratifications:
    - a) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.
    - b) Plan Design and/or Product, including a summary based on total membership.
  - 4) Monthly prompt payment interest claims report that includes, but are not limited to:
    - a) Prompt pay for adjusted claims.
    - b) Prompt pay for new claims.
    - c) Claim count.
    - d) Total interest paid.
- xi. Vendor will provide each of the following Claims and Appeals reports or reporting packages. The method for providing the report will be determined during implementation.
- 1) Monthly processed claims reports that include, but are not limited to:
    - a) Claims type.
    - b) Total claims billed.
    - c) Total claims paid.
  - 2) Monthly Deductible and Out-of-Pocket reports, by Plan Design, by month.
  - 3) Monthly COB reports that identify savings associated with both Medicare and Commercial COB.
  - 4) Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:
    - a) Denial reason.
    - b) Number of claims for each denial reason.
    - c) Total charges for each denial reason.
  - 5) Quarterly high claimant reports that include, but are not limited to (the dollar threshold for including Members on the report will be determined during implementation):
    - a) Member ID.
    - b) Plan ID.
    - c) Member age.
    - d) Diagnosis.
    - e) Service start date.
    - f) Encounter service type.
    - g) Place of service.
    - h) Provider specialty description.
    - i) Paid amount.
  - 6) Monthly medical and pharmacy appeals reports that include, but are not limited to:
    - a) Number of first level appeals received.
    - b) Number of first level appeals approved.
    - c) Number of first level appeals denied.
    - d) Number of second level appeals received.
    - e) Number of second level appeals approved.
    - f) Number of second level appeals denied.
    - g) Statistics on types of appeals received, approved, and denied at both first and second level.
  - 7) A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:
    - a) Member ID.
    - b) Member First Name.
    - c) Member Last Name.
    - d) Type of Appeal Review Decision.
    - e) Type of Appeal Category.
    - f) Date Appeal Initiated.
    - g) Final Written Date.
    - h) Appeal Decision Description.
    - i) Medication Name, Strength, and Dosage.
    - j) Method Appeal Received.
    - k) Appeal Origin.
    - l) Drug Class.

- xii. Vendor will provide the following Network report or reporting packages. The method for providing the report will be determined during implementation.
  - 1) Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.
- xiii. Vendor will provide each of the following Medical Management reports or reporting packages. The method for providing the report will be determined during implementation.
  - 1) Quarterly Medical Cost and Clinical Outcomes reports across diagnosis categories, highly prevalent, costly, and/or determined by the Plan to be clinically significant, to include HEDIS measures, and state, national, and book-of-business data segregated by Plan Designs (70/30, 80/20, HDHP,) Medicare and Non-Medicare primary status, and by Group.
  - 2) Quarterly Case Management Clinical Outcomes.
  - 3) Quarterly Preventive Care Service Utilization.
- xiv. Vendor will provide each of the following Utilization Management reports or reporting packages. The method for providing the report will be determined during implementation.
  - 1) Quarterly Utilization Management Cause, Cost and Clinical Outcomes, including, but not limited to, inpatient admissions, readmissions, emergency department visits, urgent care visits, outpatient services, behavioral health services, ambulance services, private duty nursing, pharmacy services and polypharmacy, primary care physician visits, specialist visits, prior authorizations and approvals, and high cost claims and claimants across Plan Products (70/30, 80/20, HDHP, non-Medicare) and Employing Units.
  - 2) Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.
- xv. Vendor will provide the following specialty pharmacy management report or reporting package. The method for providing the report will be determined during implementation.
  - 1) A quarterly utilization report detailing specialty pharmacy Rebates.
- xvi. Vendor will provide each of the following Customer Experience reports or reporting packages. The method for providing the report will be determined during implementation.
  - 1) The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:
    - a) Total Member calls received.
    - b) Weekly ASA rate for Member calls.
    - c) Weekly first contact resolution rate.
    - d) Weekly second contact resolution rate.
    - e) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.
    - f) TAT for completing manual enrollment updates.
    - g) Enrollment accuracy rate for the current month.
    - h) Number and percentage of clean claims processed  $\leq 30$  days.
    - i) Number and percentage of claims processed  $> 30$  days.
    - j) Number and percentage of claims processed  $> 60$  days.
    - k) Number and percentage of claims processed  $> 90$  days.
  - 2) A Quarterly Web Trends Report that provides statistics on Plan Members transaction history compared to Vendors' Book of Business data.
- xvii. Vendor will provide each of the following Recovery and Special Investigation reports or reporting packages. The method for providing the report will be determined during implementation.



- 1) Monthly recovery reporting package that includes, but is not limited to the following:
  - a) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).
  - b) Total requested or saved, by recovery type and recovery subcontractor.
  - c) Total received, by recovery type and recovery subcontractor included Plan recovery Vendors. (Example: The Plan's Subrogation Vendor's results included in reporting package alongside Vendor's other recovery results.)
  - d) Total by subcontractor, including Plan recovery Vendors.
  - e) Quarter and year to date results.
  - f) Trends.
  - g) If available, benchmark data.
- 2) Monthly Plan specific investigation reports that include, but are not limited to, the following data:
  - a) Name of provider.
  - b) Number of Members impacted.
  - c) Date case opened.
  - d) Basis for review.
  - e) Summary of case.
  - f) Status of the case.
  - g) Total projected Plan claims dollars associated with the case.
  - h) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.
- 3) A quarterly medical audit repayment report that includes, but is not limited to, the following data:
  - a) Date of Service.
  - b) Member Name.
  - c) Subscriber Number.
  - d) Claim Number.
  - e) Original Paid Amount.
  - f) Appropriate Paid Amount.
  - g) Overpayment Amount.
  - h) Amount Repaid to the Plan.
  - i) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.
  - j) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

### 5.3 COST PROPOSAL REQUIREMENTS

**If any cost information is included in the Technical Proposal and/or if any technical information is included in the Cost Proposal, the information may not be considered or the entire proposal may be rejected.**

**Vendor shall:**

- a) Submit a Cost Proposal and include the Cost Proposal separate from the Technical Proposal; and
- b) Submit the Cost Proposal in accordance with ATTACHMENT A: PRICING.

## 6.0 CONTRACT ADMINISTRATION

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By submitting a proposal, Vendor agrees to meet all stated requirements in this Section as well as any other specifications, requirements, and terms and conditions stated in this RFP.

### 6.1 DISPUTE RESOLUTION

The Parties agree that it is in their mutual interest to resolve disputes informally. A claim by Vendor shall be submitted in writing to the Plan's Contract Administrator for resolution. A claim by the State shall be submitted in writing to Vendor's Contract Administrator for resolution. The Parties shall negotiate in good faith and use all reasonable efforts to resolve such dispute(s). During the time the Parties are attempting to resolve any dispute, each shall proceed diligently to perform their respective duties and responsibilities under this Contract.

If a dispute cannot be resolved between the Parties within 30 days after delivery of notice, either Party may elect to exercise any other remedies available under this Contract, or at law. This term shall not constitute an agreement by either party to mediate or arbitrate any dispute.

## **6.2 CONTRACT CHANGES**

Contract changes, if any, over the life of the contract shall be implemented by contract amendments agreed to in writing and signed by authorized representatives of the State and Vendor.

## **6.3 DELIVERABLES, PERFORMANCE GUARANTEES, AND FEE REDUCTIONS**

### **6.3.1 General Information**

- a) Vendor shall be subject to certain reductions in fees or payments based on performance and delivery of contracted services outlined in the Section 5.0 Technical & Cost Proposal Requirements & Specifications and the schedules in Section 6.3.5. Unless otherwise specified, the reductions in fees shall be calculated as a flat dollar amount or as a percentage (%) of administrative fees paid by the Plan.
- b) Vendor shall remit payment associated with any reductions in fees through the Automated Clearing House (ACH) and include a copy of the Plan's request for payment letter. Prior to the remittance of payment, Vendor shall notify the Plan of the forthcoming payment via email. Any such Performance Guarantee payment shall be due to the Plan within 30 days of the request. Credit memo or invoice adjustment is prohibited.
- c) Failure of Vendor to accept reductions in fees according to the schedules in Section 6.3.5 for any non-compliant contract Deliverable listed in this section shall be, at the Plan's discretion, grounds for immediate termination of the Contract.
- d) Reductions in fees may be waived by the Plan in the event there are circumstances outside Vendor's control which resulted in failure to meet the established timeframe or Deliverable. However, as specified in ATTACHMENT C. 25. "No Waiver," the waiver by the State of any right or remedy on any one occasion or instance shall not constitute or be interpreted as a waiver of that or any other right or remedy on any other occasion or instance.
- e) Any delay in the submission of any contract Deliverable requires a written explanation and written approval by the Plan's Executive Administrator. However, such explanation and approval will not constitute automatic waiver of any associated reduction in fee.
- f) Vendor shall provide a written explanation to the Plan no later than 30 calendar days prior to the due date of any deliverable if a delay is anticipated. This notice shall not relieve Vendor of its responsibility, or any reduction in fees, for untimely completion of deliverables in accordance with the Contract.

### **6.3.2 Audits of Records and Performance**

The Plan reserves the right to conduct an audit of Vendor's records as specified in ATTACHMENT C. 12. "Access to Persons and Records" to validate the results of Vendor's performance. Vendor will be required to resolve any material discrepancies identified to the satisfaction of the Plan.

### **6.3.3 Performance Guarantee Timeliness Guidelines and Definitions**

- a) All files received from the Plan's EES vendor are considered enrollment data files; including but not limited to daily change files, audit files, and Member lists. Once complete information is received, the information should be updated without manual intervention into Vendor's core system.
- b) Manual enrollment updates represent all manually executed actions necessary to ensure access to care, accurate claims processing and seamless experience for Plan Members. Notification of the need for a

manual update may come from any source. Scripts that are manually initiated will be considered a manual enrollment update.

- c) Manual updates requested by Plan Staff or the Plan's EES vendor may come via email or the Plan's discrepancy log (Dlog) which is a secure, online database used to track enrollment discrepancies.
- d) Monthly enrollment audit and reconciliation process is detailed in Exhibit 5, "Monthly Audit & Reconciliation." Per Exhibit 5, the audit between the TPA and the EES vendor shall be completed within five (5) State Business Days.
- e) Plan inquiries that require a 24-hour response include any inquiries sent by any Plan staff or the Attorney General's Office to Vendor's escalation team. An automated acknowledge email is not considered a response. While the initial response does not have to include a full resolution, the response does need to appropriately acknowledge the steps required to respond in full.
- f) Exhibit 11, "Standard Reports," outlines the due dates for reports. Reports without a specific time of day noted on the report are due by 5:00 p.m. ET. If any report due date falls on a weekend or holiday, the deliverable is the first State Business Day after the scheduled date.

#### **6.3.4 Performance Guarantee Accuracy Definitions**

- a) EDI Load Rate is the number of enrollment transactions that successfully pass the EDI edits and load automatically into Vendor's system without manual intervention. The enrollment transaction should be counted at the contract, or family level.
- b) Manual entry accuracy shall be calculated at the contract, or family level. There should be one (1) point assigned at the Subscriber enrollment level. If any field on the family enrollment is inaccurately entered, the score for that enrollment is zero. (Example: Ten enrollments are pulled for audit. Five contain enrollments for more than one (1) Member of a family and five (5) are for individual enrollments. Total points available for this audit are 10 points. Upon audit, it is determined that an address was misspelled on one (1) enrollment and two (2) family Members were inaccurately enrolled on one (1) enrollment. Eight (8) out of 10 enrollments were completed accurately; therefore, the accuracy score is 80%. The audit sample size will be determined by the Plan during the implementation and the ongoing audits will be performed by Vendor. If additional inaccurate updates are identified (by the Group, Member, Plan or Plan vendors, etc.), the additional error and transaction should be included in the month's accuracy score.
- c) Call accuracy shall be determined based on Vendor's payment policies as well as the Plan's benefits, documented business rules and processes, Business Requirements, and the Service Center training materials which will be approved by the Plan prior to use. The sample size shall be determined by Vendor and the audit will be conducted by Vendor. The Plan will also pull random calls for review. If additional inaccurate calls are identified (by the Group, Member, Plan, Plan Vendors, etc.) through an audit or any other means, the additional error and transaction shall be reported in the month in which it was found. The accuracy results will identify the number of inaccurate calls for the reporting period.
- d) Financial Accuracy (Claims): Total dollar amount processed accurately divided by the total dollar amount processed in the audit sample. The total dollar amount processed accurately is calculated by subtracting the absolute values of the dollars processed in error from the total dollars processed. Underpayments and overpayments are not offset by one another.
- e) Payment Accuracy (Claims): The number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.
- f) Processing Accuracy (Claims): The number of claims processed with no procedural errors divided by the total number of claims processed.

- g) The Deposit Error Rate shall be determined by dividing the total number of inaccurate daily deposits identified during the performance period by the total number of daily deposits for the performance period. A deposit will be considered inaccurate when:
- i. Detailed backup documentation does not agree to the bank balance reported on applicable Plan depository accounts. This includes confirming the claims recovery receipt information as well as any other types of deposits are accurate in relation to the detail report. See Section 5.2.11.2.b.ix.3) a) – c).
  - ii. Plan deposits are made to the wrong account and/or receipts belonging to other entities are incorrectly deposited to the Plan's account.
- h) The Disbursements error rate shall be determined by dividing the total number of inaccurate weekly disbursements identified during the performance period by the total number of disbursements for the performance period. A disbursement will be considered inaccurate when:
- i. Weekly refunds and other disbursements, including system generated checks, EFTs, voids, and reissues, cancelled and manual checks, EFT adjustments and any other adjustments are found to be incorrect. See Section 5.2.11.2.b.ix.6).
  - ii. Plan's disbursements are drawn on the wrong account and/or payment obligations belonging to other entities are incorrectly drawn on the Plan's account.
- i) ID Card Accuracy requires that the following data elements are correct:
- i. Plan Logo.
  - ii. Plan Network.
  - iii. Group Name (Examples: Dept of State Treasurer, Wake County Public Schools, State Retirement Systems, etc.).
  - iv. Member's PCP Information.
  - v. RxBin/Group.
  - vi. Plan Design (Examples: 80/20, 70/30, and HDHP).
  - vii. Member Cost-Shares
  - viii. Plan Vendor Phone Numbers.

During implementation, Vendor shall submit an ID card audit proposal to the Plan for approval. Vendor's ID Card accuracy audit results will be utilized to measure this Performance Guarantee.

- j) Benefit configuration accuracy measures the accuracy of the benefits configured in the claims administration system(s). This includes appropriate configuration of covered and excluded benefits, and the application of appropriate copays, deductibles, and out-of-pockets. If an inaccurate benefit configuration is discovered after the start of a new Benefit Year, Vendor will pay a per day fee calculated from the date the benefit was effective until the date it is corrected in Vendor's systems.

### **6.3.5 Third Party Administration Performance Guarantees – Schedules I and II**

The Performance Guarantee section is comprised of schedules indicating the measure, description, standard, and fees at risk for each Performance Guarantee. Included are one-time Performance Guarantees around implementation of services and additional Performance Guarantees measured on a quarterly basis throughout the term of the Contract.

Continues on next page.

<b>Schedule I. Implementation Performance Guarantees</b> <i>All performance targets and results are Plan, not book of business, specific.</i>		
<b>Measure</b>	<b>Implementation</b>	<b>Monetary Risk</b>
Insurance	Proof of insurance required in ATTACHMENT C, 14. "Insurance" to be provided to the Plan within 15 calendar days of execution of Contract.	Vendor shall pay \$10,000.00 for each day the proof of insurance is late.
Performance Bond	Proof of purchase of bond to be provided to the Plan within 30 State Business Days of execution of Contract.	Vendor shall pay \$10,000.00 for each day the proof of purchase of bond is late.
Timeliness	Initial enrollment data file from Plan's EES vendor automatically loads in Vendor's system at a 95% Load-Rate within 24 hours of receipt. Any enrollment data that errors back to the EES vendor for correction, is not included in the calculation.	Vendor shall pay \$10,000.00 for each day the file is not processed in Vendor's system after the initial 24 hours turnaround time.
Timeliness	Any enrollment data that does not automatically load during the initial load from the Plan's EES vendor, must be manually loaded within five (5) State Business Days. Any enrollment data that errors back to the EES vendor for correction, is not included in the calculation.	Vendor shall pay \$10,000.00 per day for each day beyond the 5 <sup>th</sup> State Business Day that the initial enrollment is not loaded into Vendor's systems.
Accuracy	Initial pre-Go-Live enrollment audit is completed on time based on the Enrollment Audit Schedule that is developed during the Contract implementation. The audit process is outlined in Exhibit 5, "Monthly Audit & Reconciliation."	Vendor shall pay \$10,000.00 per day for each day delay in meeting the Enrollment Audit Schedule.
Timeliness	Initial implementation ID cards mailed within two (2) State Business Days of the target date established in the Implementation Plan.	Vendor shall pay \$5,000.00 for each day beyond the target date.
Accuracy	Initial implementation ID card accuracy is 100% accurate.	Vendor shall pay \$2,500.00 plus the cost of reissuing the cards.
Accuracy	Benefit Configuration	Vendor shall pay \$5,000.00 for each day beyond the January 1, 2025.
Timeliness	Depository bank accounts are set-up, tested, and operational at least 45 days prior to January 1, 2025.	Vendor shall pay \$5,000.00 for each day later than 45 days prior to January 1, 2025.
Timeliness	If applicable, disbursing bank accounts are setup, tested, and operational at least 30 days prior to January 1, 2025.	Vendor shall pay \$5,000.00 for each day later than 30 days prior to January 1, 2025.
Timeliness	All Plan vendor SSOs are implemented prior to the 2025 Open Enrollment period.	Vendor shall pay \$5,000.00 for each day beyond the target date in the implementation schedule.
Timeliness	All other Services under the Contract are fully implemented by the "Go-Live" dates which will be determined during the implementation and documented in the Implementation Plan.	Vendor shall pay 1-15 days late: \$10,000.00 per day; 15+ days late: \$20,000.00 per day.

Schedule II. Third Party Administration Services Performance Guarantees			
Measure	EDI & Enrollment Maintenance	Target	Monetary Risk
Timeliness	All daily enrollment data files received from Plan's EES vendor between 5:00 p.m. and 9:00 p.m. ET are processed and loaded in Vendor's system by 9:00 a.m. ET the following State Business Day.	100%	1%
Timeliness	The daily outbound EDI files to the Plan's EES vendor are sent $\leq$ 12:00 p.m. ET the day after the daily file from the Plan's EES vendor is received. If the daily enrollment file from the Plan's EES vendor is not received by the deadline, the PG does not apply.	99%	0.5%
Timeliness	Complete any manual enrollment updates $\leq$ three (3) State Business Days for enrollments that were accurately sent by the Plan's EES vendor but did not automatically load into Vendor's system.	99%	1%
Timeliness	Complete any manual enrollment updates requested by Plan staff or the Plan's EES vendor for Plan Members $\leq$ three (3) State Business Days of notification.	99%	0.5%
Timeliness	The monthly enrollment audit is completed within the timeframes outlined in Exhibit 5, "Monthly Audit & Reconciliation" and Vendor Audit Schedule. Either of these documents can be updated throughout the lifetime of the Contract via ADM.	100%	1%
Accuracy	EDI Load Rate	98%	0.5%
Accuracy	Manual Entry Accuracy Rate	99%	2%
Customer Experience			
Timeliness	Average Speed to Answer (ASA) $\leq$ 30 Seconds outside of Open Enrollment	98%	0.5%
Timeliness	Respond to Plan inquiries within 24 business hours of receipt.	98%	0.25%
Accuracy	Call Accuracy	Per Instance	\$500.00/call identified
Claims			
Timeliness	Claims Paid in $\leq$ 30 Days	98%	0.5%
Accuracy	Claims Financial Accuracy Rate	99%	0.5%
Accuracy	Claims Payment Accuracy Rate	99%	0.5%
Accuracy	Process Accuracy Rate	99%	0.5%
Pharmacy Benefit			
Timeliness	Specialty pharmacy rebates made out to Vendor shall be delivered to the Plan no later than 10 State Business Days after Vendor receives payment from the drug manufacturer.	100%	0.25%
Financial Performance Reporting			
Timeliness	Deliver Fiscal Year End Matrix reports by July 12 <sup>th</sup> of each year.	100%	0.25%
Timeliness	Deliver Fiscal Year End Triangulation reports by July 12 <sup>th</sup> of each year.	100%	0.25%
Banking and Finance			
Timeliness	All receipts deposited within 24 hours of receipt.	98%	0.5%
Timeliness	Daily reporting package of deposits provided to the Plan on schedule. (See Section 5.2.11.2.b.ix.3) and Exhibit 11, FIN04)	98%	0.5%
Timeliness	Weekly package of disbursement delivered $\leq$ 9:30 a.m. ET on the first State Business Day of the week.	100%	1%
Timeliness	Weekly disbursement released only upon Plan approval.	100%	1%
Accuracy	Daily deposit error rate	$\leq$ 2%	0.5%
Accuracy	Weekly disbursements error rate	$\leq$ 2%	0.5%

Annual Open Enrollment			
Timeliness	ID Cards issued not more than two (2) State Business Days from the mutually agreed upon dates of Open Enrollment project plan.	100%	Vendor shall pay \$5,000.00 for each day beyond the target date.
Accuracy	ID card accuracy is 100% accurate	100%	Vendor shall pay \$2,500.00.
Accuracy	Benefit Configuration	100%	Vendor shall pay \$5,000.00 for each day beyond the benefit effective date.

## ATTACHMENT A: PRICING

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### INSTRUCTIONS FOR DATA ACCESS and COST PROPOSAL

This section contains the submission requirements and instructions for worksheets and data files required to be submitted by Vendor.

#### ***Submission of Signed Non-Disclosure Agreement Required for Access to Attachment A: Pricing (Attachments/worksheets) and Data Files***

Each Vendor must submit a signed **Attachment I: Non-Disclosure Agreement (NDA)** to the Plan in order to gain access to Attachment A: Pricing and data files. The NDA is included as part of the Minimum Requirements and must be submitted with the Minimum Requirement Responses.

The Plan will send the signed NDAs for all Vendors meeting Minimum Requirements to its Actuarial/Analytical and Health Benefits Consulting vendor, The Segal Company (Eastern States), Inc. ("Segal"). The Segal point of contact will provide Vendor's designated recipient a link to a SFTP system. The designated recipient may access the secure site and download the cost proposal worksheets and data files that will be used for the repricing exercise and other requirements within the cost proposal. Segal will not release any cost proposal worksheets and data files to any Vendor without a signed NDA.

For informational purposes, the Segal point of contact is as follows:

Stephen Kuhn  
skuhn@segalco.com  
617-424-7341

If issues arise, Segal and Vendor are permitted to communicate via email directly with one another regarding the transmission and receipt of documents through the Secure File Transfer system. Segal and Vendor must copy [Vanessa.Davison@nctreasurer.com](mailto:Vanessa.Davison@nctreasurer.com) and [SHPCContracting@nctreasurer.com](mailto:SHPCContracting@nctreasurer.com) on such emails. This communication is limited to technical support; all substantive questions shall be submitted pursuant to the Question and Answer process set forth in the RFP.

### 1.1 Network Access

The Plan seeks to have a provider network in place that best meets the program's long-term needs. This includes a broad provider network with the least disruption and with competitive pricing. This section will address access to the proposed network of healthcare providers.

#### 1.1.1 Access Reports

Vendors are required to submit an accessibility report (Optum™, GeoAccess®, GeoNetworks, or comparable software) for the proposed provider network. Access must be reported by county.

Vendor will be required to provide a summary of participants with and without access to network providers/facilities within the established mileage parameters listed below:



Provider Type	Urban and Out-of-State	Suburban	Rural
<b>Facilities</b>			
Hospitals	1 within 20-miles	1 within 25-miles	1 within 35-miles
Ambulatory Surgical Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Urgent Care facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
Imaging Centers	1 within 20-miles	1 within 25-miles	1 within 35-miles
Inpatient Behavioral Health Facilities	1 within 20-miles	1 within 25-miles	1 within 35-miles
<b>Professional Services</b>			
<b>Primary Care</b>			
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	2 within 10-miles	2 within 15-miles	2 within 20-miles
OB/GYN (female members, age 12 and older)	2 within 10-miles	2 within 15-miles	2 within 20-miles
Pediatrician (birth through age 18)	2 within 10-miles	2 within 15-miles	2 within 20-miles
<b>Specialists</b>			
Endocrinologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Urologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Cardiologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Dermatologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Allergist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Psychologist/Psychiatrist	2 within 20-miles	2 within 25-miles	2 within 35-miles
General Surgeon	2 within 20-miles	2 within 25-miles	2 within 35-miles
Hematologist/Oncologist	2 within 20-miles	2 within 25-miles	2 within 35-miles
Chiropractor	2 within 20-miles	2 within 25-miles	2 within 35-miles

The submitted access reports (mapping and accessibility analysis) must demonstrate provider availability for EACH provider group type listed in the table above. In the production of the reports, please note the following:

Vendor must utilize Optum™, GeoAccess®, GeoNetworks or comparable software.

- The access report must indicate, by county, those participants with access and those without access according to the provider network access standards listed above.
- The access reports should include providers under contract as of September 1, 2022 and may also include providers that have executed a legally-binding letter of intent or letter of agreement with Vendor.
- Vendor is required to provide separate reporting for each proposed provider network.

A census file will be provided in a format detailed in **Attachment A-1**. Vendors should use this file to support the accessibility report.

Vendor must submit the summary grids, included in **Attachment A-2**, for its proposed provider network, along with the detailed access report(s). There are separate summaries for urban, suburban, and rural county designations. Out-of-State members will follow Urban parameters.

### 1.1.2 Providers by County

Vendors are required to submit a summary of the number of providers (under contract or with signed letter of intent) by county and category, consistent with the access reports in **Attachment A-2**.

### 1.1.3 Provider Listing

Vendors are required to submit a listing of the entire proposed provider network in **Attachment A-2**. The file should contain information for each proposed network, using the format disclosed, and identifying whether each provider is currently under contract or has entered a legally-binding letter of intent with Vendor.

## 1.2 Network Pricing

The Plan seeks to contract with an organization(s) that has proven success in managing provider costs and will submit data timely, in the required formats. The RFP was designed with knowledge of the capabilities of the market, and it is expected that each Vendor will comply with these requirements. If any issues or complications are expected, Vendors should submit questions as directed in RFP Section 2.5.

### 1.2.1 Claims Repricing File

A claims repricing file, containing participant claims experience for calendar year 2021, will be made available through a secure file transfer protocol to Vendors meeting the minimum requirements.

The layout of the fields that will be included in the repricing file are detailed in **Attachment A-3**. This attachment also contains supporting field descriptions that may be beneficial to Vendor.

Using the repricing file referenced above, **Vendors are to provide the contracted allowed amount for each service in the file**. Vendors are expected to reprice each claim line based on provider contracts in place, or near-future contract improvements bound by letters of intent, at the time of the repricing.

Three (3) fields must be populated:

- NetStatus (representing Vendor's proposed standard network) – Y / L / N
  - Y – Currently under contract
  - L – Letter of intent
  - N – Not under contract or Out-of-Network provider
- ContAmt – Repriced claim based on Vendor contract amount (or Allowed Amount) for the proposed network
- ContType (contract type) – (A, B, C, D, F, O)
  - A – Ambulatory Payment Classification
  - B – Bundled payment
  - C - Capitated
  - D – Discount off eligible charges
  - F – Fee schedule
  - O – Other contract arrangement

The file should be repriced for the provider network being proposed by Vendor.

Vendors are required to complete and submit summary results of the repricing exercise in the exact formats requested. The tabs have been pre-populated with the repricing source data and will require Vendors to supplement the fields identified. Vendors should complete the following for their proposed network:

- **Repricing by Service Category Summary – Attachment A-4:** Vendors should provide aggregate information on the contractual amount (aka, 'Allowed Amount') for each county and detailed service category, identified by the Service Category Codes in the repricing file.
- **Repricing by Provider Summary – Attachment A-5:** Vendors should provide aggregate allowed information for each provider listed.
- **Contract Improvements – Attachment A-6:** Vendors should identify any known contract improvements.

It is imperative that Vendors return data in the exact formats prescribed. Failure to do so may cause Vendor's proposal to be rejected. Attachments A-4 and A-5 should be financially identical to the detail data submitted and will be utilized to cross-check results and submissions.

Vendors must submit the complete repriced file along with any requested supporting documentation. Failure to comply may cause Vendor's proposal to be rejected.

### 1.3 Administrative Fees

The proposed administrative fees must support all the services requested in Section 5.0 "Technical and Cost Proposal Requirements and Specifications" of this RFP. **Tables A-7.1 through A-7.3 must include all costs except actual claim payments for covered Members. Unspecified fees and expenses will not be paid by the Plan.**

Vendor must provide the monthly administrative fee per subscriber for each of the five (5) years in the contract period. An exhibit with detailed instructions is included in **Attachment A-7**.

Table A-7.1 is broken out by administrative service item.

Table A-7.1 also requests PMPM pricing for some additional, optional services, if the Plan authorizes the TPA to perform those services.

If there are additional one-time credits and fees, providers should list them in Table A-7.2. Table A-7.3 requests per participant pricing for specified biometric screenings.

### 1.4 Network Pricing Guarantees

Vendor must provide network discount guarantees, guarantees not to exceed a percentage of Medicare fees, and a trend guarantee, and may provide other pricing guarantees recommended by Vendor. A detailed exhibit with instructions is provided in **Attachment A-8**. Vendors are required to submit guarantees and provide details on recommended metrics, methodology, and the amount that will be at risk. Guarantees shall be provided on separate tabs for both in state and out of state.

Discount improvements guarantees will only be reflected in projected costs to the extent Vendor is willing to provide shortfall guarantees on a dollar-for-dollar basis. Discount improvements without guarantees will not be reflected in the projected cost analysis and guarantees not on a dollar-for-dollar basis will only be reflected up to the dollar amount at-risk.

### 1.5 Self-Funded Claims Projection

This section (**Attachment A-9**) allows Vendor to estimate the expected claim and administrative cost for the proposed provider network. Based on the claims experience provided in the repricing file, Vendor is asked to estimate the expected future costs under its medical management and pricing arrangements with providers. It is expected that Vendor will map the repricing data to the proposed network. This is to be Vendor's best estimate and should be performed as accurately as possible, in good faith.

The summary projection requires thoughtful inputs at a very high level, recognizing that a detailed projection would be performed differently for each Vendor. There are two (2) inputs required of Vendors:

- **Utilization Adjustment:** If Vendor feels that its medical management will alter current utilization, Vendor should enter the expected utilization adjustment percentage. An explanation of anticipated changes is required.
- **Allowed Adjustment:** The submitted/billed charge per service is included in the summary and requires Vendor to provide an adjustment to allowable charge per service. It is understood that this is not discounts alone and will represent movement between provider charges. The goal is to get to what Vendor believes to be its per-service cost in the proposed network.

This section provides an opportunity for Vendor to demonstrate the strength of its network.

## 1.6 Data Certification

There is a required certification (**Attachment A-10**) of all information submitted, including data, guarantees, pricing worksheets, etc. Vendor's actuary should sign the certification, but signature by either Vendor's CFO or CEO will also be accepted. Appropriate language can be provided by Vendor.

## 1.7 Attachments for Attachment A: Pricing

The following attachments taken together make up Attachment A: Pricing.

Attachment A-1: Census File Format  
Attachment A-2: Network Access for Non-Medicare Membership  
Attachment A-3: Claims Repricing File Layout  
Attachment A-4: Repricing Summary - Service Category  
Attachment A-5: Repricing Summary - By Provider  
Attachment A-6: Contract Improvements  
Attachment A-7: Administrative Fees  
Attachment A-8: Network Pricing Guarantees  
Attachment A-9: Self-Funded Claims Projection  
Attachment A-10: Actuarial Certification

## ATTACHMENT B: INSTRUCTIONS TO VENDORS

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1. **READ, REVIEW AND COMPLY:** It shall be Vendor's responsibility to read this entire document, review all enclosures and attachments, and any addenda thereto, and comply with all requirements specified herein, regardless of whether appearing in these Instructions to Vendors or elsewhere in this RFP document.

Any gender-specific pronouns used herein, whether masculine or feminine, shall be read and construed as gender neutral, and the singular of any word or phrase shall be read to include the plural and vice versa.

2. **LATE PROPOSALS:** Late proposals, regardless of cause, will not be opened or considered, and will automatically be disqualified from further consideration. It shall be Vendor's sole responsibility to ensure delivery at the designated office by the designated time.
3. **ACCEPTANCE AND REJECTION:** The State reserves the right to reject any and all proposals, to waive any informality in proposals and, unless otherwise specified by Vendor, to accept any item in the proposal.
4. **BASIS FOR REJECTION:** The State reserves the right to reject any and all offers, in whole or in part, by deeming the offer unsatisfactory as to quality or quantity, delivery, price or service offered, non-compliance with the requirements or intent of this solicitation, lack of competitiveness, error(s) in specifications or indications that revision would be advantageous to the State, cancellation or other changes in the intended project or any other determination that the proposed requirement is no longer needed, limitation or lack of available funds, circumstances that prevent determination of the best offer, or any other determination that rejection would be in the best interest of the State.
5. **EXECUTION:** Failure to sign the Execution Page (numbered pages 3 -4 of the RFP) in the indicated space will render proposal non-responsive, and it shall be rejected.
6. **ORDER OF PRECEDENCE:** In cases of conflict between specific provisions in this solicitation or those in any resulting contract documents, the order of precedence shall be (high to low) (1) any special terms and conditions specific to this RFP, including any negotiated terms; (2) requirements and specifications and administration provisions in Sections 4, 5 and 6 of this RFP; (3) North Carolina General Contract Terms and Conditions in ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS; (4) Instructions in ATTACHMENT B: INSTRUCTIONS TO VENDORS; (5) ATTACHMENT A: PRICING, and (6) Vendor's proposal.
7. **INFORMATION AND DESCRIPTIVE LITERATURE:** Vendor shall furnish all information requested and in the spaces provided in this document. Further, if required elsewhere in this proposal, each Vendor shall submit with its proposal any sketches, descriptive literature and/or complete specifications covering the products and Services offered. Reference to literature submitted with a previous proposal or available elsewhere will not satisfy this provision. Failure to comply with these requirements shall constitute sufficient cause to reject a proposal without further consideration.
8. **RECYCLING AND SOURCE REDUCTION:** It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable, and less toxic to the extent that the purchase or use is practicable and cost-effective. We also encourage and promote using minimal packaging and the use of recycled/recyclable products in the packaging of commodities purchased. However, no sacrifice in quality of packaging will be acceptable. Vendor remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Vendors are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.
9. **CERTIFICATE TO TRANSACT BUSINESS IN NORTH CAROLINA:** As a condition of contract award, each out-of-State Vendor that is a corporation, limited-liability company or limited-liability partnership shall have received, and shall maintain throughout the term of the Contract, a Certificate of Authority to Transact Business in North Carolina from the North Carolina Secretary of State, as required by North Carolina law.

A State contract requiring only an isolated transaction completed within a period of six months, and not in the course of a number of repeated transactions of like nature, shall not be considered as transacting business in North Carolina and shall not require a Certificate of Authority to Transact Business.

10. **SUSTAINABILITY:** To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all responses meet the following:
- All copies of the proposal are printed double sided.
  - All submittals and copies are printed on recycled paper with a minimum post-consumer content of 30%.
  - Unless absolutely necessary, all proposals and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable.
  - Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.
11. **HISTORICALLY UNDERUTILIZED BUSINESSES:** The State is committed to retaining Vendors from diverse backgrounds, and it invites and encourages participation in the procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled. In particular, the State encourages participation by Vendors certified by the State Office of Historically Underutilized Businesses, as well as the use of HUB-certified vendors as subcontractors on State contracts.
12. **RECIPROCAL PREFERENCE:** North Carolina adheres to a reciprocal preference requirement to discourage other states from favoring their own resident Vendors by applying a percentage increase to the price of any proposal from a North Carolina resident Vendor. To the extent another state does so, North Carolina applies the same percentage increase to the proposal of a vendor resident in that state. Residency is determined by a Vendor's "Principal Place of Business," defined as that principal place from which the overall trade or business of Vendor is directed or managed.
13. **INELIGIBLE VENDORS:** As provided in N.C.G.S. § 147-86.59 and N.C.G.S. § 147-86.82, the following companies are ineligible to contract with the State of North Carolina or any political subdivision of the State: a) any company identified as engaging in investment activities in Iran, as determined by appearing on the Final Divestment List created by the State Treasurer pursuant to N.C.G.S. § 147-86.58, and b) any company identified as engaged in a boycott of Israel as determined by appearing on the List of restricted companies created by the State Treasurer pursuant to N.C.G.S. § 147-86.81. A contract with the State or any of its political subdivisions by any company identified in a) or b) above shall be void *ab initio*.
14. **CONFIDENTIAL INFORMATION:** To the extent permitted by applicable statutes and rules, the State will maintain as confidential trade secrets in its proposal that Vendor does not wish disclosed. As a condition to confidential treatment, each page containing trade secret information shall be identified in boldface at the top and bottom as "CONFIDENTIAL" by Vendor, with specific trade secret information enclosed in boxes, marked in a distinctive color or by similar indication. Cost information shall not be deemed confidential under any circumstances. Regardless of what a Vendor may label as a trade secret, the determination whether it is or is not entitled to protection will be determined in accordance with N.C.G.S. § 132-1.2. Any material labeled as confidential constitutes a representation by Vendor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C.G.S. § 132-1.2. Vendors are urged and cautioned to limit the marking of information as a trade secret or as confidential so far as is possible. If a legal action is brought to require the disclosure of any material so marked as confidential, the State will notify Vendor of such action and allow Vendor to defend the confidential status of its information.
15. **PROTEST PROCEDURES:** To protest a contract award, Vendor shall submit a written request for a protest meeting addressed to: Executive Administrator, North Carolina State Health Plan, 3200 Atlantic Avenue, Raleigh, NC 27604. The request must be received by the Plan within 30 calendar days from the date of

Contract award. The written request shall contain specific reasons and any supporting documentation for the protest. If the request does not contain this information or if the Executive Administrator determines that a meeting would serve no purpose, then the Executive Administrator may, within 10 calendar days from the date of receipt of the request, respond in writing to Vendor and deny the request for a protest meeting.

If the protest meeting is granted, the Executive Administrator will attempt to schedule the meeting within 30 calendar days after receipt of the letter, or as soon as possible thereafter. Within 10 calendar days from the date of the protest meeting, the Executive Administrator will respond to Vendor in writing with the Executive Administrator's decision.

Inclusion of this protest procedure is not intended to, and does not, waive, the Plan's exemption from Article 3 of Chapter 143 of the North Carolina General Statutes or any rules promulgated thereunder. Moreover, pursuant to N.C.G.S. § 135-48.35, a contract dispute involving the Plan is not a contested case under the Administrative Procedure Act, Chapter 150B of the North Carolina General Statutes.

16. **COMMUNICATIONS BY VENDORS:** In submitting its proposal, Vendor agrees not to discuss or otherwise reveal the contents of its proposal to any source, government or private, outside of the using or issuing agency until after the award of the Contract or cancellation of this RFP. All Vendors are forbidden from having any communications with the using or issuing agency, or any other representative of the State concerning the solicitation, during the evaluation of the proposals (i.e., after the public opening of the proposals and before the award of the Contract), unless the State directly contacts Vendor(s) for purposes of seeking clarification or another reason permitted by the solicitation. A Vendor shall not: (a) transmit to the issuing and/or using agency any information commenting on the ability or qualifications of any other Vendor to provide the advertised good, equipment, commodity; (b) identify defects, errors and/or omissions in any other Vendor's proposal and/or prices at any time during the procurement process; and/or (c) engage in or attempt any other communication or conduct that could influence the evaluation or award of a Contract related to this RFP. Failure to comply with this requirement shall constitute sufficient justification to disqualify a Vendor from a Contract award. Only those communications with the using agency or issuing agency authorized by this RFP are permitted.
17. **TABULATIONS:** Proposal tabulations can be electronically retrieved at the Interactive Purchasing System (IPS), <https://www.ips.state.nc.us/ips/BidNumberSearch.aspx>. Click on the IPS BIDS icon, click on Search for Bid, enter the bid number, and then search. Tabulations will normally be available at this web site not later than one working day after the bid opening. If negotiation is anticipated, tabulations may not be public until award. Lengthy or complex tabulations may be summarized, with other details not made available on IPS, and requests for additional details or information concerning such tabulations cannot be honored.
18. **VENDOR REGISTRATION AND SOLICITATION NOTIFICATION SYSTEM:** The North Carolina electronic Vendor Portal (eVP) allows Vendors to electronically register for free with the State to receive electronic notification of current procurement opportunities available on the Interactive Purchasing System, as well as notifications of status changes to those solicitations. Online registration and other purchasing information is available at the following website: <http://ncadmin.nc.gov/about-doa/divisions/purchase-contract>.
19. **WITHDRAWAL OF PROPOSAL:** Proposals that have been delivered by hand, U.S. Postal Service, courier, or other delivery service may be withdrawn **only** in writing and if receipt is acknowledged by the office issuing the RFP prior to the time for opening proposals identified on the cover page of this RFP (or such later date included in an Addendum to the RFP). Written withdrawal requests shall be submitted on Vendor's letterhead and signed by an official of Vendor authorized to make such request. Any withdrawal request made after the opening of proposals shall be allowed only for good cause shown and in the sole discretion of the State.
20. **INFORMAL COMMENTS:** The State shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the State during the competitive process or after award. The State is bound only by information provided in writing in this RFP and in formal Addenda.

21. **COST FOR PROPOSAL PREPARATION:** Any costs incurred by Vendor in preparing or submitting offers are Vendor's sole responsibility; the State of North Carolina will not reimburse any Vendor for any costs incurred prior to award.
22. **INSPECTION AT VENDOR'S SITE:** The State reserves the right to inspect, at a reasonable time, the equipment, item, plant, or other facilities of a prospective Vendor prior to Contract award, and during the Contract term as necessary for the State's determination that such equipment, item, plant, or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.



## **ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS & CONDITIONS**

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### **1. PERFORMANCE AND DEFAULT:**

- a) It is anticipated that the tasks and duties undertaken by the Vendor under the contract which results from the State solicitation in this matter (Contract) shall include Services, and/or the manufacturing, furnishing, or development of goods and other tangible features or components, as Deliverables.
- b) Vendor grants the State a personal non-transferable and non-exclusive right to use and access, all Services and other functionalities or Services provided, furnished or accessible under this Agreement. The State may utilize the Services as agreed herein. The State is authorized to access State Data provided by the State and any Vendor-provided data as specified herein and to transmit revisions, updates, deletions, enhancements, or modifications to the State Data. This shall include the right of the State to, and access to, Support without Vendor requiring a separate maintenance or support agreement unless otherwise specifically agreed in writing. User access to the Services shall be routinely provided by Vendor and may be subject to a more specific Service Level Agreement (SLA) agreed to in writing by the parties. In the absence of an SLA, Vendor agrees to provide the Services at least in the manner that it provides accessibility to the services to comparable users.
- c) The State's right to access the Services and its associated services neither transfers, vests, nor infers any title or other ownership right in any intellectual property rights of Vendor or any third party, nor does this right of access transfer, vest, or infer any title or other ownership right in any intellectual property associated with the Services unless otherwise agreed to by the parties. The provisions of this paragraph will not be construed as a sale of any ownership rights in the Services. Any Services or technical and business information owned by Vendor or its suppliers or licensors made accessible or furnished to the State shall be and remain the property of Vendor or such other party, respectively. Vendor has a limited, non-exclusive license to access and use any State Data as provided to Vendor, but solely for performing its obligations under this Agreement and in confidence as provided herein. Vendor or its suppliers shall at minimum, and except as otherwise agreed, provide telephone assistance to the State for all Services procured hereunder during the State's normal business hours (unless different hours are specified herein). Vendor warrants that its Support and customer service and assistance will be performed in accordance with generally accepted industry standards. The State has the right to receive the benefit of upgrades, updates, maintenance releases or other enhancements or modifications made generally available to Vendor's users for similar Services. Vendor may, at no additional charge, modify the Services to improve operation and reliability or to meet legal requirements.
- d) Vendor will provide to the State the same Services for updating, maintaining, and continuing optimal performance for the Services as provided to other similarly situated Users of the Services, but minimally as provided for and specified herein. The technical and professional activities required for establishing, managing, and maintaining the Services environment are the responsibilities of Vendor. Any training specified herein will be provided by Vendor to specified State users for the fees or costs as set forth herein or in an SLA.
- e) Some Services provided online pursuant to this Solicitation may, in some circumstances, be accompanied by a user clickwrap agreement. The term clickwrap agreement refers to an agreement that requires the end user to manifest his or her assent to terms and conditions by clicking an "ok" or "agree" button on a dialog box or pop-up window as part of the process of access to the Services. All terms and conditions of any clickwrap agreement provided with any Services solicited herein shall have no force and effect and shall be non-binding on the State, its employees, agents, and other authorized users of the Services.

- f) If Vendor modifies or replaces the Services provided to the State and other comparable users, and if the State has paid all applicable Fees, the State shall be entitled to receive, at no additional charge, access to a newer version of the Services that supports substantially the same functionality as the then accessible version of the Services. Newer versions of the Services containing substantially increased functionality may be made available to the State for an additional subscription fee. In the event of either of such modifications, the then accessible version of the Services shall remain fully available to the State until the newer version is provided to the State and accepted. If a modification materially affects the functionality of the Services as used by the State, the State, at its sole option, may defer such modification.
  - g) If, through any cause, Vendor shall fail to fulfill in timely and proper manner the obligations under the Contract, the State shall have the right to terminate the Contract by giving written notice to Vendor and specifying the effective date thereof. In that event, any or all finished or unfinished deliverable items under the Contract prepared by Vendor shall, at the option of the State, become its property, and Vendor shall be entitled to receive just and equitable compensation for any acceptable work completed as to which the option is exercised. Notwithstanding, Vendor shall not be relieved of liability to the State for damages sustained by the State by virtue of any breach of the Contract, and the State may withhold any payment due Vendor for the purpose of setoff until such time as the exact amount of damages due the State from such breach can be determined. The State reserves the right to require at any time a performance bond or other acceptable alternative performance guarantees from a Vendor without expense to the State.
  - h) In the event of default by Vendor, the State may procure the goods and Services necessary to complete performance hereunder from other sources and hold Vendor responsible for any excess cost occasioned thereby. In addition, in the event of default by Vendor under the Contract, or upon Vendor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against Vendor, the State may immediately cease doing business with Vendor, immediately terminate the Contract for cause, and may take action to debar Vendor from doing future business with the State.
  - i) The State may document and take into account in awarding or renewing future procurement contracts the general reputation, performance, and performance capabilities of the Vendor under this Contract.
2. **GOVERNMENTAL RESTRICTIONS:** In the event any Governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship or performance of the goods or Services offered prior to their delivery, it shall be the responsibility of Vendor to notify the Contract Administrator at once, in writing, indicating the specific regulation which required such alterations. The State reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.
3. **AVAILABILITY OF FUNDS:** Any and all payments to Vendor shall be dependent upon and subject to the availability of funds to the agency for the purpose set forth in the Contract.
4. **TAXES:** Any applicable taxes shall be invoiced as a separate item.
- a) The State does not enter into Contracts with Vendors if Vendor or its affiliates meet one of the conditions of N.C.G.S. § 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under N.C.G.S. § 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of Vendor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the proposal document Vendor certifies that it and all of its affiliates, (if it has affiliates), collect(s) the appropriate taxes.
  - b) The agency(ies) participating in the Contract are exempt from Federal Taxes, such as excise and transportation. Exemption forms submitted by Vendor will be executed and returned by the using agency.

- c) Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.

5. **SITUS AND GOVERNING LAWS:** This Contract is made under and shall be governed and construed in accordance with the laws of the State of North Carolina, without regard to its conflict of laws rules, and within which State all matters, whether sounding in Contract or tort or otherwise, relating to its validity, construction, interpretation, and enforcement shall be determined.

6. **PAYMENT TERMS:** Payment terms are Net not later than 30 days after receipt of correct invoice or acceptance of goods, whichever is later. The using agency is responsible for all payments to Vendor under the Contract. Payment by some agencies may be made by procurement card, if Vendor accepts that card (Visa, MasterCard, etc.) from other customers, and it shall be accepted by the Vendor for payment under the same terms and conditions as any other method of payment accepted by Vendor. If payment is made by procurement card, then payment may be processed immediately by Vendor.

The State does not agree in advance, in contract, pursuant to Constitutional limitations, to pay costs such as interest, late fees, penalties, or attorney's fees. This Contract will not be construed as an agreement by the State to pay such costs and will be paid only as ordered by a court of competent jurisdiction.

7. **NON-DISCRIMINATION:** Vendor will take necessary action to comply with all Federal and State requirements concerning fair employment and employment of people with disabilities, and concerning the treatment of all employees without regard to discrimination on the basis of any prohibited grounds as defined by Federal and State law.

8. **CONDITION AND PACKAGING:** Unless otherwise provided by special terms and conditions or specifications, it is understood and agreed that any item offered or shipped has not been sold or used for any purpose and shall be in first class condition. All containers/packaging shall be suitable for handling, storage, or shipment.

9. **INTELLECTUAL PROPERTY WARRANTY AND INDEMNITY:** Vendor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or patent-pending invention, article, device, or appliance delivered in connection with the Contract.

a) Vendor warrants to the best of its knowledge that:

- i. The Services do not infringe any intellectual property rights of any third party; and
- ii. There are no actual or threatened actions arising from, or alleged under, any intellectual property rights of any third party;

b) Should any Services supplied by Vendor become the subject of a claim of infringement of a patent, copyright, Trademark or a trade secret in the United States, Vendor, shall at its option and expense, either procure for the State the right to continue using the Services, or replace or modify the same to become non-infringing. If neither of these options can reasonably be taken in Vendor's judgment, or if further use shall be prevented by injunction, Vendor agrees to cease provision of any affected Services, and refund any sums the State has paid Vendor and make every reasonable effort to assist the State in procuring substitute Services. If, in the sole opinion of the State, the cessation of use by the State of any such Services due to infringement issues makes the retention of other items acquired from Vendor under this Agreement impractical, the State shall then have the option of terminating the Agreement, or applicable portions thereof, without penalty or termination charge; and Vendor agrees to refund any sums the State paid for unused Services.

c) Vendor, at its own expense, shall defend any action brought against the State to the extent that such action is based upon a claim that the Services supplied by Vendor, their use or operation, infringes on a patent, copyright, trademark or violates a trade secret in the United States. Vendor

shall pay those costs and damages finally awarded or agreed in a settlement against the State in any such action. Such defense and payment shall be conditioned on the following:

- i. That Vendor shall be notified within a reasonable time in writing by the State of any such claim; and,
    - ii. That Vendor shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise provided, however, that the State shall have the option to participate in such action at its own expense.
  - d) Vendor will not be required to defend or indemnify the State if any claim by a third party against the State for infringement or misappropriation results from the State's material alteration of any Vendor-branded Services, or from the continued use of the good(s) or Services after receiving notice they infringe on a trade secret of a third party.
  - e) Vendor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or patent-pending invention, article, device, or appliance delivered in connection with the Contract.
10. **TERMINATION FOR CONVENIENCE:** If this Contract contemplates deliveries or performance over a period of time, the State may terminate this Contract at any time by providing 60 days' notice in writing from the State to Vendor. In that event, any or all finished or unfinished deliverable items prepared by Vendor under this Contract shall, at the option of the State, become its property. If the Contract is terminated by the State as provided in this section, the State shall pay for those items for which such option is exercised, less any payment or compensation previously made.
11. **ADVERTISING:** Vendor agrees not to use the existence of the Contract or the name of the State of North Carolina as part of any commercial advertising or marketing of products or Services. A Vendor may inquire whether the State is willing to act as a reference by providing factual information directly to other prospective customers.
12. **ACCESS TO PERSONS AND RECORDS:** During and after the term hereof, the State Auditor and any using agency's internal auditors shall have access to persons and records related to the Contract to verify accounts and data affecting fees or performance under the Contract.
13. **ASSIGNMENT:** No assignment of Vendor's obligations nor Vendor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority and solely as a convenience to Vendor, the State may:
- a) Forward Vendor's payment check directly to any person or entity designated by Vendor, and
  - b) Include any person or entity designated by Vendor as a joint payee on Vendor's payment check.

In no event shall such approval and action obligate the State to anyone other than Vendor and Vendor shall remain responsible for fulfillment of all Contract obligations. Upon advance written request, the State may, in its unfettered discretion, approve an assignment to the surviving entity of a merger, acquisition or corporate reorganization, if made as part of the transfer of all or substantially all of Vendor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of the Contract.

14. **INSURANCE:**

- a) **COVERAGE** - During the term of the Contract, Vendor at its sole cost and expense shall provide commercial insurance of such type and with such terms and limits as may be reasonably associated with the Contract. As a minimum, Vendor shall provide and maintain the following coverage and limits:
  - i. **Worker's Compensation** - Vendor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability

coverage with minimum limits of \$500,000.00, covering all of Vendor's employees who are engaged in any work under the Contract in North Carolina. If any work is sub-contracted, Vendor shall require the sub-Contractor to provide the same coverage for any of his employees engaged in any work under the Contract within the State.

- ii. **Commercial General Liability** - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$1,000,000.00 Combined Single Limit. Defense cost shall be in excess of the limit of liability.
- iii. **Automobile** - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used within North Carolina in connection with the Contract. The minimum combined single limit shall be \$250,000.00 bodily injury and property damage; \$250,000.00 uninsured/under insured motorist; and \$2,500.00 medical payment.

- b) **REQUIREMENTS** - Providing and maintaining adequate insurance coverage is a material obligation of Vendor and is of the essence of the Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. Vendor shall at all times comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or the Contract. The limits of coverage under each insurance policy maintained by Vendor shall not be interpreted as limiting Vendor's liability and obligations under the Contract.

**15. GENERAL INDEMNITY:** Vendor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, Services, materials, or supplies in connection with the performance of the Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by Vendor in the performance of the Contract and that are attributable to the negligence or intentionally tortious acts of Vendor provided that Vendor is notified in writing within 30 days from the date that the State has knowledge of such claims. Vendor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Vendor goods or Services to the State. As part of this provision for indemnity, if federal funds are involved in this procurement, the Vendor warrants that it will comply with all relevant and applicable federal requirements and laws, and will indemnify and hold and save the State harmless from any claims or losses resulting to the State from the Vendor's noncompliance with such federal requirements or law in this Contract. The representation and warranty in the preceding sentence shall survive the termination or expiration of the Contract. The State does not participate in indemnification due to Constitutional restrictions, or arbitration, which effectively and unacceptably waives jury trial. See, G.S. 22B-3, -10.

**16. ELECTRONIC PROCUREMENT:**

- a) Purchasing shall be conducted through the Statewide E-Procurement Service. The State's third-party agent shall serve as the Supplier Manager for this E-Procurement Service. Vendor shall register for the Statewide E-Procurement Service within two (2) business days of notification of award in order to receive an electronic purchase order resulting from award of this contract.
- b) Reserve.
- c) Reserve.
- d) Reserve.
- e) Vendor shall at all times maintain the confidentiality of its username and password for the Statewide E-Procurement Services. If Vendor is a corporation, partnership, or other legal entity,

then Vendor may authorize its employees to use its password. Vendor shall be responsible for all activity and all charges by such employees. Vendor agrees not to permit a third party to use the Statewide E-Procurement Services through its account. If there is a breach of security through Vendor's account, Vendor shall immediately change its password and notify the Supplier Manager of the security breach by email. Vendor shall cooperate with the State and the Supplier Manager to mitigate and correct any security breach.

17. **SUBCONTRACTING:** Performance under the Contract by Vendor shall not be subcontracted without prior written approval of the State's assigned Contract Administrator. Unless otherwise indicated, acceptance of a Vendor's proposal shall include approval to use the Subcontractor(s) that have been specified therein.
18. **CONFIDENTIALITY:** Vendor information that cannot be shown to be, e.g., a trade secret, may be subject to public disclosure under the terms of the State Public Records Act (SPRA), beginning at N.C.G.S. § 132.1. Blanket assertions of confidentiality are not favored, but confidentiality of specific material meeting one or more exceptions in the SPRA will be honored. Vendors are notified that if the confidentiality of material is challenged by other parties, the Vendor has the responsibility of defending the assertion of confidentiality.

Any State information, data, instruments, documents, studies, or reports given to or prepared or assembled by or provided to Vendor under the Contract shall be kept as confidential, used only for the purpose(s) required to perform the Contract and not divulged or made available to any individual or organization without the prior written approval of the State.

19. **CARE OF STATE DATA AND PROPERTY:** Vendor agrees that it shall be responsible for the proper custody and care of any data owned and furnished to Vendor by the State (State Data), or other State property in the hands of Vendor, for use in connection with the performance of the Contract or purchased by or for the State for the Contract. Vendor will reimburse the State for loss or damage of such property while in Vendor's custody.

The State Data in the hands of Vendor shall be protected from unauthorized disclosure, loss, damage, destruction by a natural event or other eventuality. Such State Data shall be returned to the State in a form acceptable to the State upon the termination or expiration of this Agreement. Vendor shall notify the State of any security breaches within 24 hours as required by N.C.G.S. § 143B.1379. See N.C.G.S. § 75-60 *et seq.*

20. **OUTSOURCING:** Any Vendor or subcontractor providing call or contact center services to the State of North Carolina or any of its agencies shall disclose to inbound callers the location from which the call or contact center services are being provided.

If, after award of a contract, Vendor wishes to relocate or outsource any portion of performance to a location outside the United States, or to contract with a subcontractor for any such the performance, which subcontractor and nature of the work has not previously been disclosed to the State in writing, prior written approval must be obtained from the State agency responsible for the contract.

Vendor shall give notice to the using agency of any relocation of Vendor, employees of Vendor, subcontractors of Vendor, or other persons providing performance under a State contract to a location outside of the United States.

21. **COMPLIANCE WITH LAWS:** Vendor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business and its performance in accordance with the Contract, including those of federal, state, and local agencies having jurisdiction and/or authority.
22. **ENTIRE AGREEMENT:** This RFP and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements. This RFP, any addenda hereto, and Vendor's proposal are incorporated herein by reference as though set forth verbatim.

All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

**23. ELECTRONIC RECORDS:** The State will digitize all Vendor responses to this solicitation, if not received electronically, as well as any awarded contract together with associated procurement-related documents. These electronic copies shall constitute a preservation record, and shall serve as the official record of this procurement with the same force and effect as the original written documents comprising such record. Any electronic copy, printout, or other output readable by sight shown to reflect such record accurately shall constitute an "original."

**24. AMENDMENTS:** This Contract may be amended only by a written Amendment duly executed by the State and Vendor. No changes in the technical requirements & specifications, time for performance, or other contractual terms shall be effective without a written Amendment.

Notwithstanding this requirement, (1) if needed or applicable, the addition of BRDs or Implementation Plans or ADMs may be developed or modified in writing and signed by Vendor's Contract Administrator for day to day activities or other individual authorized to bind Vendor, and the Plan's Contract Administrator for day to day activities or other designee approved by the Plan's Executive Administrator; and (2) due dates referenced in the technical requirements & specifications as "to be determined by the Plan" will be established in writing by the Plan's Contract Administrator for day to day activities through either the Implementation Plan, a BRD or an ADM. Such documents are incorporated into the Contract when signed and are given the precedence as set forth in RFP Section 4.13 "Contract Documents".

**25. NO WAIVER:** Notwithstanding any other language or provision in the Contract, nothing herein is intended nor shall be interpreted as a waiver of any right or remedy otherwise available to the State under applicable law. The waiver by the State of any right or remedy on any one occasion or instance shall not constitute or be interpreted as a waiver of that or any other right or remedy on any other occasion or instance.

**26. FORCE MAJEURE:** Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations as a result of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

**27. SOVEREIGN IMMUNITY:** Notwithstanding any other term or provision in the Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity or other State or federal constitutional provision or principle that otherwise would be available to the State under applicable law.

**28. PERFORMANCE BOND:** Vendor shall provide contract performance security based upon ten percent (10%) of the estimated contract total based on Vendor's cost proposal. This security will be in the form of a surety bond licensed in North Carolina with a Best's rating of no less than A-. The contract performance surety will be provided to the Plan's Contracting Section within 30 calendar days from the date of execution of the contract. This security must remain in effect for the entire term of the contract. A new surety bond must be issued if the contract is renewed or extended.

**ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR**

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Vendor shall detail the location(s) at which performance will occur, as well as the manner in which it intends to utilize resources or workers outside of the United States in the performance of The Contract.

Vendor shall complete items 1 and 2 below.

**1. Will any work under this Contract be performed outside of the United States?** YES ☐ NO ☐

If "YES":

a) List the location(s) outside of the United States where work under the Contract will be performed by the Vendor, any subcontractors, employees, or any other persons performing work under the Contract.

b) Specify the manner in which the resources or workers will be utilized:

**2. Where within the United States will work be performed?**

**NOTES:**

1. The State will evaluate the additional risks, costs, and other factors associated with the utilization of workers outside of the United States prior to making an award.
2. Vendor shall provide notice in writing to the State of the relocation of the Vendor, employees of the Vendor, subcontractors of the Vendor, or other persons performing services under the Contract to a location outside of the United States.
3. All Vendor or subcontractor personnel providing call or contact center services to the State of North Carolina under the Contract **shall disclose** to inbound callers the location from which the call or contact center services are being provided.



**ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION**

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Name of Vendor: \_\_\_\_\_

The undersigned hereby certifies that: [check all applicable boxes]

- ☐ Vendor is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.

Date of latest audit: \_\_\_\_\_ (if no audit within past 18 months, explain reason below.)

- ☐ Vendor has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.
- ☐ Vendor is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.
- ☐ Vendor is not the subject of any current litigation or findings of noncompliance under federal or state law.
- ☐ Vendor has not been the subject of any past or current litigation, findings in any past litigation, or findings of noncompliance under federal or state law that may impact in any way its ability to fulfill the requirements of this Contract.
- ☐ He or she is authorized to make the foregoing statements on behalf of Vendor.

**Note:** This shall constitute a continuing certification and Vendor shall notify the Contract Administrator within 30 days of any material change to any of the representations made herein.

**If any one or more of the foregoing boxes is NOT checked, Vendor shall explain the reason(s) in the space below. Failure to include an explanation may result in Vendor being deemed non-responsive and its submission rejected in its entirety.**

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Signature

Date

---

Printed Name

Title

**[This Certification must be signed by an individual authorized to speak for Vendor]**

## ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION

### HISTORICALLY UNDERUTILIZED BUSINESSES

Historically Underutilized Businesses (HUBs) consist of minority, women, and disabled business firms that are at least fifty-one percent owned and operated by an individual(s) from one of these categories. Also included in this category are disabled business enterprises and non-profit work centers for the blind and severely disabled.

The State invites and encourages participation in this procurement process by businesses owned by minorities, women, the disabled, disabled business enterprises, and non-profit work centers for the blind and severely disabled. This includes utilizing individual(s) from these categories as subcontractors to perform the functions required in this Solicitation.

The Vendor shall respond to questions below, as applicable.

### PART I: HUB CERTIFICATION

Is Vendor a NC-certified HUB entity? ☐ Yes ☐ No

If **yes**, provide Vendor #: \_\_\_\_\_

If **no**, does Vendor qualify for certification as HUB? ☐ Yes ☐ No

Vendors that check "yes" will be referred to the HUB Office for assistance in acquiring certification.

### PART II: PROCUREMENT OF GOODS - SUPPLIERS

For Goods procurements, are you using Tier 2 suppliers? ☐ Yes ☐ No

If **yes**, then provide the following information:

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid price

**PART III: PROCUREMENT OF SERVICES - SUBCONTRACTORS**

For Services procurements, are you using Subcontractors to perform any of the services being procured under this solicitation?      **Yes** ☐    **No** ☐

If **yes**, then provide the following information:

Company Name	Company Address	Website Address	Contact Name	Contact Email	Contact Phone	NC HUB certified?	Percent of total bid price

**Need more information?**

Questions concerning the completion of this form should be presented during the Q&A period through the process defined in the Solicitation document.

Questions concerning NC HUB certification, contact the **North Carolina Office of Historically Underutilized Businesses** at 984-236-0130 or [huboffice.doa@doa.nc.gov](mailto:huboffice.doa@doa.nc.gov).

## **ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT**

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This Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Business Associate Agreement ("BAA" or "Agreement") is entered into between the North Carolina State Health Plan for Teachers and State Employees ("Plan"), a division and Covered Healthcare Component of the North Carolina Department of State Treasurer ("DST"), and [INSERT NAME OF ENTITY] (hereinafter "Contractor"), referred to as "Party" or collectively as "Parties." This BAA is effective when signed by the Parties and, except as otherwise required, shall remain in effect for the term of the Contract, including any extensions or renewals.

### **BACKGROUND**

DST includes, as a division, the Plan. The Plan is a health benefit plan which, standing alone, would be a covered entity under HIPAA. DST includes several divisions that do not qualify as covered entities and whose functions are not regulated by HIPAA, and thus has designated itself a "Hybrid Entity." The Parties believe that the relationship between Contractor and the Plan is such that Contractor is or may be a Business Associate as defined by the HIPAA Privacy and Security Rules.

The purpose of this BAA between Contractor and the Plan is to protect Plan Member information in accordance with the HIPAA Privacy and Security Rules. The Parties enter this BAA with the intent to comply with HIPAA provisions that allow: 1) a Covered Healthcare Component of a Hybrid Entity (the Plan) to disclose Protected Health Information ("PHI") to a Business Associate; and 2) a Business Associate (i.e., Contractor) to create, maintain, transmit, or receive PHI on behalf of the Plan after the Plan obtains satisfactory assurances that Contractor will appropriately safeguard the information.

Specifically, Sections 261 through 264 of the Federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the United States Department of Health and Human Services to develop standards to protect the security, confidentiality, and integrity of health information. The "Health Information Technology for Economic and Clinical Health" ("HITECH") Act (Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5)) modified and amended the Administrative Simplification provisions. Pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services ("Secretary") issued regulations modifying 45 C.F.R. Parts 160 and 164 (the "HIPAA Rules"), as further amended by the Omnibus Final Rule (78 Fed. Reg. 5566), (hereinafter, the Administrative Simplification provisions, HITECH, such rules, amendments, and modifications, including any that are subsequently adopted, will be collectively referred to as "HIPAA").

The Parties wish to enter into an agreement through which Contractor will provide certain services and/or products to the Plan. Pursuant to such agreement, Contractor may be considered a Business Associate of the Plan as defined by HIPAA in that Contractor may have access to PHI to meet the requirements of the Contract. The Parties agree as follows:

### **I. GENERAL TERMS AND CONDITIONS**

- A. **Definitions:** Except as otherwise defined herein, any and all capitalized terms or abbreviations of capitalized terms in this Agreement shall have the definitions set forth by HIPAA. In the event of an inconsistency between the provisions of this BAA and mandatory provisions of HIPAA, HIPAA shall control. Where provisions of this BAA are different from those mandated by HIPAA, but are nonetheless permitted by HIPAA, the provisions of this BAA shall control.
- B. **Ambiguous Terms:** In case of ambiguous, inconsistent, or conflicting terms within this BAA, such terms shall be resolved to allow for compliance with HIPAA.
- C. **Application of Civil and Criminal Penalties:** Contractor acknowledges that it is subject to 42 U.S.C. 1320d-5 and 1320d-6 in the same manner as such sections apply to a Hybrid Entity, to the extent that Contractor violates §§ 13401(a), 13404(a), or 13404(b) of the HITECH Act and 45 C.F.R. §164.502(e)

and 164.504(e). Furthermore, Contractor is liable for the acts of its own Business Associates under 45 C.F.R. §160.402(c), who are considered Subcontractors when they have access to Plan PHI.

- D. **Assignment:** Contractor shall not assign or transfer any right or interest in this BAA. Any attempt by Contractor to assign or transfer any right or interest in this BAA is void and has no effect.
- E. **Forum:** The laws of the State of North Carolina shall govern this BAA and any and all interpretations of this BAA. The venue for any claim, demand, suit, or causes of action shall be in the state and federal courts located in North Carolina.
- F. **Hybrid Entity:** HIPAA defines a Hybrid Entity as one that uses or discloses PHI for only a part of its business operations. DST has taken the designation of Hybrid Entity because it includes the Plan as a division.
- G. **Indemnification:** Any Breaches of HIPAA or this BAA shall be subject to the indemnification clause which can be found in Section 15, "General Indemnity" of Attachment C, "North Carolina General Contract Terms and Conditions" of the Contract.
- H. **Regulatory References:** Any reference in this BAA to a federal or state statute or regulation (whether specifically or generally) means that statute or regulation which is in effect on the date of any action or inaction relating to the BAA section which refers to such statute or regulation.
- I. **Stricken Provisions:** In the event any portion of this BAA is determined by a court or other body of competent jurisdiction to be invalid or unenforceable, that portion alone will be deemed void, and the remainder of the BAA will continue in full force and effect.
- J. **Termination of BAA:** Except as otherwise provided below, either Party shall have the right to terminate the Contract if either Party determines that the other Party has violated any material term of this BAA. Upon either Party's belief of a material breach of this BAA by the other Party, the non-breaching Party:
  - 1. Shall give written notice of belief of material breach within a reasonable time after forming that belief. The non-breaching Party shall provide an opportunity for the breaching Party to cure the breach or end the violation and, if the breaching Party does not cure the breach or end the violation within the time specified by the non-breaching Party, the non-breaching Party may exercise such rights as are specified in the Contract; or
  - 2. May immediately exercise such rights as are specified in the Contract if the breaching Party has breached a material term of this BAA and cure is not possible; or
  - 3. Shall report the violation to the Secretary of the United States Department of Health and Human Services if neither termination nor cure is possible. The Plan shall abide by Federal reporting regulations.

## **II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

- A. Contractor acknowledges and agrees that all PHI created, maintained, transmitted, received, or used by Contractor in relation to the Contract shall be subject to this BAA. This obligation to protect Plan Member privacy and to keep such PHI confidential survives the termination, cancellation, expiration, or other conclusion of the BAA as set forth below.
- B. Contractor agrees it is aware of and will comply with all provisions of HIPAA that are directly applicable to Business Associates.
- C. Contractor shall use or disclose any PHI solely as would be permitted by HIPAA if such use or disclosure were made by Covered Entity: (1) for meeting its obligations as set forth in the Contract, or any other agreements between the Parties evidencing their business relationship; or (2) as required

by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Contract (if consistent with this Agreement and HIPAA), or HIPAA. All such uses and disclosures shall be subject to the limits set forth in 45 CFR § 164.514 regarding limited data sets and 45 CFR § 164.502(b) regarding the minimum necessary requirements.

- D. Contractor shall develop, document, implement, maintain, and use appropriate administrative, physical, and technical safeguards to prevent unauthorized use or disclosure of PHI, and to protect the integrity, availability, and confidentiality of that PHI. The safeguards that Contractor implements shall meet the requirements set forth by the United States Department of Health and Human Services including, but not limited to, any requirements set forth in HIPAA and North Carolina state law as applicable.
- E. Contractor shall implement security policies and procedures, and provide the Plan's HIPAA Privacy Officer ("HPO") with a copy of such.
- F. Contractor agrees that if it enters into an agreement with any agent or Subcontractor, under which PHI could or would be disclosed or made available to the agent or Subcontractor, Contractor shall have an appropriate BAA that conforms to applicable law, and is consistent with this Agreement. The terms of a BAA that Contractor enters into with its agent or Subcontractor shall meet or exceed the protections of this BAA. The BAA shall be in place with the agent or Subcontractor before any PHI is disclosed or otherwise made available to the agent or Subcontractor.
- G. Contractor shall disclose to the Plan a list of any and all agents or Subcontractors who will have access to or use of PHI on behalf of the Contractor for the benefit of the Plan. These disclosures shall be made prior to or upon signing this BAA. Any subsequent changes or additions to this list must be approved in writing by the Plan prior to any new agent or Subcontractor being provided access to PHI on behalf of the Plan.
- H. If Contractor provides PHI created, maintained, transmitted, or received by the Plan to any agent or Subcontractor, the agent or Subcontractor shall agree that with respect to such information, the same or greater restrictions and conditions that apply through this BAA to Contractor shall also apply to the agent or Subcontractor.
- I. Contractor shall obtain and document "satisfactory assurances" of any agent or Subcontractor to whom it provides PHI on behalf of the Plan through a written contract or other agreement with Contractor that meets the requirements of 45 C.F.R. §164.504(e).
- J. Contractor agrees that if and to the extent it conducts in whole or part Standard Transactions on behalf of the Plan, Contractor shall comply, and shall require any and all agents or Subcontractors involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Parts 160 and 162 and the HITECH Act as if they were the Plan. Contractor shall not enter into (or permit its agents or Subcontractors to enter into) any trading partner contracts in connection with the conduct of Standard Transactions for or on behalf of the Plan that:
  - 1. Changes the definition, data condition, or use of data element or segment in Standard Transaction;
  - 2. Adds any data element or segment to the maximum defined data set;
  - 3. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or
  - 4. Changes the meaning or intent of the Standard Transaction's implementation specification.
- K. If Contractor receives a request for access to inspect or obtain a copy of PHI in a designated record set from a Member or representative of the Member, Contractor shall alert the Plan of such request

within three business days. At the request of the Plan and in a reasonable time and manner, Contractor shall provide access to PHI in a Designated Record Set (to the extent Contractor maintains PHI in a Designated Record Set) to the Plan, or (as directed by the Plan) to an individual or an individual's personal representative, for inspection and copy in order to meet obligations under 45 C.F.R. § 164.524. This paragraph applies only to that PHI that is in Contractor's care, custody, or control.

- L. At the request of the Plan or an individual or that individual's Personal Representative and in the time and manner requested, Contractor shall make any amendment(s) to PHI in a Designated Record Set (to the extent Contractor maintains PHI in a Designated Record Set) that the Plan directs or agrees to pursuant to 45 C.F.R. § 164.526. This paragraph applies only to the PHI that is in Contractor's care, custody, or control.
- M. Contractor agrees that the Plan shall have the right to audit its policies, procedures, and practices related to the use and disclosure of the Plan's PHI.
- N. Contractor shall provide the Plan with copies of all policies, procedures, and practices related to the use and disclosure of Plan PHI prior to or upon execution of this BAA.

### **III. BREACH NOTIFICATION REQUIREMENTS**

- A. Upon discovery by Contractor of a suspected or actual Breach of Unsecured PHI, Contractor must notify the Plan's HPO, in writing, within three business days. For purposes of this section, "discovery" means having obtained knowledge in any manner from any source and in any form, including from an agent or Subcontractor. This notice does not need to be a final report, but must inform the Plan's HPO of an approximate number of individuals affected by the Breach, whether there is an ongoing risk of improper disclosure, and what steps are being taken to mitigate the Breach and/or ongoing risk of disclosure. See "Attachment A" for the Plan's HPO's contact information.
- B. Contractor is not required to report Unsuccessful Security Incidents. For purposes of this BAA, Unsuccessful Security Incidents is defined as pings and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, as long as no such incident results in unauthorized access, acquisition, use, or disclosure of PHI.
- C. Upon discovery of a Breach, Contractor shall conduct any risk assessment necessary to determine whether notification is required and will maintain any related records in accordance with Contractor's internal policies and procedures and the applicable provisions of the Breach Notification Rule as interpreted by Contractor. The risk assessment must consider the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; the unauthorized person who used the PHI or to whom the disclosure was made; whether the PHI was actually acquired or viewed; and the extent to which the risk to the PHI has been mitigated. The risk assessment must be thorough, conducted in good faith, and reach a reasonable conclusion. Contractor shall provide the Plan with a final signed copy of the risk assessment or report within three business days of its completion, no later than ten business days after discovery (unless otherwise agreed to by the Plan's HPO).
- D. Contractor shall mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this BAA or HIPAA.
- E. Contractor shall submit a formal report to the Plan's HPO without unreasonable delay, but no later than ten business days after discovery. The formal report shall include, to the extent possible, the following:
  - 1. A brief description of what happened (identify the nature of the non-permitted use or disclosure), including the date of the Breach, the date of the discovery of the Breach, and the date the Breach was reported to the Contractor's Privacy Official;

2. A description of the nature of the Unsecured PHI that was involved in the Breach (e.g., Member's full name, Social Security number, date of birth, home address, account number, etc.);
  3. Identify who made the non-permitted use or disclosure;
  4. Identify the recipient(s) of the non-permitted use or disclosure;
  5. A description of what Contractor did or is doing to investigate the Breach;
  6. A description of what Contractor did or will do to mitigate risks, harmful effects, and losses of the non-permitted use or disclosure;
  7. Identify what corrective action Contractor took or will take to prevent and protect against further Breaches;
  8. Identify the steps Members should take to protect themselves from potential harm resulting from the Breach;
  9. Contact procedures for Members to ask questions of or learn additional information from the Contractor, which shall include a toll-free telephone number, e-mail address, Web site, or postal address; and
  10. Provide such other information related to the Breach as the Plan may reasonably request.
- F. If Contractor determines that a Breach of Unsecured PHI has occurred, Contractor shall provide written notice, on behalf of the Plan, without unreasonable delay, but no later than thirty calendar days following the date the Breach of Unsecured PHI is or reasonably should have been discovered by Contractor, or such later date as is authorized under 45 C.F.R. §164.412, to:
11. each individual whose Unsecured PHI has been, or is reasonably believed by Contractor to have been, accessed, acquired, used, or disclosed as a result of the Breach; and
  12. the media, to the extent required under 45 C.F.R. §164.406.
- G. Contractor shall send notices to individuals using the last known address of the individual on file with Contractor, unless the individual has agreed to electronic notice as set forth in 45 C.F.R. §164.404. If the notice to any individual is returned as undeliverable, Contractor shall alert the Plan, and take such action as is required by the Breach Notification Rule.
- H. Contractor shall be responsible for the drafting, content, form, and method of delivery of each of the notices required to be provided by Contractor under this section. Contractor shall comply, in all respects, with 45 C.F.R. § 164.404 and any other applicable notification provisions of the Breach Notification Rule, including without limitation 45 C.F.R. Part 164 Subpart D, Section 13402 of the HITECH Act, and applicable state law, as interpreted by Contractor.
- I. Contractor notices must be reviewed and approved by the Plan's HPO before being sent to Plan Members, published to the media, or otherwise made public to any person or entity that is not a Party to this Agreement.
- J. Any notices required to be delivered by Contractor shall be at the expense of Contractor.
- K. Contractor shall provide to the Plan or an individual, in the reasonable time and manner requested by the HPO, information collected in accordance with Section III of this BAA, to permit the Plan to respond to a request by an individual or that individual's Personal Representative for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.



- L. Contractor shall provide the Plan with an annual report of all suspected or actual Breaches of Unsecured PHI by Contractor, and by any agent or Subcontractor of Contractor within sixty days of January 1 of the year following the Breaches.

#### **IV. ACCOUNTING FOR DISCLOSURES AND SALE OF DATA**

- A. If applicable, Contractor shall comply with HITECH Act provisions regarding accounting for disclosures of PHI and Electronic Health Records ("EHR").
- B. Contractor shall comply with the prohibition on the sale of PHI and EHR set forth in 42 U.S.C. § 17935(d).
- C. Contractor shall not sell PHI or any derivation thereof, including deidentified data, without the express written approval of the Plan.
- D. Contractor shall use and disclose PHI for Marketing purposes only as expressly directed by the Plan, and in accordance with 42 U.S.C. § 17936(a).
- E. Contractor agrees that the Plan shall review all Marketing materials given to, prepared, or assembled by Contractor prior to its disclosure in order to meet obligations under HITECH Act, Title XIII, Subtitle D, Section 13406, and 45 C.F.R. §§ 164.501, 164.508, and 164.514.

#### **V. PERMITTED USES AND DISCLOSURES BY CONTRACTOR**

- A. Except as otherwise limited in this BAA, Contractor may use or disclose PHI on behalf of, or to provide services to, the Plan as described in RFP#270-20220830TPAS Third Party Administrative Services ("Contract").
- B. Except as otherwise limited in this BAA, Contractor may use PHI for the proper management and administration of the Contract or to carry out the legal responsibilities of Contractor.
- C. Including all disclosures permitted or required by law, any use or disclosure of PHI or data derived from PHI (including De-Identified Data and Limited Data Sets) not related to the Contractor fulfilling its obligations to the Plan under the Contract will be reported to the Plan in writing within thirty days. Such notice shall include information about what data was used or disclosed, for what purpose the data was used or disclosed, the date(s) the data was used or disclosed, and any other information reasonably requested by the Plan.
- D. Except as otherwise limited in this BAA, Contractor may disclose PHI for the proper management and administration of the Contract, if disclosures are required by law; or if Contractor obtains reasonable assurances by means of a written agreement from the person or entity to whom the information is disclosed that it shall remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the entity. The person or entity must notify Contractor of any instances it is aware of that the confidentiality of the information has been Breached.
- E. To the extent provided for under the Contract, and except as otherwise limited in this BAA, Contractor may use PHI to provide Data Aggregation services to the Plan as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
- F. Contractor may use PHI to report violations of law to appropriate federal and state authorities, as permitted by 45 C.F.R. § 164.502(j)(1).
- G. Contractor shall make internal practices, books, and records - including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created, maintained, transmitted, or received by Contractor on behalf of the Plan - available to the Plan, or to the Secretary, in a time and manner requested or designated by the Secretary or the Plan, for purposes of determining the Plan's and Contractor's compliance with HIPAA.

- H. If an individual or an individual's personal representative requests an accounting of disclosures of PHI (in accordance with 45 C.F.R. § 164.528), Contractor shall provide documentation of disclosures of PHI (and information related to such disclosures) in the same manner as would be required of the Plan. Contractor shall alert the Plan of any such request within ten business days of its receipt.
- I. Contractor shall limit the use, disclosure, or request of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request if performing any function or act on behalf of the Plan. 45 C.F.R. §164.502(b).
- J. Contractor shall be in compliance with the HIPAA minimum necessary provision (45 C.F.R. § 164.502) if it limits its uses, disclosures, or requests of PHI to a limited data set to the extent practicable or, if needed, to the minimum necessary to accomplish an intended purpose.
- K. The Minimum Necessary Standard does not apply to such uses, disclosures, and requests set forth in 45 C.F.R. § 164.502(b)(2).
- L. Contractor is prohibited from receiving direct or indirect remuneration (subject to certain enumerated exceptions) in exchange for any PHI of a Member, unless a valid authorization has been obtained from the Member in accordance with 45 C.F.R. § 164.508. A valid authorization includes, in accordance with such section, a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Member.

## **VI. OBLIGATIONS OF THE PLAN**

- A. The Plan shall notify Contractor of any limitation(s) in the Plan's notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Contractor's use or disclosure of PHI.
- B. The Plan shall notify Contractor of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Contractor's use or disclosure of PHI.
- C. The Plan shall notify Contractor of any restriction to the use or disclosure of PHI that the Plan has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI.
- D. The Plan shall not request that Contractor use or disclose PHI in any manner that would be impermissible by the Plan under HIPAA.

## **VII. TRANSITION, RETENTION, AND DESTRUCTION OF RECORDS AND DATA**

- A. **Transition of Records and Data:** Upon termination, cancellation, expiration, or other conclusion of the Contract, Contractor shall assist the Plan, upon written request, in transitioning all PHI to the Plan or other entity designated by the Plan in a format determined by the Plan.
- B. **Retention, Destruction, and Return of non-PHI Records and Data:** Contractor and its agents or Subcontractors shall retain all documentation (including documentation in electronic form) required under 45 C.F.R. § 164.530(j)(1) for six years from the date of its creation or the date when it last was in effect, whichever is later. 45 C.F.R. §164.530(j)(2).
- C. **Return or Destruction of PHI:** Within a reasonable time after termination, cancellation, expiration, or other conclusion of the Contract, Contractor and its agents or Subcontractors shall:
  - 1. Return to the Plan or destroy any and all PHI, in whatever form or medium (including any electronic medium under Contractor's and its agents' or Subcontractors' custody or control), that Contractor and its agents or Subcontractors created or received while carrying out a function on behalf of the Plan. Such return or destruction shall occur within a reasonable time period after the termination,

cancellation, expiration, or other conclusion of the Contract as agreed to by the Parties. If the Parties cannot mutually agree upon a reasonable time period for such return or destruction, Contractor and its agents or Subcontractors shall return or securely destroy all Plan PHI no later than 90 days after the termination, cancellation, expiration, or other conclusion of the Contract. The Plan will communicate such time period to Contractor in a Contract closeout letter.

- a) Guidelines for Destruction: Contractor and its agents or Subcontractors shall destroy PHI in accordance with the approved methods outlined by the National Institute of Standards and Technology (NIST) Special Publication 800-88 Revision 1, or the most current subsequent update.
- b) Certificate of Data Sanitization: No later than thirty days after all PHI has been destroyed, an authorized representative of Contractor and its agents or Subcontractors with knowledge of the data destruction shall complete, sign, and return to the Plan an attestation of destruction supplied by the Plan.. Contractor shall return the signed attestation by email to the Manager of Contracts and Compliance, or designee.

#### **VIII. SECURITY OF PHI**

- A. Contractor shall comply with the provisions of 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316 relating to implementation of administrative, physical, and technical safeguards with respect to Electronic PHI in the same manner that such provisions apply to a HIPAA Covered/Hybrid Entity.
- B. Contractor shall obtain security-related written assurances from HIPAA covered Subcontractors by way of business associate agreements conforming to applicable law and consistent with the terms under this Agreement.
- C. Contractor shall implement and maintain policies and procedures for compliance with the Security Rule.
- D. Contractor shall follow all documentation and maintenance requirements under the Security Rule.
- E. Contractor shall also comply with any additional security requirements contained in the HITECH Act that are applicable to a HIPAA Covered/Hybrid Entity.

#### **IX. SURVIVAL OF OBLIGATION TO PROTECT PHI**

- A. If return or destruction of any PHI is not feasible after termination, cancellation, expiration, or other conclusion of the Contract, Contractor shall extend the protections of this BAA to the PHI retained, and limit its further use or disclosure of such PHI to those purposes that make return or destruction of that information infeasible.
- B. Contractor shall sign an attestation as to why the PHI cannot be returned or destroyed, and affirm in writing that the protections of this BAA will be indefinitely extended to the retained PHI.
- C. If destruction of the retained PHI occurs at any point after Contractor has stated that return or destruction of PHI is not feasible, Contractor shall provide the Plan with an attestation of destruction which will include the date(s) of destruction, method(s) of destruction, and the reason(s) for destruction.

**[SIGNATURE PAGE FOLLOWS]**

The Plan and Contractor have executed this Business Associate Agreement in two originals, one of which is retained by Contractor, and one by the Plan.

**North Carolina Department of State Treasurer**

By: Dale R. Folwell, CPA or Delegate

Signature: \_\_\_\_\_

Title: State Treasurer of North Carolina

Date: \_\_\_\_\_

**North Carolina State Health Plan for Teachers and State Employees**

By: Dee Jones

Signature: \_\_\_\_\_

Title: Executive Administrator

Date: \_\_\_\_\_

**[INSERT NAME OF CONTRACTOR]**

By: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Attachment A: Department of State Treasurer HIPAA Privacy Officer (“HPO”)**

Chris Almberg, Esq.  
HIPAA Privacy Officer  
3200 Atlantic Avenue  
Raleigh, NC 27604  
(919) 814-4428  
Chris.Almberg@nctreasurer.com

## ATTACHMENT H: HIPAA QUESTIONNAIRE

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As a covered entity, it is the responsibility of the North Carolina State Health Plan (Plan) to ensure its Members' health information is protected from use and disclosures not allowed under the Health Insurance Portability and Accountability Act (HIPAA), as well as applicable state and federal laws. The Plan takes this responsibility very seriously.

The purpose of this HIPAA Questionnaire is to allow the Plan to evaluate the HIPAA compliance of a prospective or current vendor who may request or require Member data containing protected health information (PHI). As a threshold to being considered to do business with the Plan, the Vendor must demonstrate that it meets the Plan's expectations for HIPAA compliance. The information provided below will be used by the Plan to determine the Vendor's level of understanding of HIPAA privacy and security rules, as well as its compliance status.

The Vendor is encouraged to thoroughly respond to all questions to the best of its ability and provide copies of all requested documentation. The Plan encourages the Vendor to have its privacy officer or other compliance specialist complete this questionnaire. Any incomplete responses may negatively impact the Plan's evaluation of the Vendor's HIPAA compliance, including a determination that the Vendor does not meet the Plan's expectations.

All responses must be typed. Handwritten responses will not be accepted.

If the Vendor maintains that any information contained in requested documentation is proprietary or otherwise confidential, the Vendor may redact these portions and supply the un-redacted portions for review.

### Vendor Information

Company name:

Address (city, state, and zip code):

Website URL:

Name of person completing form, and role:

Email address:

Phone number:

Fax number:

HIPAA compliance person's name, title, phone number, and email address, if different than person completing form:

Date you are completing this form:

**\*\* Please note that you must update the contact information provided in this questionnaire within 30 days of any change in personnel. \*\***

**For all questions, if more detail is needed than the space provided allows for, please attach a separate page.**

**Compliance Questionnaire**

1. Details of the individual responsible for HIPAA Compliance (if this designated position does not exist, provide the details of the employee who typically handles HIPAA privacy and security issues within your company or organization).

Name:

Title:

Address:

Phone number:

E-mail address:

Certification designation (e.g., CHC, CISSP, CIPP, CHP, CHPSE, etc.):

Date certified:

2. If they are not certified, provide detailed information regarding training that has been provided to the person responsible for HIPAA compliance (e.g., date last received training, name of company or person that provided training, etc.).

**Employee HIPAA Training**

3. Which employees receive HIPAA training? How frequently is their training refreshed?
4. Do all the above employees receive comprehensive training (i.e., training which covers the privacy and security of PHI; both physical and technical)? Yes ☐ No ☐
  - a. If no, provide details of the level of training made available to employees.
5. When was HIPAA training last updated? When is the next planned update?
6. Are there internal HIPAA privacy policies and procedures in place which govern the privacy practices of the organization and its employees? Yes ☐ No ☐
7. Attach a copy of all internal/employee-facing privacy policies and procedures.
  - a. Note when the privacy policies were last reviewed or updated:
8. Are employees trained on the privacy policies and procedures? Yes ☐ No ☐
9. Are employees required to sign an agreement stating they have read and understand the privacy policies and procedures? Yes ☐ No ☐
10. Are there internal HIPAA security policies and procedures in place which govern the security practices of the organization and its employees? Yes ☐ No ☐
11. Attach a copy of all internal/employee-facing security policies and procedures.
  - a. Note when the security policies were last reviewed or updated:
12. Are employees trained on the security policies and procedures? Yes ☐ No ☐
13. Are employees required to sign an agreement stating they have read and understand the security policies and procedures? Yes ☐ No ☐
14. Can you provide documentation that all employees have completed training? Yes ☐ No ☐

15. Has your organization received any certifications regarding HIPAA compliance? (If yes, please provide copies of the certification and the date when the certification was awarded.)
16. When was the last time your company was audited to determine HIPAA compliance? Provide date the audit was performed and the name of the company who performed it. Provide copies of the audit findings.

**Data Security**

17. Provide details of the methods the company employs to secure and render PHI unusable, unreadable, or indecipherable to unauthorized individuals.
18. Describe security procedures – physical, technical, and administrative – in place to ensure the confidentiality of PHI internally, and when transmitting data externally to the Plan or to Plan vendors.
19. Do you have procedures to identify and respond to suspected or known security incidents; mitigate (to the extent possible) harmful effects of known security incidents; and document incidents and their outcomes? Please describe.
20. Has the company conducted a risk assessment and gap analysis to address any findings? Yes ☐ No ☐

If yes: Date:      Performed by:

21. Can you provide a copy of a SOC2, Type 2 security assessment report or a report performed under another security framework that can be cross-walked to the appropriate NIST-800-53 security control requirements (e.g., ISO 27001, HITRUST) for each service component used/involved in the proposed services? Yes (*please attach*) ☐ No ☐
- a. How often does the company conduct these types of audits?
22. Provide the number of HIPAA violations reported to the Office of Civil Rights (OCR) in the last five years, the details of the violation, and include the amount of the fine incurred (if any).
23. Does the company have in place procedures for the destruction of PHI compliant with the standards set forth in NIST Special Publication 800-88 Revision 1 (or most recent update) located at: <https://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-88r1.pdf>? Yes ☐ No ☐
- a. If yes, please describe the procedure for that destruction.

**Subcontractor Information**

24. Do you outsource work to Subcontractors who would have access to Plan data and PHI and who may qualify as Business Associates as defined by HIPAA? Provide the names of the companies, contact information, and details of what they are contracted to do.
25. Have you entered into Business Associate Agreements (BAAs) with all Subcontractors who may qualify as Business Associates to your company or the Plan for this work? If yes, provide copies of the executed BAA(s).
26. How do you enforce and monitor HIPAA policies with Subcontractors and Business Associates? What penalties or fixes are in place for violations?
27. Have you conducted an audit of any Subcontractors or Business Associates? Can you provide information as to whether they are HIPAA compliant at this time? Include all available SOC2, Type 2 or substitute reports for Subcontractors and Business Associates.

**Emergency/Contingency Plans**



28. Describe the company's disaster recovery plan for data backup, data recovery, and system testing should a disaster occur (e.g., flood, fire, or system failure).

- a. Provide the details of any incident that that has required activating the disaster recovery plan within the last two years, and any changes to the plan that were made as a result.

29. Describe the company's business continuity plan in the event of a disaster (e.g., flood, fire, power failure, system failure).

- a. Provide the details of any incident that that has required activating the business continuity plan within the last two years.

*I hereby certify that the information provided above and attached hereto is true and correct to the best of my knowledge and belief.*

\_\_\_\_\_  
**Name (Type)**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**ATTACHMENT I: NONDISCLOSURE AGREEMENT**

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By signing and returning this document, Vendor (*insert company name* \_\_\_\_\_), **understands and agrees to the following:**

1. Upon the Plan's determination that Vendor has met the Minimum Requirements, Vendor will be provided access to Plan Data.
2. This Data is being provided for the sole purpose of assisting Vendor in preparing a responsive and responsible proposal to the TPA Services RFP (RFP#270-20220830TPAS) and is for the purpose of Plan Operations.
3. Vendor shall not use the Data for any purpose other than to assist in preparing a response to the TPA Services RFP and shall treat the Data as confidential.
4. Vendor shall not distribute or share the Data with any person or entity not assisting Vendor in preparing a response to the TPA Services RFP. Vendor shall hold any person or entity assisting in preparing the response to the TPA Services RFP to the same terms of this Nondisclosure Agreement as Vendor is held.
5. If Vendor does not bid on the TPA Services RFP, Vendor shall, upon making that decision, immediately destroy the Data from Vendor's files or records. Vendor shall not retain or maintain any copies of the Data.
6. If Vendor submits a proposal in response to the TPA Services RFP, Vendor shall immediately destroy the Data from Vendor's files or records upon notification that an award has been made or the TPA Services RFP has been cancelled.
7. Vendor shall destroy and dispose of Plan Data using the guidelines outlined in the National Institute of Standards of Technology (NIST) Special Publication 800-88 Revision 1 located at: <https://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-88r1.pdf>.
8. After all Data has been destroyed, an authorized representative of Vendor with knowledge of the Data destruction shall complete, sign, and return the Plan's Certificate of Data Sanitization within 30 days of the event giving rise to Vendor's obligation to destroy the Data. Vendor can obtain a copy of the certificate by e-mailing Chris Almberg at [Chris.Almberg@nctreasurer.com](mailto:Chris.Almberg@nctreasurer.com) with a copy to [SHPCContracting@nctreasurer.com](mailto:SHPCContracting@nctreasurer.com).
9. Provide the name, title, and email address of the individual designated to receive Data and Attachment A: Pricing. Do not respond with group/generic names and/or group/generic email addresses as these will not suffice.  
  
Name: \_\_\_\_\_  
  
Title: \_\_\_\_\_  
  
Email: \_\_\_\_\_
10. If during the procurement process it becomes necessary for Vendor to replace the individual previously identified in 9. above, Vendor shall immediately provide a signed and updated NDA that includes the replacement individual's name, title, and email address.

Vendor agrees to the above restrictions on the use of the Data:

BY: \_\_\_\_\_  
(Person authorized to bind Vendor)

## ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION

<b>Vendor Name:</b>		
<b>Street Address:</b>		
<b>City, State, Zip Code:</b>		
<b>Telephone Number:</b>		
<b>AUTHORIZED REPRESENTATIVES TO BIND VENDOR:</b>		
List individuals with authority to bind Vendor in connection with this Contract and future contractual documents.		
<b>Name:</b>	<b>Title:</b>	<b>Email:</b>
<b>Name:</b>	<b>Title:</b>	<b>Email:</b>
<b>Name:</b>	<b>Title:</b>	<b>Email:</b>
<b>AUTHORIZED REPRESENTATIVE TO RESPOND TO QUESTIONS:</b>		
List individual with the authority to answer questions and provide clarifications concerning Vendor's proposal.		
<b>Name:</b>	<b>Title:</b>	<b>Email:</b>
<b>Signature:</b>		
By signing below: You hereby certify that you have the authority to sign on behalf of Vendor named above and acknowledge that if this Contract is awarded to your entity, the responses included in this Minimum Requirements Submission will become a binding portion of the Contract.		
<b>Print name:</b>	<b>Title:</b>	
<b>Vendor's authorized signature:</b>	<b>Date:</b>	

## **ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE**

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ATTACHMENT K: MINIMUM REQUIREMENTS RESPONSE is posted on the Ariba landing page and can be accessed at the following link: <http://discovery.ariba.com/rfx/13956411>.

Vendor shall complete ATTACHMENT K by only marking either "Confirm" or Does Not Confirm" as a response for each Minimum Requirement. Under no circumstances will narrative or text from Vendor be accepted as a response.

## **ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE**

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ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE is posted on the Ariba landing page and can be accessed at the following link: <http://discovery.ariba.com/rfx/13956411>.

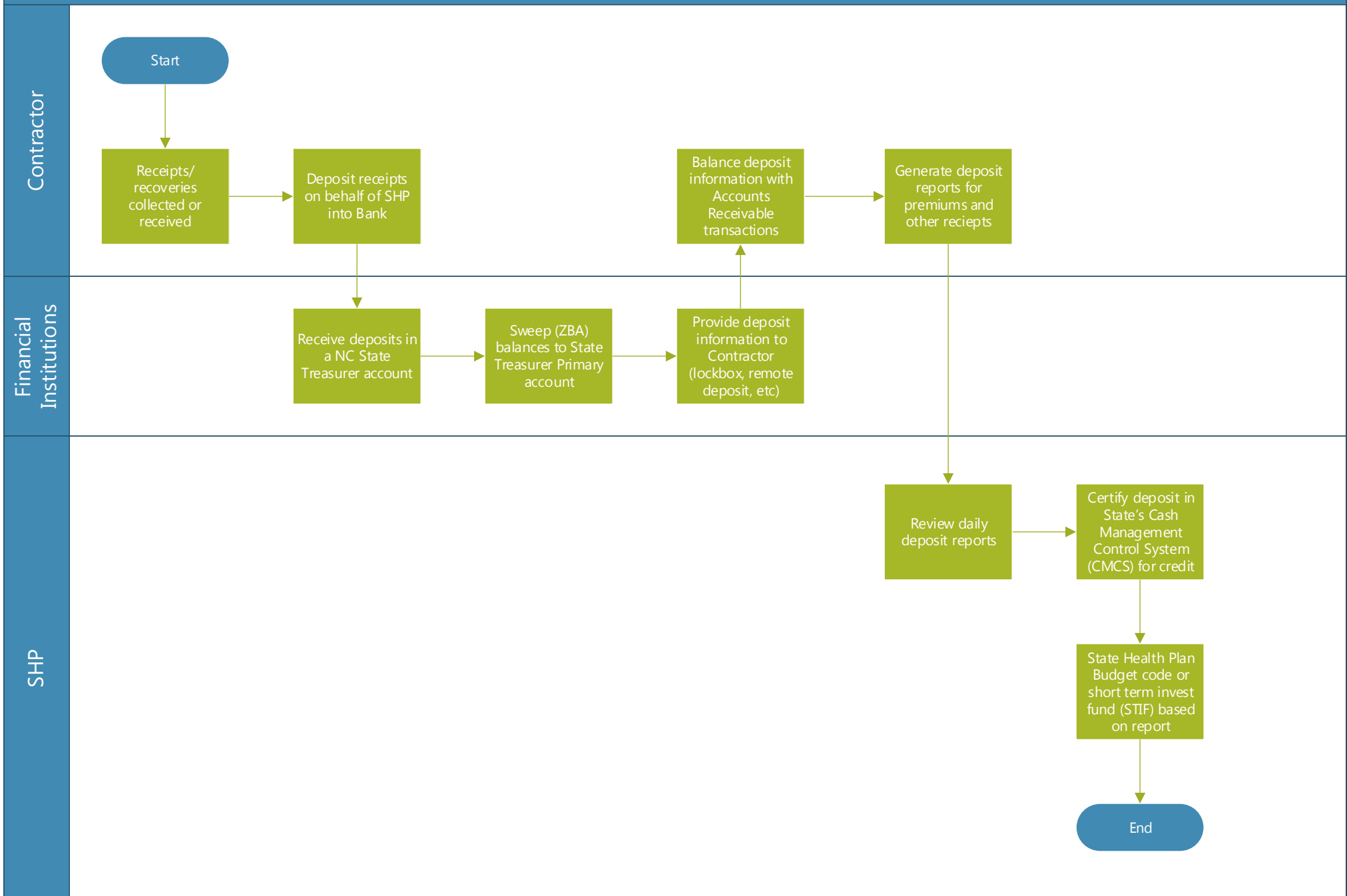
Vendor shall complete ATTACHMENT L by only marking either "Confirm" or Does Not Confirm" as a response for each Technical Requirement. Under no circumstances will narrative or text from Vendor be accepted as a response.

## EXHIBITS

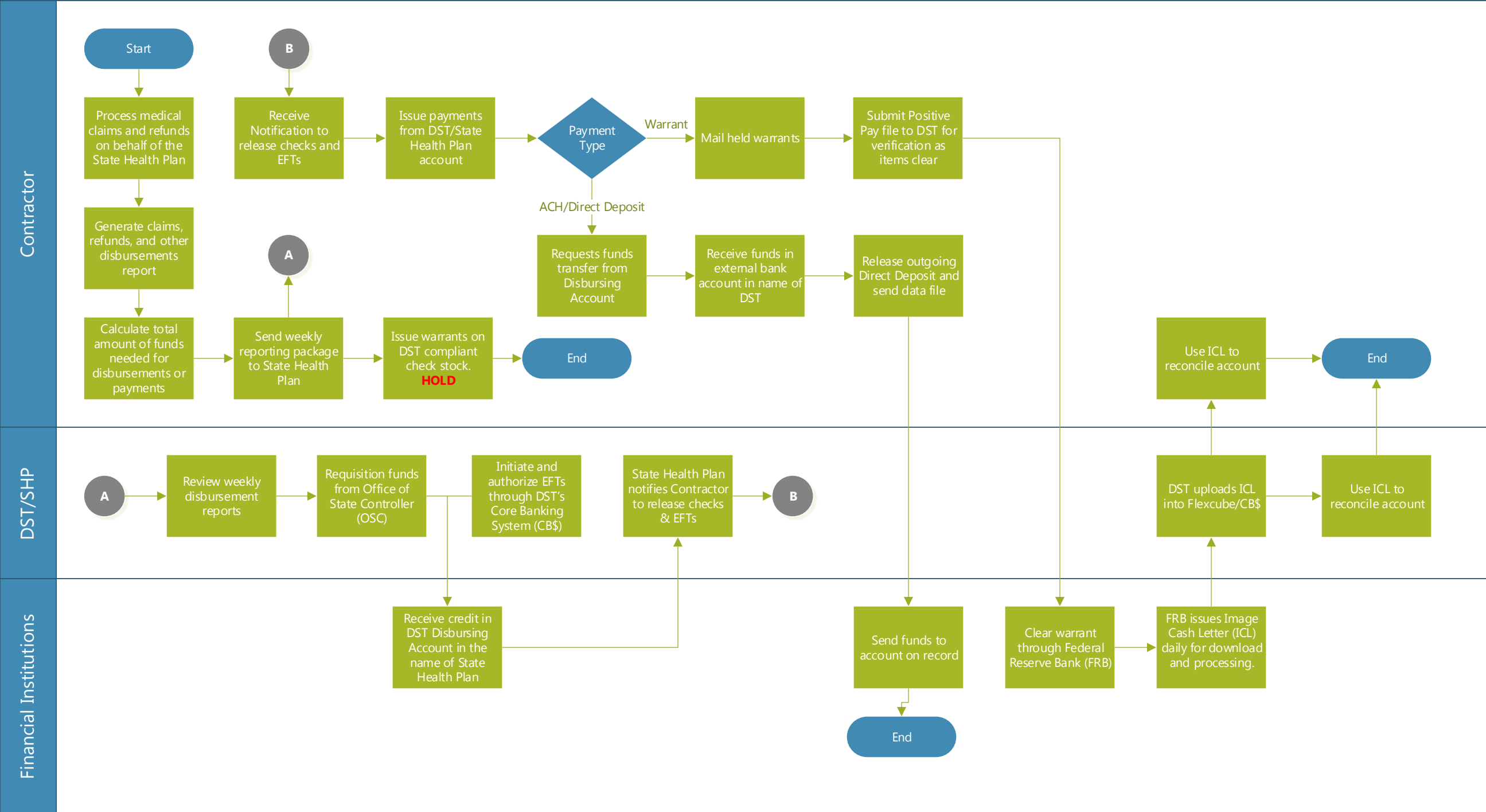
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Exhibit 1	Deposits and Disbursement Process
Exhibit 2	PCP Copay Incentive Scenarios
Exhibit 3	Group Structure
Exhibit 4	Vendor Data Feeds
Exhibit 5	Monthly Audit & Reconciliation
Exhibit 6	PCP Selection Tool & Maintenance
Exhibit 7	Sample ID Cards
Exhibit 8	Sample EOB
Exhibit 9	Claims Phantom Processing Plan – Medicare Part B
Exhibit 10	State Health Plan Recovery Workflows
Exhibit 11	Standard Reports
Exhibit 12	Matrix Reports

# Exhibit 1 Deposits and Disbursement Process



Disbursement of Funds through State Health Plan





## Exhibit 2 PCP Copay Incentive Scenarios

Member Selected	Claim Scenarios	Copay
Participating PCP with participating location	Claim processes with the selected participating PCP and selected participating location	Tier 1
Participating PCP with participating location	Claim processes with the selected participating PCP in a different location (same practice)	Tier 1
Participating PCP with non-participating location	Claim processes with selected participating PCP in selected non-participating practice	Tier 3
Non-participating provider with different non-participating location	Claim processes with a different non-participating provider in a different non-participating practice	Tier 3
Participating PCP with participating location	Claim processes with a different participating provider in the selected participating practice	Tier 1
Participating PCP with participating location	Claim processes with a different participating provider in a different practice	Tier 3
Non-participating provider with non-participating location	Claim processes with the selected non-participating provider in the selected non-participating practice	Tier 2
Non-participating provider with non-participating location	Claim processes with a different non-participating provider in selected non-participating practice	Tier 2
Non-participating provider with non-participating location	Claim processes with selected non-participating provider in different non-participating practice	Tier 2
Non-participating provider with non-participating location	Claim processes with a different non-participating provider in a different non-participating practice	Tier 3
Participating provider with non-participating location	Claim processes with selected participating provider in a different non-participating location (same practice)	Tier 3
No PCP Selected	All claim scenarios (except preventive services)	Tier 3

**Exhibit 3 Group Structure**

<b>Subgroup Number</b>	<b>SUBGROUP NAME</b>	<b>EMPLOYER TYPE/ENTITY</b>
1001	GOVERNOR'S OFFICE	STATE AGENCY/BEACON
1002	DEPARTMENT OF SECRETARY OF STATE	STATE AGENCY/BEACON
1003	DEPARTMENT OF STATE AUDITOR	STATE AGENCY/BEACON
1004	DEPARTMENT OF STATE TREASURER	STATE AGENCY/BEACON
1005	DEPARTMENT OF PUBLIC INSTRUCTION	STATE AGENCY/BEACON
1006	NC COMMUNITY COLLEGE ADM	STATE AGENCY/BEACON
1007	DEPARTMENT OF JUSTICE	STATE AGENCY/BEACON
1008	AGRICULTURE CONSUMER SERVICES	STATE AGENCY/BEACON
1009	DEPARTMENT OF LABOR	STATE AGENCY/BEACON
1010	DEPARTMENT OF INSURANCE	STATE AGENCY/BEACON
1011	DEPARTMENT OF ADMINISTRATION	STATE AGENCY/BEACON
1012	STATE BUDGET & MANAGEMENT	STATE AGENCY/BEACON
1013	ADMINISTRATIVE HEARINGS	STATE AGENCY/BEACON
1014	OFFICE OF STATE CONTROLLER	STATE AGENCY/BEACON
1015	MILITARY AND VETERANS AFFAIRS	STATE AGENCY/BEACON
1016	DEPARTMENT OF TRANSPORTATION	STATE AGENCY/BEACON
1017	ENVIRONMENTAL QUALITY	STATE AGENCY/BEACON
1018	WILDLIFE RESOURCES COMMISSION	STATE AGENCY/BEACON
1019	HEALTH HUMAN SERVICES	STATE AGENCY/BEACON
1020	DEPARTMENT OF PUBLIC SAFETY	STATE AGENCY/BEACON
1021	DEPARTMENT OF COMMERCE	STATE AGENCY/BEACON
1022	DEPARTMENT OF INFORMATION TECHNOLOGY	STATE AGENCY/BEACON
1023	DEPARTMENT OF REVENUE	STATE AGENCY/BEACON
1024	DEPT OF NATURAL & CULTURAL RESOURCES	STATE AGENCY/BEACON
1025	JUDICIAL BRANCH	STATE AGENCY/BEACON
1026	SCHOOL OF SCIENCE & MATH	STATE AGENCY/BEACON
1027	NC AUCTIONEER LICENSING BOARD	STATE AGENCY/BEACON
1028	NC PSYCHOLOGY BOARD	STATE AGENCY/BEACON
1029	NC BOARD OF OPTICIANS	STATE AGENCY/BEACON
1030	NC BOARD OF BARBER EXAM	STATE AGENCY/BEACON
1032	DIVISION OF SERVICES FOR THE BLIND	STATE AGENCY
1033	UNC HEALTH CARE	UNIVERSITY
1034	GENERAL ASSEMBLY - LEGISLATORS	STATE AGENCY
1035	GENERAL ASSEMBLY	STATE AGENCY
1036	EDUCATION LOTTERY	STATE AGENCY
1037	UNIVERSITY OF NC PRESS	STATE AGENCY
1038	NC BOARD OF PHARMACY	STATE AGENCY
1039	NC HOUSING FINANCE AGENCY	STATE AGENCY
1040	INNOVATIVE SCHOOL DISTRICT	STATE AGENCY
1041	NC CEMETERY COMMISSION	STATE AGENCY
1042	UNC ASHEVILLE	UNIVERSITY
1043	APPALACHIAN STATE UNIVERSITY	UNIVERSITY
1044	WESTERN CAROLINA UNIVERSITY	UNIVERSITY

1045	UNC CHARLOTTE	UNIVERSITY
1046	UNC GREENSBORO	UNIVERSITY
1047	NC A & T STATE UNIVERSITY	UNIVERSITY
1048	WINSTON-SALEM STATE UNIVERSITY	UNIVERSITY
1049	NC SCHOOL OF THE ARTS	UNIVERSITY
1050	UNC CHAPEL HILL	UNIVERSITY
1051	NC STATE UNIVERSITY	UNIVERSITY
1052	NC CENTRAL UNIVERSITY	UNIVERSITY
1053	UNC WILMINGTON	UNIVERSITY
1054	FAYETTEVILLE STATE UNIVERSITY	UNIVERSITY
1055	UNC PEMBROKE	UNIVERSITY
1056	EAST CAROLINA UNIVERSITY	UNIVERSITY
1057	ELIZABETH CITY STATE UNIVERSITY	UNIVERSITY
1058	A-B TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1059	TRI-COUNTY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1060	HAYWOOD COMMUNITY COLLEGE	COMMUNITY COLLEGE
1061	BLUE RIDGE COMMUNITY COLLEGE	COMMUNITY COLLEGE
1062	SOUTHWESTERN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1063	WESTERN PIEDMONT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1064	CALDWELL COMMUNITY COLLEGE	COMMUNITY COLLEGE
1065	CATAWBA VALLEY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1066	CLEVELAND COMMUNITY COLLEGE	COMMUNITY COLLEGE
1067	MCDOWELL TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1068	MAYLAND COMMUNITY COLLEGE	COMMUNITY COLLEGE
1069	ISOTHERMAL COMMUNITY COLLEGE	COMMUNITY COLLEGE
1070	WILKES COMMUNITY COLLEGE	COMMUNITY COLLEGE
1071	MITCHELL COMMUNITY COLLEGE	COMMUNITY COLLEGE
1072	SOUTH PIEDMONT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1073	GASTON COLLEGE	COMMUNITY COLLEGE
1074	CENTRAL PIEDMONT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1075	MONTGOMERY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1076	RICHMOND COMMUNITY COLLEGE	COMMUNITY COLLEGE
1077	ROWAN-CABARRUS COMMUNITY COLLEGE	COMMUNITY COLLEGE
1078	STANLY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1079	DAVIDSON-DAVIE COMMUNITY COLLEGE	COMMUNITY COLLEGE
1080	GUILFORD TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1081	RANDOLPH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1082	ROCKINGHAM COMMUNITY COLLEGE	COMMUNITY COLLEGE
1083	FORSYTH TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1084	SURRY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1085	ALAMANCE COMMUNITY COLLEGE	COMMUNITY COLLEGE
1086	DURHAM TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1087	CENTRAL CAROLINA COMMUNITY COLLEGE	COMMUNITY COLLEGE
1088	SANDHILLS COMMUNITY COLLEGE	COMMUNITY COLLEGE
1089	PIEDMONT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1090	JOHNSTON COMMUNITY COLLEGE	COMMUNITY COLLEGE
1091	VANCE GRANVILLE COMMUNITY COLLEGE	COMMUNITY COLLEGE

1092	WAKE TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1093	BLADEN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1094	SOUTHEASTERN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1095	FAYETTEVILLE TECH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1096	ROBESON COMMUNITY COLLEGE	COMMUNITY COLLEGE
1097	SAMPSON COMMUNITY COLLEGE	COMMUNITY COLLEGE
1098	JAMES SPRUNT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1099	CAPE FEAR COMMUNITY COLLEGE	COMMUNITY COLLEGE
1100	COASTAL CAROLINA COMMUNITY COLLEGE	COMMUNITY COLLEGE
1101	BRUNSWICK COMMUNITY COLLEGE	COMMUNITY COLLEGE
1102	BEAUFORT COUNTY COMMUNITY COLLEGE	COMMUNITY COLLEGE
1103	EDGECOMBE COMMUNITY COLLEGE	COMMUNITY COLLEGE
1104	HALIFAX COMMUNITY COLLEGE	COMMUNITY COLLEGE
1105	ROANOKE-CHOWAN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1106	MARTIN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1107	NASH COMMUNITY COLLEGE	COMMUNITY COLLEGE
1108	COLLEGE OF THE ALBEMARLE	COMMUNITY COLLEGE
1109	PITT COMMUNITY COLLEGE	COMMUNITY COLLEGE
1110	WILSON COMMUNITY COLLEGE	COMMUNITY COLLEGE
1111	CARTERET COMMUNITY COLLEGE	COMMUNITY COLLEGE
1112	CRAVEN COMMUNITY COLLEGE	COMMUNITY COLLEGE
1113	LENOIR COMMUNITY COLLEGE	COMMUNITY COLLEGE
1114	PAMLICO COMMUNITY COLLEGE	COMMUNITY COLLEGE
1115	WAYNE COMMUNITY COLLEGE	COMMUNITY COLLEGE
1116	FRANCINE DELANY NEW SCHOOL	CHARTER SCHOOL
1117	LAKE NORMAN CHARTER	CHARTER SCHOOL
1118	ARAPAHOE CHARTER SCHOOL	CHARTER SCHOOL
1119	THE FRANKLIN ACADEMY	CHARTER SCHOOL
1120	SUMMIT CHARTER SCHOOL	CHARTER SCHOOL
1121	HOBGOOD CHARTER SCHOOL	CHARTER SCHOOL
1122	SALLIE B HOWARD	CHARTER SCHOOL
1123	DILLARD ACADEMY CHARTER SCHOOL	CHARTER SCHOOL
1124	THE LEARNING CENTER	CHARTER SCHOOL
1125	LINCOLN CHARTER SCHOOL	CHARTER SCHOOL
1126	ACADEMY OF MOORE COUNTY	CHARTER SCHOOL
1127	DISCOVERY CHARTER SCHOOL	CHARTER SCHOOL
1128	POCOSIN INNOVATIVE CHARTER	CHARTER SCHOOL
1129	GLOW ACADEMY	CHARTER SCHOOL
1130	EAST WAKE ACADEMY	CHARTER SCHOOL
1131	ALAMANCE COMMUNITY SCHOOL	CHARTER SCHOOL
1132	MAUREEN JOY CHARTER SCHOOL	CHARTER SCHOOL
1133	MOUNTAIN COMMUNITY SCHOOL	CHARTER SCHOOL
1135	STARS CHARTER SCHOOL	CHARTER SCHOOL
1136	RALEIGH CHARTER HIGH SCHOOL	CHARTER SCHOOL
1137	AMERICAN RENAISSANCE SCHOOL	CHARTER SCHOOL
1138	THOMAS JEFFERSON CLASSICAL ACADEMY	CHARTER SCHOOL
1139	CHILDREN'S VILLAGE ACADEMY	CHARTER SCHOOL

1140	VANCE CHARTER SCHOOL	CHARTER SCHOOL
1141	EVERGREEN COMMUNITY CHARTER SCHOOL	CHARTER SCHOOL
1143	MILLENNIUM CHARTER ACADEMY	CHARTER SCHOOL
1144	HALIWA-SAPONI TRIBAL SCHOOL	CHARTER SCHOOL
1145	SUCCESS INSTITUTE	CHARTER SCHOOL
1146	CAPE FEAR CENTER FOR INQUIRY	CHARTER SCHOOL
1147	SOUTHERN WAKE ACADEMY	CHARTER SCHOOL
1148	ARTSPACE CHARTER SCHOOL	CHARTER SCHOOL
1149	KIPP GASTON COLLEGE PREPARATORY	CHARTER SCHOOL
1150	GRAY STONE DAY SCHOOL	CHARTER SCHOOL
1151	MT DISCOVERY CHARTER SCHOOL	CHARTER SCHOOL
1152	ARTS BASED SCHOOL	CHARTER SCHOOL
1153	CENTRAL PARK SCHOOL	CHARTER SCHOOL
1154	RIVER MILL ACADEMY	CHARTER SCHOOL
1155	CLOVER GARDEN SCHOOL	CHARTER SCHOOL
1156	COMMUNITY SCH OF DAVIDSON	CHARTER SCHOOL
1157	CAROLINA INTERNATIONAL SCHOOL	CHARTER SCHOOL
1158	MAGELLAN CHARTER SCHOOL	CHARTER SCHOOL
1159	THE HAWBRIDGE SCHOOL	CHARTER SCHOOL
1160	SOCRATES ACADEMY	CHARTER SCHOOL
1161	TWO RIVERS COMMUNITY SCHOOL	CHARTER SCHOOL
1162	ROXBORO COMMUNITY SCHOOL	CHARTER SCHOOL
1163	CHARLOTTE SECONDARY SCHOOL	CHARTER SCHOOL
1164	NEUSE CHARTER SCHOOL	CHARTER SCHOOL
1165	WILMINGTON PREPARATORY ACADEMY	CHARTER SCHOOL
1166	PINE LAKE PREPARATORY	CHARTER SCHOOL
1167	VOYAGER ACADEMY	CHARTER SCHOOL
1168	BETHANY COMMUNITY SCHOOL	CHARTER SCHOOL
1169	TILLER SCHOOL	CHARTER SCHOOL
1170	ENO RIVER ACADEMY	CHARTER SCHOOL
1171	ENDEAVOR CHARTER SCHOOL	CHARTER SCHOOL
1172	MOUNTAIN ISLAND CHARTER SCHOOL	CHARTER SCHOOL
1173	HENDERSON COLLEGIATE	CHARTER SCHOOL
1174	LAKE LURE CLASSICAL ACADEMY	CHARTER SCHOOL
1175	BREVARD ACADEMY	CHARTER SCHOOL
1176	GLOBAL SCHOLARS ACADEMY	CHARTER SCHOOL
1177	RESEARCH TRIANGLE HIGH SCHOOL	CHARTER SCHOOL
1178	NORTH EAST CAROLINA PREP SCHOOL	CHARTER SCHOOL
1179	STERLING MONTESSORI ACADEMY	CHARTER SCHOOL
1180	WATERS EDGE VILLAGE SCHOOL	CHARTER SCHOOL
1181	CORNERSTONE CHARTER ACADEMY	CHARTER SCHOOL
1182	BEAR GRASS CHARTER SCHOOL	CHARTER SCHOOL
1183	NORTHEAST REGIONAL SCHOOL	CHARTER SCHOOL
1184	CASA ESPERANZA MONTESSORI	CHARTER SCHOOL
1185	WILLOW OAK MONTESSORI CH SCHOOL	CHARTER SCHOOL
1186	FALLS LAKE ACADEMY	CHARTER SCHOOL
1187	CLASSICAL PINNACLE ACADEMY	CHARTER SCHOOL

1188	OXFORD PREPARATORY SCHOOL	CHARTER SCHOOL
1189	INVEST COLLEGIATE CONSORTIUM	CHARTER SCHOOL
1190	ISLAND MONTESSORI CHARTER	CHARTER SCHOOL
1191	UWHARRIE CHARTER ACADEMY	CHARTER SCHOOL
1192	CORVIAN COMMUNITY SCHOOL	CHARTER SCHOOL
1193	ZECA INC	CHARTER SCHOOL
1194	SOUTHEASTERN ACADEMY	CHARTER SCHOOL
1195	THE EXPEDITION SCHOOL	CHARTER SCHOOL
1196	BRADFORD PREPARATORY SCHOOL	CHARTER SCHOOL
1197	INVEST COLLEGIATE - IMAGINE	CHARTER SCHOOL
1198	THE EMEREAU FOUNDATION	CHARTER SCHOOL
1199	RALEIGH OAK CHARTER SCHOOL	CHARTER SCHOOL
1200	MOORE MONTESSORI COMMUNITY SCHOOL	CHARTER SCHOOL
1201	JACKSON DAY SCHOOL	CHARTER SCHOOL
1202	REACHING ALL MINDS ACADEMY	CHARTER SCHOOL
1203	PIEDMONT COMMUNITY CHARTER SCHOOL	CHARTER SCHOOL
1204	KIPP HALIFAX	CHARTER SCHOOL
1205	FRANKLIN SCHOOL OF INNOVATION	CHARTER SCHOOL
1206	SHINING ROCK CLASSICAL ACADEMY	CHARTER SCHOOL
1207	NORTHEAST ACADEMY	CHARTER SCHOOL
1208	KIPP DURHAM	CHARTER SCHOOL
1209	EXCELSIOR CLASSICAL ACADEMY	CHARTER SCHOOL
1210	PIONEER SPRINGS COMMUNITY SCHOOL	CHARTER SCHOOL
1211	VERITAS COMMUNITY SCHOOL	CHARTER SCHOOL
1212	LONGLEAF SCHOOL OF THE ARTS	CHARTER SCHOOL
1213	ALLIANCE PREPARATORY SCHOOLS	CHARTER SCHOOL
1214	FERNLEAF COMMUNITY CHARTER	CHARTER SCHOOL
1215	BLADEN COUNTY	LOCAL GOVERNMENT
1216	WASHINGTON COUNTY	LOCAL GOVERNMENT
1217	RUTHERFORD COUNTY	LOCAL GOVERNMENT
1218	FOOTHILLS HEALTH DISTRICT	LOCAL GOVERNMENT
1219	TOWN OF FOREST CITY	LOCAL GOVERNMENT
1220	TOWN OF LAKE LURE	LOCAL GOVERNMENT
1221	TOWN OF BLACK CREEK	LOCAL GOVERNMENT
1222	TOWN OF SUNSET BEACH	LOCAL GOVERNMENT
1223	BEAUFORT COUNTY	LOCAL GOVERNMENT
1224	MITCHELL COUNTY	LOCAL GOVERNMENT
1225	TOWN OF TABOR CITY	LOCAL GOVERNMENT
1226	TOWN OF BLACK MOUNTAIN	LOCAL GOVERNMENT
1227	TOWN OF OCEAN ISLE BEACH	LOCAL GOVERNMENT
1228	TOWN OF KURE BEACH	LOCAL GOVERNMENT
1229	TOWN OF BILTMORE FOREST	LOCAL GOVERNMENT
1230	TOWN OF BLOWING ROCK	LOCAL GOVERNMENT
1231	MONTGOMERY COUNTY	LOCAL GOVERNMENT
1232	TOWN OF ELIZABETHTOWN	LOCAL GOVERNMENT
1233	SURRY COUNTY	LOCAL GOVERNMENT
1234	BAY RIVER METRO SEWER	LOCAL GOVERNMENT

1235	CITY OF BESSEMER	LOCAL GOVERNMENT
1236	CITY OF CONOVER	LOCAL GOVERNMENT
1237	TOWN OF BROADWAY	LOCAL GOVERNMENT
1238	TOWN OF BENSON	LOCAL GOVERNMENT
1239	LAND OF SKY REGIONAL COUNCIL	LOCAL GOVERNMENT
1240	GREENE COUNTY	LOCAL GOVERNMENT
1241	TOWN OF SEVEN DEVILS	LOCAL GOVERNMENT
1242	TOWN OF BEAUFORT	LOCAL GOVERNMENT
1243	JONES COUNTY	LOCAL GOVERNMENT
1244	TOWN OF RUTHERFORDTON	LOCAL GOVERNMENT
1245	TOWN OF SPINDALE	LOCAL GOVERNMENT
1246	TOWN OF OAK ISLAND	LOCAL GOVERNMENT
1247	HIGH COUNTRY COUNCIL OF GOVERNMENTS	LOCAL GOVERNMENT
1248	PASQUOTANK COUNTY	LOCAL GOVERNMENT
1249	TOWN OF INDIAN BEACH	LOCAL GOVERNMENT
1250	CALDWELL COUNTY	LOCAL GOVERNMENT
1251	CITY OF GOLDSBORO	LOCAL GOVERNMENT
1252	CITY OF MORGANTON	LOCAL GOVERNMENT
1253	CITY OF WHITEVILLE	LOCAL GOVERNMENT
1254	WESTERN PIED REG TRANSIT AUTHORITY	LOCAL GOVERNMENT
1255	CITY OF LOWELL	LOCAL GOVERNMENT
1256	ALBEMARLE REGIONAL HEALTH SERVICES	LOCAL GOVERNMENT
1257	PENDER COUNTY GOVERNMENT	LOCAL GOVERNMENT
1258	PERQUIMANS COUNTY	LOCAL GOVERNMENT
1259	ALBEMARLE DISTRICT JAIL	LOCAL GOVERNMENT
1260	CAPE FEAR PUBLIC UTILITY	LOCAL GOVERNMENT
1261	CITY OF LINCOLNTON	LOCAL GOVERNMENT
1262	PETTIGREW REGIONAL LIBRARY	LOCAL GOVERNMENT
1263	ROCKY MOUNT-WILSON REG AIRPORT	LOCAL GOVERNMENT
1264	TOWN OF BURNSVILLE	LOCAL GOVERNMENT
1265	TOWN OF CHINA GROVE	LOCAL GOVERNMENT
1266	TOWN OF CLAYTON	LOCAL GOVERNMENT
1267	TOWN OF COVE CITY	LOCAL GOVERNMENT
1268	TOWN OF FAIR BLUFF	LOCAL GOVERNMENT
1269	TOWN OF MARS HILL	LOCAL GOVERNMENT
1270	TOWN OF PRINCEVILLE	LOCAL GOVERNMENT
1271	TOWN OF ROBERSONVILLE	LOCAL GOVERNMENT
1272	UPPER COASTAL PLAIN COUNCIL	LOCAL GOVERNMENT
1273	APPALACHIAN REGIONAL LIBRARY	LOCAL GOVERNMENT
1274	CITY OF MOUNT AIRY ABC BOARD	LOCAL GOVERNMENT
1275	DOBSON ABC	LOCAL GOVERNMENT
1276	EC-PC AIRPORT AUTHORITY	LOCAL GOVERNMENT
1277	PILOT MOUNTAIN ABC BOARD	LOCAL GOVERNMENT
1278	POLK COUNTY LOCAL GOVERNMENT	LOCAL GOVERNMENT
1279	TOWN OF ARCHER LODGE	LOCAL GOVERNMENT
1280	TOWN OF BRUNSWICK	LOCAL GOVERNMENT
1281	TOWN OF LAUREL PARK	LOCAL GOVERNMENT

1282	TOWN OF MOMEYER	LOCAL GOVERNMENT
1283	TOWN OF SPARTA	LOCAL GOVERNMENT
1284	TOWN OF SELMA	LOCAL GOVERNMENT
1285	TOWN OF WALLACE	LOCAL GOVERNMENT
1286	BERTIE COUNTY	LOCAL GOVERNMENT
1287	BERTIE-MARTIN REGIONAL JAIL	LOCAL GOVERNMENT
1288	ASHE COUNTY	LOCAL GOVERNMENT
1289	MARTIN COUNTY	LOCAL GOVERNMENT
1290	MARTIN COUNTY ABC BOARD	LOCAL GOVERNMENT
1291	TOWN OF MAGGIE VALLEY	LOCAL GOVERNMENT
1292	BURKE COUNTY TOURISM	LOCAL GOVERNMENT
1293	MARTIN COUNTY TOURISM	LOCAL GOVERNMENT
1294	NASH COUNTY	LOCAL GOVERNMENT
1295	TOWN OF FREMONT	LOCAL GOVERNMENT
1296	NASH COUNTY ABC BOARD	LOCAL GOVERNMENT
1297	FIRST CRAVEN	LOCAL GOVERNMENT
1298	TOWN OF SHALLOTTE	LOCAL GOVERNMENT
1299	CITY OF DUNN	LOCAL GOVERNMENT
1300	CITY OF LINCOLNTON ABC	LOCAL GOVERNMENT
1301	PAMLICO COUNTY	LOCAL GOVERNMENT
1302	TOWN OF MAYSVILLE	LOCAL GOVERNMENT
1303	COLUMBUS COUNTY	LOCAL GOVERNMENT
1304	TOWN OF LILESVILLE	LOCAL GOVERNMENT
1305	ALBEMARLE COMMISSION	LOCAL GOVERNMENT
1306	ANSON COUNTY	LOCAL GOVERNMENT
1307	APPALACHIAN DISTRICT HEALTH	LOCAL GOVERNMENT
1308	CITY OF SALUDA	LOCAL GOVERNMENT
1309	GRANVILLE-VANCE HEALTH	LOCAL GOVERNMENT
1310	KERR-TAR REGIONAL COUNCIL	LOCAL GOVERNMENT
1311	MARTIN TYRRELL WASHINGTON HEALTH	LOCAL GOVERNMENT
1312	NORTHERN REGIONAL HOSPITAL	LOCAL GOVERNMENT
1313	ONslow COUNTY ABC BOARD	LOCAL GOVERNMENT
1314	ONslow WATER AND SEWER AUTHORITY	LOCAL GOVERNMENT
1315	TOE RIVER HEALTH DISTRICT	LOCAL GOVERNMENT
1316	TOWN OF CASWELL BEACH	LOCAL GOVERNMENT
1317	TOWN OF HOLLY RIDGE	LOCAL GOVERNMENT
1318	TOWN OF MAYODAN	LOCAL GOVERNMENT
1319	TOWN OF MOUNT GILEAD	LOCAL GOVERNMENT
1320	TOWN OF NASHVILLE	LOCAL GOVERNMENT
1321	TOWN OF PILOT MOUNTAIN	LOCAL GOVERNMENT
1322	TOWN OF RURAL HALL	LOCAL GOVERNMENT
1323	TOWN OF ST JAMES	LOCAL GOVERNMENT
1324	TOWN OF TAYLORTOWN	LOCAL GOVERNMENT
1325	VILLAGE OF TOBACCOVILLE	LOCAL GOVERNMENT
1326	YANCEY COUNTY	LOCAL GOVERNMENT
1327	CLINTON ABC BOARD	LOCAL GOVERNMENT
1328	SILER CITY ABC BOARD	LOCAL GOVERNMENT



1329	WALNUT COVE ABC BOARD	LOCAL GOVERNMENT
1330	CHATHAM COUNTY ABC BOARD	LOCAL GOVERNMENT
1331	GRANITE FALLS ABC BOARD	LOCAL GOVERNMENT
1332	ANGIER ABC BOARD	LOCAL GOVERNMENT
1333	ALBEMARLE ABC BOARD	LOCAL GOVERNMENT
1334	TOWN OF MOUNT PLEASANT	LOCAL GOVERNMENT
1335	HERTFORD COUNTY ABC BOARD	LOCAL GOVERNMENT
1336	PITTSBORO ABC BOARD	LOCAL GOVERNMENT
1337	BLACK MOUNTAIN ABC BOARD	LOCAL GOVERNMENT
1338	TOWN OF MARSHALL	LOCAL GOVERNMENT
1339	TOWN OF LELAND	LOCAL GOVERNMENT
1340	PERSON COUNTY ABC BOARD	LOCAL GOVERNMENT
1341	CENTENNIAL AUTHORITY	LOCAL GOVERNMENT
1342	TOWN OF MATTHEWS	LOCAL GOVERNMENT
1343	CENTER PIGEON FIRE DEPARTMENT	LOCAL GOVERNMENT
1344	BUNCOMBE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1345	ASHEVILLE CITY SCHOOLS	LOCAL EDUCATION AGENCY
1346	CHEROKEE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1347	CLAY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1348	GRAHAM COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1349	HAYWOOD COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1350	HENDERSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1351	JACKSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1352	MACON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1353	MADISON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1354	POLK COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1355	SWAIN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1356	TRANSYLVANIA COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1357	YANCEY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1358	ALEXANDER COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1359	ALLEGHANY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1360	ASHE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1361	AVERY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1362	BURKE COUNTY PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
1363	CALDWELL COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1364	CATAWBA COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1365	HICKORY CITY SCHOOLS	LOCAL EDUCATION AGENCY
1366	NEWTON-CONOVER CITY SCHOOLS	LOCAL EDUCATION AGENCY
1367	CLEVELAND COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1368	LINCOLN COUNTY SCHOOL	LOCAL EDUCATION AGENCY
1369	MCDOWELL COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1370	MITCHELL COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1371	RUTHERFORD COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1372	WATAUGA COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1373	WILKES COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1374	ANSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1375	GASTON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY

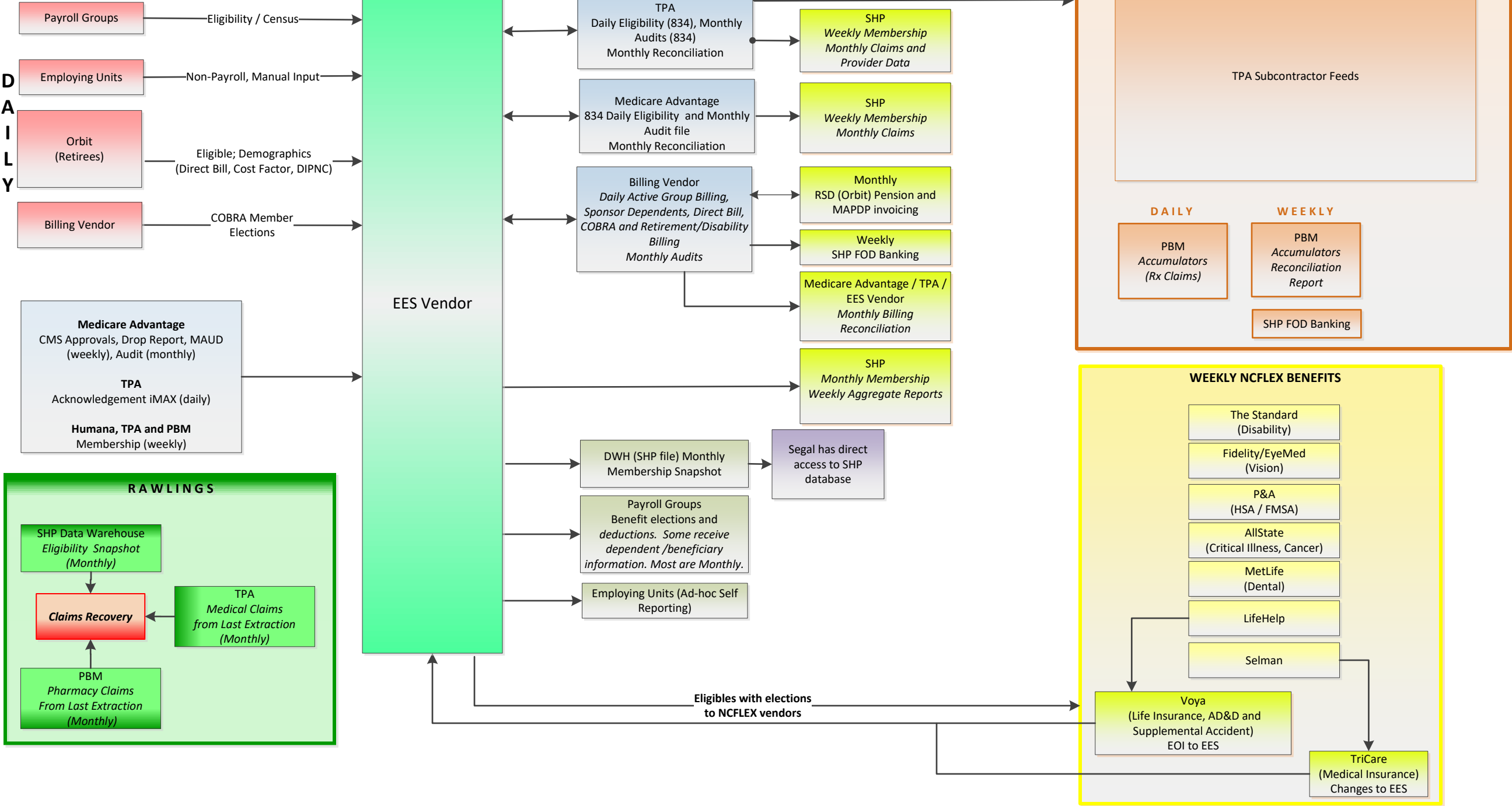
1376	CHARLOTTE MECKLENBURG SCHOOLS	LOCAL EDUCATION AGENCY
1377	MONTGOMERY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1378	RICHMOND COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1379	UNION COUNTY PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
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1381	KANNAPOLIS CITY SCHOOLS	LOCAL EDUCATION AGENCY
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1383	MOORESVILLE GRADED SCHOOL DISTRICT	LOCAL EDUCATION AGENCY
1384	STANLY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1385	DAVIDSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1386	LEXINGTON CITY SCHOOLS	LOCAL EDUCATION AGENCY
1387	THOMASVILLE CITY SCHOOLS	LOCAL EDUCATION AGENCY
1388	GUILFORD COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1389	RANDOLPH COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1390	ASHEBORO CITY SCHOOLS	LOCAL EDUCATION AGENCY
1391	ROCKINGHAM COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1392	DAVIE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1393	WINSTON-SALEM FORSYTH SCHOOLS	LOCAL EDUCATION AGENCY
1394	ROWAN-SALISBURY SCHOOLS	LOCAL EDUCATION AGENCY
1395	STOKES COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1396	SURRY COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1397	ELKIN CITY SCHOOLS	LOCAL EDUCATION AGENCY
1398	MOUNT AIRY CITY SCHOOLS	LOCAL EDUCATION AGENCY
1399	YADKIN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1400	ALAMANCE-BURLINGTON LOCAL EDUCATION AGENCY	LOCAL EDUCATION AGENCY
1401	CASWELL COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1402	CHATHAM COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1403	DURHAM PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
1404	GRANVILLE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1405	LEE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1406	MOORE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1407	ORANGE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1408	CH-CARRBORO CITY SCHOOLS	LOCAL EDUCATION AGENCY
1409	PERSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1410	FRANKLIN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1411	HARNETT COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1412	JOHNSTON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1413	VANCE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1414	WARREN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1415	WAKE COUNTY PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
1416	BRUNSWICK COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1417	DUPLIN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1418	NEW HANOVER COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1419	ONslow COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1420	PENDER COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1421	SCOTLAND COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1422	BLADEN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY

1423	COLUMBUS COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1424	WHITEVILLE CITY SCHOOLS	LOCAL EDUCATION AGENCY
1425	CUMBERLAND COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1426	HOKE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1427	PUBLIC SCHOOLS OF ROBESON COUNTY	LOCAL EDUCATION AGENCY
1428	SAMPSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1429	CLINTON CITY SCHOOLS	LOCAL EDUCATION AGENCY
1430	BEAUFORT COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1431	BERTIE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1432	CAMDEN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1433	EDENTON CHOWAN SCHOOLS	LOCAL EDUCATION AGENCY
1434	CURRITUCK COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1435	DARE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1436	EDGEcombe COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1437	GATES COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1438	HALIFAX COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1439	ROANOKE RAPIDS GRADED SCHOOLS	LOCAL EDUCATION AGENCY
1440	WELDON CITY SCHOOLS	LOCAL EDUCATION AGENCY
1441	HERTFORD COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1442	HYDE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1443	MARTIN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1444	NASH COUNTY PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
1445	NORTHAMPTON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1446	ELIZABETH CITY PASQ PUBLIC SCHOOLS	LOCAL EDUCATION AGENCY
1447	PERQUIMANS COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1448	PITT COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1449	TYRRELL COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1450	WASHINGTON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1451	WILSON COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1452	CARTERET COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1453	CRAVEN COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1454	GREENE COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1455	JONES COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
1456	LENOIR COUNTY SCHOOLS	LOCAL EDUCATION AGENCY
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Exhibit 4 VENDOR DATA FEEDS

for 1/1/2022

Revised: 05/25/2022





# Monthly Audit & Reconciliation

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## Overview

Each Plan vendor audits their information against the Eligibility and Enrollment System (EES) and reconciles billing against COBRA Administration and Billing System (CABS) and /or Third Party Administrator (TPA). It is recommended that each vendor designate a person to monitor these activities and ensure key dates are met each comparison cycle. The Plan will monitor and track of each step from a bird's eye view. There are three goals to this process:

Consistency – With multiple vendors, EDI is very complex and auditing across vendors becomes more difficult as well. This process will achieve the same completion times, discrepancy rate, and comparison process across all vendors.

Timeliness – This process will achieve full completion of every audit and reconciliation within every month. This will ensure we are providing the correct benefits for members before the effective date and that we are billing the appropriate rates before invoices are created.

Efficiency – With over 700,000 members, even a 1% discrepancy rate is too high for any vendor to manually update in time to make an impact on invoices or coverage. The Plan has strategically streamlined the process and updates at each vendor in this document.

## Scope

The current audit and reconciliation schedule is reviewed by all vendors on an annual basis.

All vendors will meet:

- Extraction of Vendor's files being delivered must have been extracted within 12 hours
- Processing of Vendor's files being received must be an automated compare within a consecutive 24-hour window
- 2 business day turnaround time.
- Due dates are based upon receipt date of file,
- For example:
  - A file delivered at 5:00pm EST on the 28<sup>th</sup> will be due back at 5:00pm EST on the 30<sup>th</sup>
  - A file delivered at 8:00 am EST on the 28<sup>th</sup> will be due back at 8:00 am EST on the 30<sup>th</sup>

## Current Audits

Audit refers to the comparing of enrollment information only.

- Each monthly/quarterly audit results will be returned in 2 business days, after delivery of file, per vendor.
- The yearly audit schedule will be included as an appendix each year.

Below is a list of all the current audits:

- Cost Factor, Direct Bill Flag, Date of Death

- Monthly between EES and Retirement System Division (RSD)
- Monthly between EES and CABS
- RSD Enrollment
  - Monthly between EES and TPA
  - Monthly between TPA and CABS
  - Monthly between EES and CABS
- Active group enrollment
  - Monthly between EES and TPA
- Pharmacy enrollment
  - Monthly between EES and PBM
- Direct Bill enrollment
  - Monthly between EES and CABS
  - Monthly between TPA and CABS
- MAPDP Enrollment
  - Monthly between EES and MAPDP

### Current Reconciliations

Reconciliation refers to the comparing of premiums after invoices have been generated.

- CABS and MAPDP Reconciliations have a TAT of 2 business days per vendor.
- The yearly audit schedule will be included as an appendix each year

Below is a list of all the current reconciliations:

- RSD Invoice and Monthly Error Report
  - RSD and CABS



## Fields to Compare

Listed are the fields to be compared by vendor:

	<b>CABS</b>	<b>MAPD</b>	<b>TPA</b>	<b>PBM</b>
SSN	Yes	Yes	Yes	Yes
First name	Yes	Yes	Yes	Yes
Last name	Yes	Yes	Yes	Yes
Date of birth	Yes	Yes	Yes	Yes
Gender	Yes	Yes	Yes	Yes
Relationship (person type)	Yes	No	Yes	No
Mailing address	Yes	Yes	Yes	Yes
Physical address	No	No	No	No
Vendor specific IDs	Yes	Yes	Yes	Yes
Cost factor	Yes	Yes	No	No
Direct bill	Yes	No	No	No

Plan effective date	Yes	Yes	Yes	Yes
Plan termination date	Yes	Yes	Yes	Yes
PWC	Yes	No	No	No
Plan	Yes	Yes	Yes	Yes
Coverage level	Yes	No	Yes	No
Rate	Yes	No	No	No
Medicare ID	No	Yes	Yes	Yes
Entitlement reason	Yes	Yes	Yes	Yes
Part A effective date	No	Yes	Yes	Yes
Part A termination date	No	Yes	Yes	Yes
Part B effective date	No	Yes	Yes	Yes
Part B termination date	No	Yes	Yes	Yes
Medicare eligibility effective date	No	Yes	Yes	Yes
Medicare eligibility termination date	No	Yes	Yes	Yes
Medicare primacy effective date	Yes	Yes	Yes	Yes
Medicare primacy termination date	Yes	Yes	Yes	Yes
Phantom A effective date	No	Yes	Yes	Yes
Phantom A termination date	No	Yes	Yes	Yes
Phantom B effective date	No	Yes	Yes	Yes
Phantom A termination date	No	Yes	Yes	Yes

**Demographics:** Demographic information has various input methods, Payroll files/Key Entry, Members, CABS, and MAPDP. Currently demographic changes made at CMS (via MAPDP), CABS, and by groups (via payroll file or member update) are being sent to EES for updating.

- TPA maintains the address provided by EES.
- PBM maintains the address provided by EES unless mail order is requested.
- EES maintains the address provided by MAPDP, the groups, and/or member input.
- MAPDP maintains the one address provided by CMS, interpreted as the physical address. If EES sends a separate mailing address this will be maintained at MAPDP as well.
- CABS maintains the address provided by EES and a separate billing address for COBRA members.

EES will continue to provide full files for audits and vendors will audit on the fields provided in the respective BRDs. Vendors may choose to compare on and update additional demographic fields in their system. For example, TPA may decide to do a full comparison on addresses before sending out ID cards for the new plan year.

**Medicare:** The only Entitlement reason that has any bearing on Medicare primacy is ESRD. At this time, every vendor should be managing ESRD entitlements manually to accommodate the 30 or 33 month coordination period. Outside of ESRD, the Employment Status of the member dictates the primacy of Medicare regardless of the entitlement or group. CMS is the system of record for Medicare data and EES is the system of record for Medicare primacy. Any vendors receiving updates from CMS, directly or indirectly, are responsible for ensuring that information is updating within EES for the accurate calculation of primacy.

- TPA provides Medicare updates via the outbound file

- MAPDP provides Medicare updates via the weekly discrepancy file

## Performing the Compares

To maintain consistency across vendors and varying comparisons, the Plan has outlined the expected methodology for audits and reconciliations. Each vendor should match on what creates a unique member in their system; for example, EES would use Person Oracle ID (POID).

EES provides what coverage the member has in their system for a specified plan year, at the time of the audit. For further details, see solutions document for each specific vendor.

Audit files will also contain terminated members processed since the last audit extract. It is imperative that this population is audited, there is an array of updates made on terminated members in eBenefits that may not send to all vendors. Audits where termed members appear, the terms will be included on the audit for the full plan period

Comparisons performed by:

- EES and RSD: *EES*
- EES and TPA: *TPA*
- EES and MAPDP: *MAPDP*
- EES and PBM: *PBM*
- EES and CABS: *CABS*
- CABS and TPA: *CABS*
- CABS and MAPDP: *MAPDP*

## System of Record

Fields	
TPA	Member Identifier (TPA assigned ID number), PCP Association Changes, Phantom Processing
EES	Name, DOB, Gender, SSN, Incentives, Benefit Elections, Coverage Election, Effective Date, Expiration Date, Primacy, PCP,
CMS (via TPA, MAPDP)	Medicare Identifier, Part A Eff Date, Part A Exp Date, Part B Eff Date, Part B Exp Date
RSD	Cost Factor, Cost Factor effective date Direct Bill Flag, Direct Bill effective date

The automatic comparison referenced above should include the below steps:

If the comparison yields more than 1% of the total in discrepancies, the comparison should not continue. At that point an email needs to be sent notifying the Plan and any affected vendors that additional research into the file is needed due to the number of discrepancies.

### Report Out

Each report out on discrepancies should include the following counts, as soon as the comparison is complete:

	Audits	Recons
Demographics	Name, DOB, Gender, SSN, Member Identifier	Cost Factor, Cost factor effective date, Direct Bill Flag, Direct bill effective date
Coverage	In one system but not the other, Effective/Term Date Mismatches	In one system but not the other
Elections	Incentives, Benefit Elections, Coverage Election, PCP	Rates
Medicare	HICN/MBI, Part A Eff Date, Part A Exp Date, Part B Eff Date, Part B Exp Date, Primacy, Phantom Eff Date, Phantom Term	Primacy

Once the comparison is complete and automation has been run, results should be shared with The Plan and the appropriate vendors.



## Automation of updates

Automation is expected for any data that is not subject to change based on an effective date. This includes DOB, Gender, Member Identifier, term dates, Medicare Identifier, Medicare Effective/Expiration Dates. Additionally, automation should be utilized to update Medicare Primacy as EES is the system of record.

Effective date mismatches should be reviewed to determine if the date should overwrite what currently exists or if another segment of coverage should be added to what currently exists. Manual updates are to be made by each vendor in their own system.

## Retirement Members

The audit/recon cycle will be kicked off every month with the Cost Factor, Direct Bill and DOD comparison and will end with the reconciliation. Dates may vary due to weekends and/or holidays for each step below. When the due date is on a weekend or holiday; file will be delivered the next business day.

- RSD delivers CF, DB, and DOD file to EES:
- Monthly RSD Audit with EES for MAPDP and TPA to begin as soon as the RSD audit is complete.
- These RSD audits should be complete in CABS in time for the Direct Bill ACH and invoices. (Last updates through the file that will be applied before ACH triggers)
- The deduction file will be generated and sent and the invoices for RSD will be generated.
- The payroll deduction error/void file should be received, and deduction errors worked before paper invoices are created.
- The RSD recon with CABS for MAPDP should begin the day after the invoices are generated.
- CABS will evaluate each member invoiced individually (to account for splits) and provide feedback to MAPDP/TPA
- The reconciliation should be complete by end of the month, to restart the cycle.

## All Members

These audits are done prospectively to ensure the future month has the correct enrollment. The audit/recon cycle will begin the process and will end with the invoices generating.

- EES deliver audit file to TPA, CAB, and PBM per agreed upon schedule.
- All discrepancies should be completed per agreed upon schedule.

## Ongoing Monitoring and Review

Each audit and reconciliation will be tracked to ensure we are meeting our consistency, timeliness, and efficiency goals. Every year the audit process will be reviewed to ensure the best practices are in place. The below metrics will be calculated based on the data provided each month:

	Measured	Calculation	Threshold
Discrepancy rate	By Category	impacted members/number of possible impacted members	.05%
Automation rate	Overall	number of automatic updates/total number of discrepancies	95%
% change	By Category	(current month total – last month total)/last month total	5%
Discrepancy rate vs accuracy rate	By Category	100 - (Accuracy rate + Discrepancy rate)	+ or -2%
Average Completion Time	By Vendor	Day work began – Day work completed	>5 days
Repetition of Discrepancy	By Member	Count of how many members had a discrepancy over multiple months in the same category	5 members
Repetition of Member	By Member	Count of how many members had a discrepancy one month and appeared on other vendors compare the next month	5 members

Once the threshold is met, root cause analysis will need to be performed.

### Root Cause Analysis Example

A Root Cause Analysis email should contain the following details:



- Issue Name for Future Reference: *Short Title for Issue*
- Description of Issue: *Explanation of what is occurring*
- Immediate Symptoms: *What's the immediate effect of the issue?*
- Immediate Solution: *Is there a stop gap that can be put in place to limit impact?*
- Immediate Impact: *Number of people currently impacted; gained via analyzing the entire Plan population against criteria that fit the issue.*
- Downstream Impact: *What else can be affected due to this issue? What may occur if this issue isn't resolved within a specific time frame?*
- Long Term Impact: *Number of people potentially impacted in the future?*
- Root Cause: *Beyond the items listed above what is the reason the issue exists? The "5 Why" method works well to get to the bottom of the cause list.*
- Failure Point: *Person, Process, or Technology?*

## Special Audits

The below audits are performed less frequently and will have specific dates assigned as the audits approach.

### CMS Quarterly Audit

Every 45 days TPA sends a list of all Medicare enrollments to CMS. Then CMS responds to TPA confirming the details for the Medicare eligible members. TPA compares the list to what is in their system at the time of the file and automates any updates.

- TPA compares Medicare values to values within their system
- Mismatches are categorized and provided to SHP and EES for review
- TPA scripts updates
- EES receives Medicare updates from TPA
- Auto enrollment updates primacy in EES
- Updated coverage is sent to applicable vendors

### Yearly Rate Configuration Audit

Vendors must audit the billing rates in CABS and TPA

- Vendors will provide results of their audit to the Plan
- Updates must be made prior to first billing cycle.

## Version History

Version	Date	Author	Overview of Changes
1.0	2/1/2018	Martina Jones, Plan Integration Team	Created Initial Plan
2.0	3/12/18	Martina Jones, Plan Integration Team	Incorporated updates specific to CABS systems and fields compared. Added CABS and TPA Direct Bill (COBRA) audit. Included vendor responsibility in example timeline
3.0	12/4/20	Plan integration	Replaced UHC with MAPDP
4.0	9/22/2021	Plan Integration	Restructure, wording, and current year updates
5.0	5/27/22	Plan Integration	Removed outdated recon references, reworked for premium billing to be handled by CABS

## TPA Responsibilities for PCP

TPA establishes Provider Network

TPA maintains the Provider Network on routine basis

TPA establishes interface of Provider Network that is accessible by EES and member

Selected PCP information is received from EES and is printed on the member's ID card

Member is prompted by TPA to select a PCP if current PCP is no longer valid

TPA reconciles PCP selections with EES on a routine basis via audit

## Interface between TPA and EES

Selected PCP information is sent to TPA from EES

PCP identifiers are generated

PCP effective date(s) are assigned

Interface will allow members' various search options for PCP selection

## Member PCP Selection

Member is directed to select a PCP in the OE workflow via EES

Member is directed to select a PCP during initial enrollment via EES

Member self-prompts to select a PCP via EES or TPA

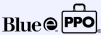
# Exhibit 7 Sample ID Cards



Provider Type	CPP	Non CPP
Selected PCP*	\$0	\$30
Phys/Occu/Spch Therapy/Chiro	\$36	\$72
Specialist	\$47	\$94
Behavioral Health	\$0	\$45
Urgent Care	\$45	
ER	\$337 + Ded & 30%	
<b>Other Info</b>	<b>INN</b>	<b>NON</b>
Ind Deductible	\$1,500	\$3,000
Ind OOP Max	\$5,900	\$11,800
Family Deductible	\$4,500	\$9,000
Family OOP Max	\$16,300	\$32,600

\* If PCP not selected, in-network copay \$45

CPP: Clear Pricing Project  
INN: In-network/OON: Out-of-network  
OOP: Out-of-pocket



Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID:  
**SMPL0001**

Your Group

Date Issued:

**01/01/2021**

Group No:

**SR1009**

RXBIN:

**000000**

RXPCN:

**000**

RXGRP:

**000000**

**Primary Care Provider (PCP)**

Dr. PCP

123 Anywhere Street

123-456-7890

**NC SHP Network**

**70/30 Plan**

*Paid for by YOU and other NC Taxpayers*

1391-SH-3867 (C/S NAME) SH-SR-1009-\$45-2020-M[01/01]

20200814T0C Sh: 0 Bin 1  
JODA Env [1] C Sets 1 of 1



State Health Plan Administered by:



*Claims may be subject to review. For nonparticipating providers, members are responsible for ensuring the prior review/cert is obtained. For non-NC providers, members are responsible for ensuring the prior review/cert is obtained for Professional and/or outpatient services.*

*BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only for this self-funded plan and does not assume any financial risk for claims.*

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Project Provider and Save!**

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**www.SHPNC.org**

**CVS** caremark® Pharmacy Benefits Administrator

Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID:

**SMPL0001**

**Phone**

Benefits & Claims  
Eligibility & Enrollment\*  
Find Non-NC Providers  
Provider Service  
Prior Review/Certification  
Behavioral Health  
Pharmacy Help Desk\*  
CVS Caremark\*

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**855-859-0966**  
**800-810-2583**  
**800-214-4844**  
**800-672-7897**  
**800-367-6143**  
**800-364-6331**  
**888-321-3124**

\*Contracts directly with State Health Plan

**Mail**

BlueCross and BlueShield of North Carolina  
PO Box 30087  
Durham, NC 27702-0035

*Providers send claims to their local  
BlueCross BlueShield Plan*

**Online**

**SHPNC.org**

1391-SH-3754 (C/S NAME) SH-SR-1009-\$45-2020-M[01/01]

20200814T0C Sh: 0 Bin 1  
JODA Env [1] C Sets 1 of 1



Provider Type	CPP	Non CPP
Selected PCP*	\$0	\$10
Phy/Occu/Spch Therapy/Chiro	\$26	\$52
Specialist	\$40	\$80
Behavioral Health	\$0	\$25
Urgent Care	\$70	
ER	\$300 + Ded & 20%	
Other Info	INN	OON
Ind Deductible	\$1,250	\$2,500
Ind OOP Max	\$4,890	\$9,780
Family Deductible	\$3,750	\$7,500
Family OOP Max	\$14,670	\$29,340

\* If PCP not selected, in-network copay \$25

CPP: Clear Pricing Project  
 INN: In-network/OON: Out-of-network OOP: Out-of-pocket



Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID:  
**SMPL0001**

Your Group

Date Issued:

**01/01/2021**

Group No:

**SR1009**

RXBIN:

**000000**

RXPCN:

**000**

RXGRP:

**000000**

**Primary Care Provider (PCP)**

Dr. PCP

123 Anywhere Street

123-456-7890

**NC SHP Network**

**80/20 Plan**

**Paid for by YOU and other NC Taxpayers**

1391-SH-3867 (C/S NAME) SI-SR 1009-445-2020 - MID(VI)

20200814T0C Sh: 0 Bin 1  
J0DA Env [1] CSets 1 of 1



State Health Plan Administered by:



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**CVS** caremark® Pharmacy Benefits Administrator

Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID: **SMPL0001**

**Phone**

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 PO Box 30087  
 Durham, NC 27702-0035

*Providers send claims to their local  
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20200814T0C Sh: 0 Bin 1  
J0DA Env [1] CSets 1 of 1



1391-SH-3754 (C/S NAME) SI-SR 1009-445-2020 - MID(VI)



# North Carolina State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

**Treasurer Dale R. Folwell, CPA**

## In-Network Member Responsibility

Preventive Care	<b>\$0</b>	
Coinurance	<b>50% after ded</b>	
Prescription Drug	<b>50% after ded</b>	
<b>Other Info</b>	<b>INN</b>	<b>OON</b>
Ind Deductible	<b>\$5,000</b>	<b>\$10,000</b>
Ind OOP Max	<b>\$6,450</b>	<b>\$12,900</b>
Family Deductible	<b>\$10,000</b>	<b>\$20,000</b>
Family OOP Max	<b>\$12,900</b>	<b>\$25,800</b>

INN: In-network/OON: Out-of-network

OOP: Out-of-pocket

\* High Deductible Health Plan



Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID:

**SMPL0001**

Your Group

Date Issued:

**01/01/2021**

Group No:

**SR1009**

RXBIN:

**000000**

RXPCN:

**000**

RXGRP:

**000000**

**NC SHP Network**

**HDHP\***

***Paid for by YOU and other NC Taxpayers***

1381-SH 3754 (C/SINAME) SH-SR1009-345-2020--M(DP/V)

20200814T0C Sh: 0 Bin 1  
J0DA Env [1] Csets 1 of 1



State Health Plan Administered by:



**BlueCross  
BlueShield**

*Claims may be subject to review. For nonparticipating providers, members are responsible for ensuring the prior review/cert is obtained. For non-NC providers, members are responsible for ensuring the prior review/cert is obtained for Professional and/or outpatient services.*

*BlueCross and BlueShield of North Carolina, an independent licensee of the BlueCross and BlueShield Association, provides administrative services only for this self-funded plan and does not assume any financial risk for claims.*

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**CVS** caremark® Pharmacy Benefits Administrator

Subscriber: **JOHN A SAMPLE** [01]

Member:

Subscriber ID:

**SMPL0001**

## Phone

Benefits & Claims  
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Find Non-NC Providers  
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**888-234-2416  
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800-364-6331  
888-321-3124**

\*Contracts directly with State Health Plan

## Mail

BlueCross and BlueShield of North Carolina  
PO Box 30087  
Durham, NC 27702-0035

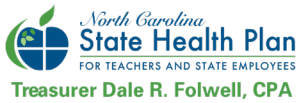
*Providers send claims to their local  
BlueCross BlueShield Plan*

**Online**

**SHPNC.org**

20200814T0C Sh: 0 Bin 1  
J0DA Env [1] Csets 1 of 1





PO Box 30085  
Durham, NC 27702

John Sample  
123 Main Street  
Anyplace, NC 26789

**Paid for by you and other NC Taxpayers**

## YOUR CLAIM SUMMARY

August 14, 2018

This Explanation of Benefits (EOB) shows how claims were processed by your plan. **It is NOT a bill.** It's a way to check that the care you received and the amount billed by your providers are accurate. Keep this for your records.

### Subscriber Details

Name: **John Sample**

Subscriber ID: **YPYW#####**

Plan: **North Carolina State Health Plan 80/20**

## HAVE QUESTIONS?



Visit **[www.shpnc.org](http://www.shpnc.org)**



Call **888-234-2416** (Monday – Friday, 8 a.m. – 6 p.m. ET)

Servicio al Cliente **888-234-2416** (Lunes – Viernes, 8 a.m. – 6 p.m. ET)



Watch a video on how to read this EOB at **[shpnc.org/????](http://shpnc.org/????)**



TTY/TDD (for the speech and hearing impaired): **800-442-7028**

## OVERVIEW

### 5 claims

Processed by Blue Cross and Blue Shield of North Carolina (Blue Cross NC). **Below is a total of those claims.** You'll find information on each claim in the "Claim Details" section.

Total Amount Provider(s) Charged:	<b>\$2,844.00</b>	The original amount charged by the provider(s) you visited before any in-network discounts or State Health Plan payments were applied.
State Health Plan Member Savings:	<b>— \$1,044.00</b>	You saved <b>\$969.00</b> by using in-network providers. The State Health Plan paid <b>\$75.00</b> towards the claims in this summary. <b>Overall, being a State Health Plan member saved you 37% off the total amount charged.</b>
What Provider(s) May Bill You:	<b>= \$1,800.00</b>	The remaining amount after your discount and what your plan paid in benefits. (It may not reflect payments already made by you or another insurance company.) <b>Your provider(s) may bill you directly for this amount.</b>



### TAKE NOTE:

- There are **3 alert codes** which includes **1 DENIAL** (look for the **!** icon in the "Claim Details" section).
- Find tools and resources at **[www.shpnc.org](http://www.shpnc.org)**.

## Header Goes Here

Body copy would go here.

Learn more at **[URL]**.

Blue Cross NC provides administrative services only for this plan. Your plan sponsor retains sole responsibility for funding the claim payments. The information listed in the "Your Plan at a Glance" section shows the most current benefit period information on your plan as of August 14, 2018. The "Applied To-Date" will reflect the total amount applied throughout the benefit period on the plan. This amount may include all applied before and after any changes in benefits or dependents covered during the current benefit period.

Para obtener asistencia en español, comuníquese con el departamento de servicio al cliente al número que aparece al respaldo de su tarjeta del seguro.

**NOTE:** We provide these definitions to help you understand important terms. Refer to your benefit booklet for full details. In the event of any inconsistency between these definitions and your benefit booklet, the benefit booklet shall govern.

<b>Alert Code</b>	A message explaining how a service was processed or alerting you to a problem with the claim. It helps you see how the plan decided what it will pay for the services you received.
<b>Allowed Amount</b>	The reduced rate Blue Cross NC negotiated with in-network providers for covered services. This is one of the reasons in-network care saves you money. For example, a doctor may charge \$150 for a visit — but Blue Cross NC negotiated an allowed amount of \$100. Thus, you save \$50 as a plan member.
<b>Amount Not Covered / Other Liability</b>	This can include non-covered services, out-of-network costs above the allowed amount and services that didn't get prior review (approval) as required.
<b>Appeal</b>	A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).
<b>Coinsurance</b>	Your share of the cost for a covered service after meeting your deductible. (The rest is paid by the State Health Plan.) It's calculated as a percentage of the allowed amount. For example: If your coinsurance is 20%, you'd pay \$20 if the allowed amount is \$100.
<b>Copayment (Copay)</b>	A fixed amount (for example, \$15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered service.
<b>Covered Services</b>	Refer to your benefit booklet for details on which health care services are covered by your plan.
<b>Date of Care</b>	This is the date you received the services listed on the claim.
<b>Deductible</b>	The amount each individual pays for covered services before the health plan starts to pay. Most plans have a different deductible for in-network providers and out-of-network providers. Copays, coinsurance, non-covered services and charges above the allowed amount do not count toward your deductible.
<b>Family Deductible</b>	Once the sum of all family member payments meets the family deductible, each member begins to pay the copay or coinsurance amount.
<b>Family Out-of-Pocket Limit</b>	Once this limit is reached, the plan pays 100% of covered services for each family member.
<b>In-Network</b>	Doctors, hospitals, clinics and other providers that contract with your plan to provide services at a lower rate.
<b>In-Network Discount</b>	The amount you saved by using a provider that is in-network for your plan. It's the difference between what your provider charged and the allowed amount.
<b>Out-of-Network</b>	Services from doctors, hospitals, clinics and other providers that don't have a contract with your plan. They usually cost you more than in-network providers.
<b>Out-of-Pocket Limit</b>	The total amount you'll spend during a benefit year before the State Health Plan starts to pay 100% of covered services. It does not include premiums, charges over allowed amounts or non-covered services.
<b>Plan's Limit</b>	This is the specific deductible, coinsurance or out-of-pocket limit for your plan.
<b>Service</b>	The type of care you got. Different services can share the same label, like "Medical" or "Facility." This helps protect your privacy. Contact your provider or Customer Service for more details on a service.
<b>State Health Plan Member Savings</b>	The total amount you saved from in-network discounts and plan payments.
<b>State Health Plan Paid</b>	The amount the State Health Plan paid for services you received. Please note that this amount may be \$0 if you receive services that go towards your deductible and your deductible has not been met or if your copay is equal to or more than the allowed amount. As a State Health Plan member you receive discounts by using providers that are in-network.
<b>Total Provider May Bill You</b>	What you'll ultimately pay the provider after any in-network discount and plan payments are applied. Keep in mind that it does not reflect payments you've already made to the provider. For example, it could show a \$25 copay that you paid at the time of the visit. That's why we say it's what your provider "may" bill you. By comparing EOBs with bills from your provider, you can make sure everything is accurate and avoid overpaying.



3 claims for JOHN (ID: YPYW#####)

**Provider Name:** In-N-Out QwickCare

**Claim Number:** ## #####-###-##

**Date of Care:** July 30, 2018

Service:	Provider Charged:	Allowed Amount:	In-Network Discount:	State Health Plan Paid:*	Applied to Deductible:	Copayment or Coinsurance:	Not Covered / Other Liability:	Alerts (See table at the end)
CONSULTATION (99245)	\$570.00	\$470.00	\$100.00	\$0.00	\$470.00	\$0.00	\$0.00	<div>! E51</div> <div>! SC1</div>
MEDICAL (12345)	\$50.00	\$40.00	\$10.00	\$0.00	\$40.00	\$0.00	\$0.00	
LABORATORY (12345)	\$120.00	\$100.00	\$20.00	\$0.00	\$100.00	\$0.00	\$0.00	
<b>Total Amount Provider Charged: \$740.00</b>		<b>State Health Plan Member Savings: \$130.00</b>			<b>Total Provider May Bill You: \$610.00</b> (Does not include any payments you've already made.)			

**Provider Name:** Ray's Radiology

**Claim Number:** ## #####-###-##

**Date of Care:** July 30, 2018

Service:	Provider Charged:	Allowed Amount:	In-Network Discount:	State Health Plan Paid:*	Applied to Deductible:	Copayment or Coinsurance:	Not Covered / Other Liability:	Alerts (See table at the end)
X-RAY (91919)	\$99.00	\$50.00	\$49.00	\$0.00	\$50.00	\$0.00	\$0.00	
<b>Total Amount Provider Charged: \$99.00</b>		<b>State Health Plan Member Savings: \$49.00</b>			<b>Total Provider May Bill You: \$50.00</b> (Does not include any payments you've already made.)			

**Provider Name:** Beverly Crusher

**Claim Number:** ## #####-###-##

**Date of Care:** June 22, 2018

Service:	Provider Charged:	Allowed Amount:	In-Network Discount:	State Health Plan Paid:*	Applied to Deductible:	Copayment or Coinsurance:	Not Covered / Other Liability:	Alerts (See table at the end)
MEDICAL (12345)	\$110.00	\$40.00	\$70.00	\$0.00	\$40.00	\$0.00	\$0.00	
LABORATORY (12345)	\$220.00	\$100.00	\$120.00	\$0.00	\$100.00	\$0.00	\$0.00	
<b>Total Amount Provider Charged: \$330.00</b>		<b>State Health Plan Member Savings: \$190.00</b>			<b>Total Provider May Bill You: \$140.00</b> (Does not include any payments you've already made.)			

2 claims for BEATRICE (ID: YPYW#####)

**Provider Name:** Julian Bashir

**Claim Number:** ## #####-###-##

**Date of Care:** July 19, 2018

Service:	Provider Charged:	Allowed Amount:	In-Network Discount:	State Health Plan Paid:*	Applied to Deductible:	Copayment or Coinsurance:	Not Covered / Other Liability:	Alerts (See table at the end)
PREVENTIVE CARE (01010)	\$95.00	\$75.00	\$20.00	\$75.00	\$0.00	\$0.00	\$0.00	
<b>Total Amount Provider Charged: \$95.00</b>		<b>State Health Plan Member Savings: \$95.00</b>			<b>Total Provider May Bill You: \$0.00</b> (You do not need to pay anything on this claim.)			

**Provider Name:** Grey-Sloan Memorial

**Claim Number:** ## #####-###-##

**Date of Care:** July 28, 2018 – July 30, 2018

**The claim below has one or more services denied (see Alerts column).**

Service:	Provider Charged:	Allowed Amount:	In-Network Discount:	State Health Plan Paid:*	Applied to Deductible:	Copayment or Coinsurance:	Not Covered / Other Liability:	Alerts (See table at the end)
HOSPITAL (5555)	\$1,580.00	\$1,000.00	\$580.00	\$0.00	\$0.00	\$0.00	\$1,000.00	<b>E2U</b>
<b>Total Amount Provider Charged: \$1,580.00</b>		<b>State Health Plan Member Savings: \$580.00</b>			<b>Total Provider May Bill You: \$1,000.00</b> (Does not include any payments you've already made.)			

\* **State Health Plan Paid:** The amount the State Health Plan paid for services you received. Please note that this amount may be \$0 if you receive services that go towards your deductible and your deductible has not been met or if your copay is equal to or more than the allowed amount. As a State Health Plan member you receive discounts by using providers that are in-network.

### ! What the alert codes mean:

- E51** Claim adjusted based on provider's fee schedule change.
- SC1** Allowed amount may have been adjusted based on site of service contractual arrangement differential.
- E2U** Claim denied because this service was billed with a different place of service while patient was in an inpatient setting. Member is responsible for any charges reported in "Amount provider may bill you."

### Not sure what a charge is for? Different provider name listed?

Different services can share the same label, like "Medical" or "Laboratory." This helps protect your privacy. If the provider you saw is not the one listed on a claim, another contracted provider in the same practice or facility may have submitted the claim. For details on a specific service, contact your health care provider or call Customer Service at **888-234-2416**. You can learn more about your plan by viewing your benefit booklet at [www.shpnc.org](http://www.shpnc.org).

## TAKE ACTION: BE A WATCHDOG / PROTECT YOUR HEALTH CARE PURSE

**Review the claim(s) that had services denied.** The section titled "Your appeal rights" explains your options and next steps.

**Compare what's in this EOB with any bills sent by your provider. That way, you can make sure everything is correct and you aren't overcharged.** If you have any questions, contact Customer Service at **888-234-2416**.

**If you suspect fraud, abuse or improper billing:** Let us know by calling our confidential hotline at **800-324-4963**.

**To access Blue Connect<sup>SM</sup>, visit [www.shpnc.org](http://www.shpnc.org) and click eBenefits to log in to the Plan's enrollment system. Blue Connect offers great online resources so you can:**

- View detailed benefit information and where you are in terms of meeting your deductible
- Review claim details
- Find a variety of health and wellness discounts using Blue365<sup>®1</sup>

## YOUR PLAN AT A GLANCE

### Year-to-date summary from January 1, 2018 to August 14, 2018

Since some providers do not file claims right away, this may not reflect all services from the current plan year.

**Subscriber Name:** John Sample

**Plan Name:** North Carolina State Health Plan 80/20

**Dependents:** Beatrice Sample

**Subscriber ID:** YPYW#####

**Group ID:** #####

### Payment overview for John:

Once your deductible is met, your plan begins paying a share of the cost.

After reaching your out-of-pocket limit, your plan pays for all covered services.

DEDUCTIBLE (IN-NETWORK)	OUT-OF-POCKET LIMIT (IN-NETWORK)	DEDUCTIBLE (OUT-OF-NETWORK)	OUT-OF-POCKET LIMIT (OUT-OF-NETWORK)
<b>90% met</b>	<b>60% met</b>	<b>7% met</b>	<b>5% met</b>
\$507.11 left to meet this deductible	\$3,007.11 left to reach this limit	\$9,260.00 left to meet this deductible	\$14,260.00 left to reach this limit
Applied To-Date: \$4,492.89	Applied To-Date: \$4,492.89	Applied To-Date: \$740.00	Applied To-Date: \$740.00
Plan's Limit: \$5,000	Plan's Limit: \$7,500	Plan's Limit: \$10,000	Plan's Limit: \$15,000

### Payment overview for Beatrice:

DEDUCTIBLE (IN-NETWORK)	OUT-OF-POCKET LIMIT (IN-NETWORK)	DEDUCTIBLE (OUT-OF-NETWORK)	OUT-OF-POCKET LIMIT (OUT-OF-NETWORK)
<b>2% met</b>	<b>1% met</b>	<b>0% met</b>	<b>0% met</b>
\$4,925.00 left to meet this deductible	\$7,425.00 left to reach this limit	\$10,000.00 left to meet this deductible	\$15,000.00 left to reach this limit
Applied To-Date: \$75.00	Applied To-Date: \$75.00	Applied To-Date: \$0.00	Applied To-Date: \$0.00
Plan's Limit: \$5,000	Plan's Limit: \$7,500	Plan's Limit: \$10,000	Plan's Limit: \$15,000

### Payment overview for your family:

Once your family deductible is met, your plan begins paying a share of the cost for everyone covered by the plan — even if they have not met their individual deductible. After reaching your family out-of-pocket limit, your plan pays for all covered services for everyone under the plan — even if they have not met their individual out-of-pocket limit.

DEDUCTIBLE (IN-NETWORK)	OUT-OF-POCKET LIMIT (IN-NETWORK)	DEDUCTIBLE (OUT-OF-NETWORK)	OUT-OF-POCKET LIMIT (OUT-OF-NETWORK)
<b>91% met</b>	<b>61% met</b>	<b>7% met</b>	<b>5% met</b>
\$432.11 left to meet this deductible	\$2,932.11 left to reach this limit	\$9,260.00 left to meet this deductible	\$14,260.00 left to reach this limit
Applied To-Date: \$4,567.89	Applied To-Date: \$4,567.89	Applied To-Date: \$740.00	Applied To-Date: \$740.00
Plan's Limit: \$5,000	Plan's Limit: \$7,500	Plan's Limit: \$10,000	Plan's Limit: \$15,000

## YOUR APPEAL RIGHTS

Don't agree with a claim decision? You or someone you name to act on your behalf (*an authorized representative*) have the right to appeal it. Blue Cross and Blue Shield of North Carolina (Blue Cross NC) will then review the decision.

### How to appeal

**First, download the forms needed.** You'll find appeal forms and authorization forms (naming someone to act on your behalf) on [www.shpnc.org](http://www.shpnc.org).

**Send the completed forms to Blue Cross NC.** We must receive your written appeal request within 180 days of the date on this Explanation of Benefits (EOB). Be sure to include your name, subscriber ID number, the date of care and the name of the doctor or hospital. Attach any other documents that are relevant to the claim, too. You can then send it by mail or fax.

**Mail your appeal to:**  
State Health Plan c/o Blue Cross NC  
Appeals Department, Level 1  
PO Box 30055  
Durham, NC 27702-3055

**Fax your appeal to:**  
919-765-4409

If your appeal is denied, you may be able to ask for an external review by an independent third party. After reviewing the denial, this independent third party will then issue a final decision.

### For more details on a claim

You can request copies of all documents related to a claim at no cost to you. This may include internal rules or protocols used to make this decision. If our decision is based on medical necessity, experimental treatment or a similar exclusion, it may also include an explanation of the scientific/clinical judgment for the decision based on your medical situation. You can mail this request to: State Health Plan c/o Blue Cross NC; PO Box 30085; Durham, NC 27702. You can also visit [bcbsnc.com/MedicalPolicies](http://bcbsnc.com/MedicalPolicies) or call Customer Service at **888-234-2416**.

### Privacy protection

Detailed service descriptions aren't on EOBs for privacy reasons. But you have the right to know which codes your provider submitted — and what they mean. You can get them directly from the provider or by calling Customer Service at **888-234-2416**.

### North Carolina Department of Insurance (NCDOI)

The NCDOI can answer your health insurance questions. For help with an appeal, call Health Insurance Smart NC at 1-855-408-1212; visit [www.ncdoi.com/Smart](http://www.ncdoi.com/Smart) for the External Review and Request form; or write to them at: NCDOI; Health Insurance Smart NC; 1201 Mail Service Center; Raleigh, NC 27699-1201. To visit in person, you'll find Health Insurance Smart NC's physical address at [www.ncdoi.com/Smart](http://www.ncdoi.com/Smart).

### Help us prevent fraud and protect your State Health Plan!

Please review this EOB carefully. If you suspect fraud, abuse, a mistake or improper billing, let us know. Call the toll-free confidential hotline at **800-324-4963**.

1 Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under the policies with Blue Cross NC. Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Neither Blue Cross NC nor BCBSA recommends, endorses, warrants or guarantees any specific Blue365 vendor or item. This program may be modified or discontinued at any time without prior notice.

BLUE CROSS®, BLUE SHIELD®, the Cross and Shield symbols, registered marks and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other marks and trade names are the property of their respective owners. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association. U13966, 4/18

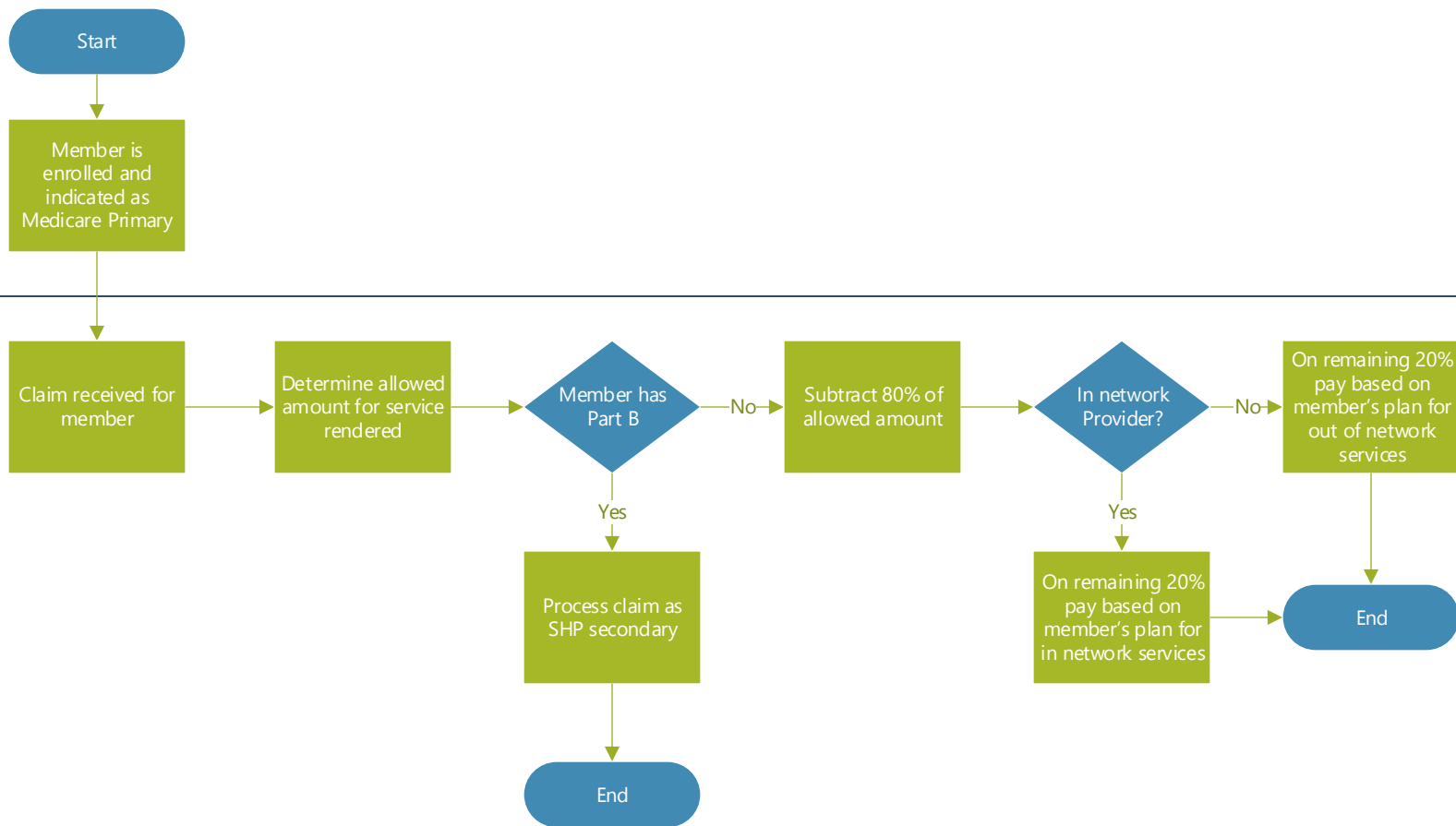
**Have a question about  
your claims or benefits?**

Please contact Customer Service  
at **888-234-2416**.

## Exhibit 9 Claims Processing Phantom Plan – Medicare Part B

EES Vendor

TPA Vendor

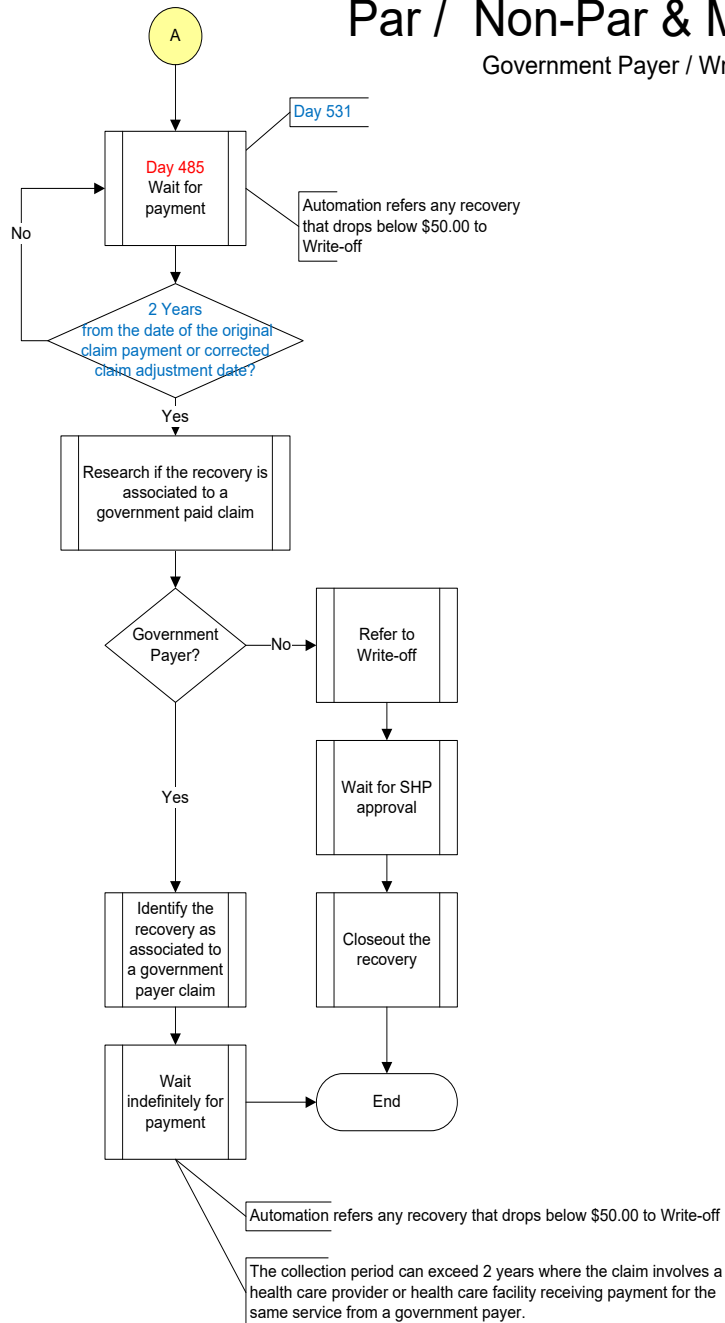


5-Feb-16

## Exhibit 10 State Health Plan Recovery Workflows

### Par / Non-Par & MTF Provider

Government Payer / Write-Off Logic



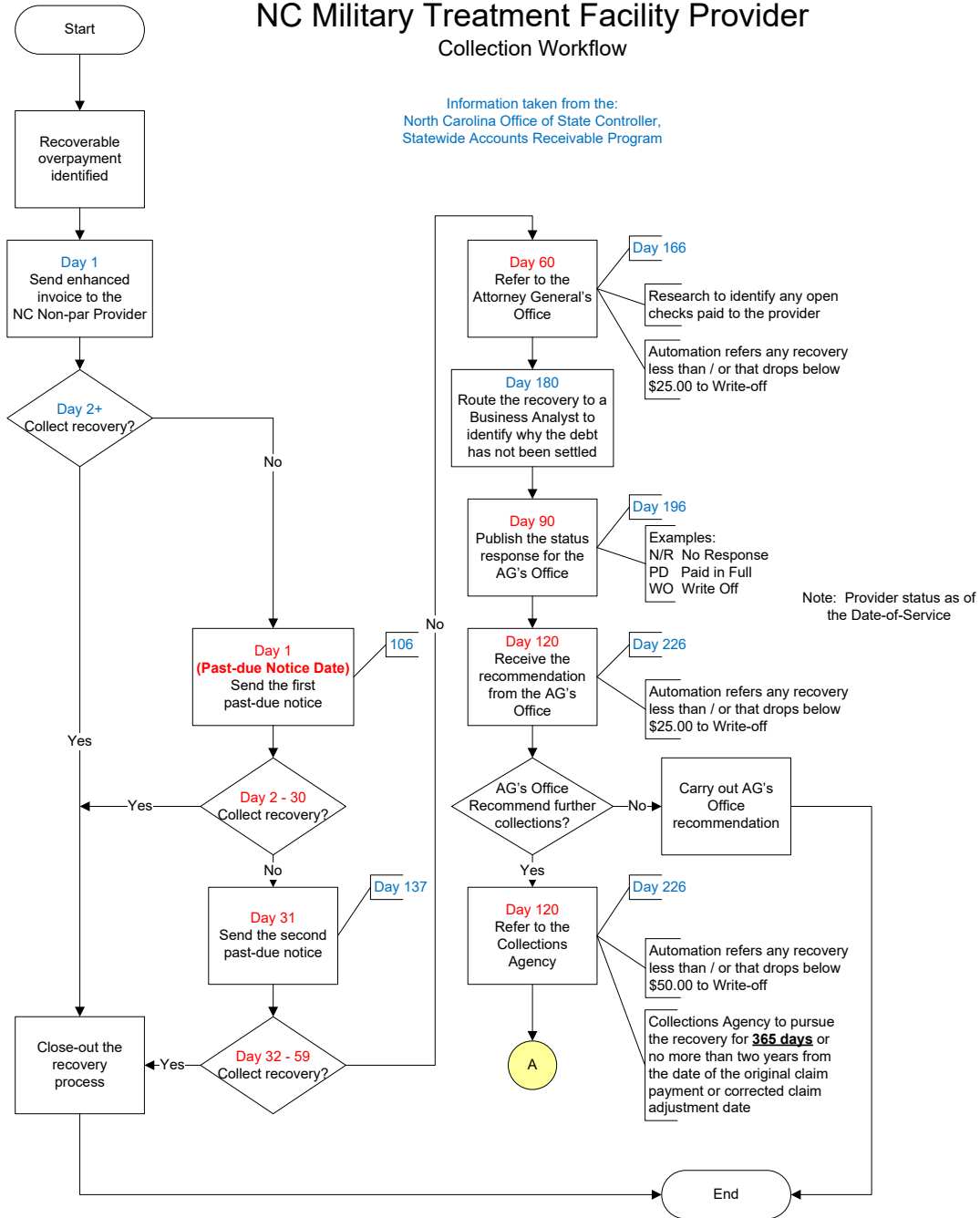
16-Aug-13

### Military Treatment Provider Workflow

# Exhibit 10 State Health Plan Recovery Workflows

## NC Military Treatment Facility Provider Collection Workflow

Information taken from the:  
North Carolina Office of State Controller,  
Statewide Accounts Receivable Program



Note: A provider recovery will be referred to write-off at any point in the process flow if the recovery is greater than or equal to 2 years from the date of original claim payment or corrected claim adjustment date **and** the recovery does not involve a health care provider or health care facility receiving payment for the same service from a government payer.

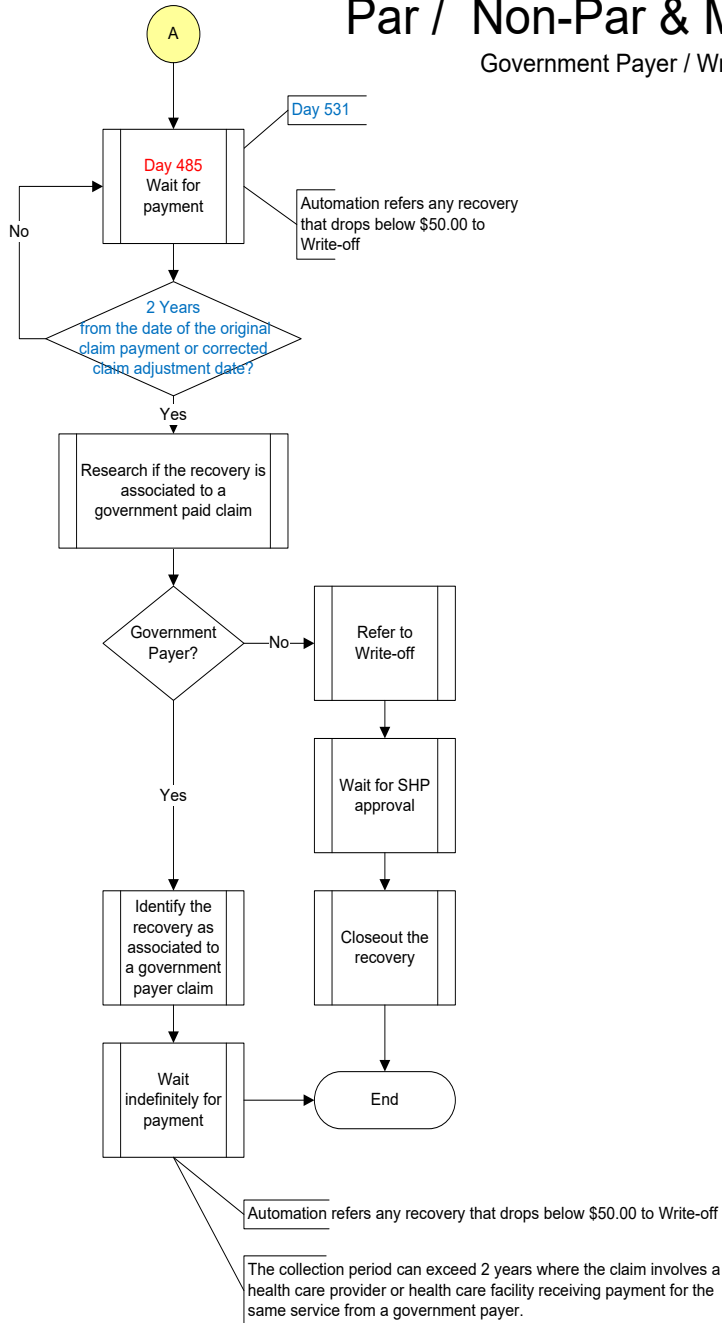
5-Feb-16



## Exhibit 10 State Health Plan Recovery Workflows

### Par / Non-Par & MTF Provider

Government Payer / Write-Off Logic



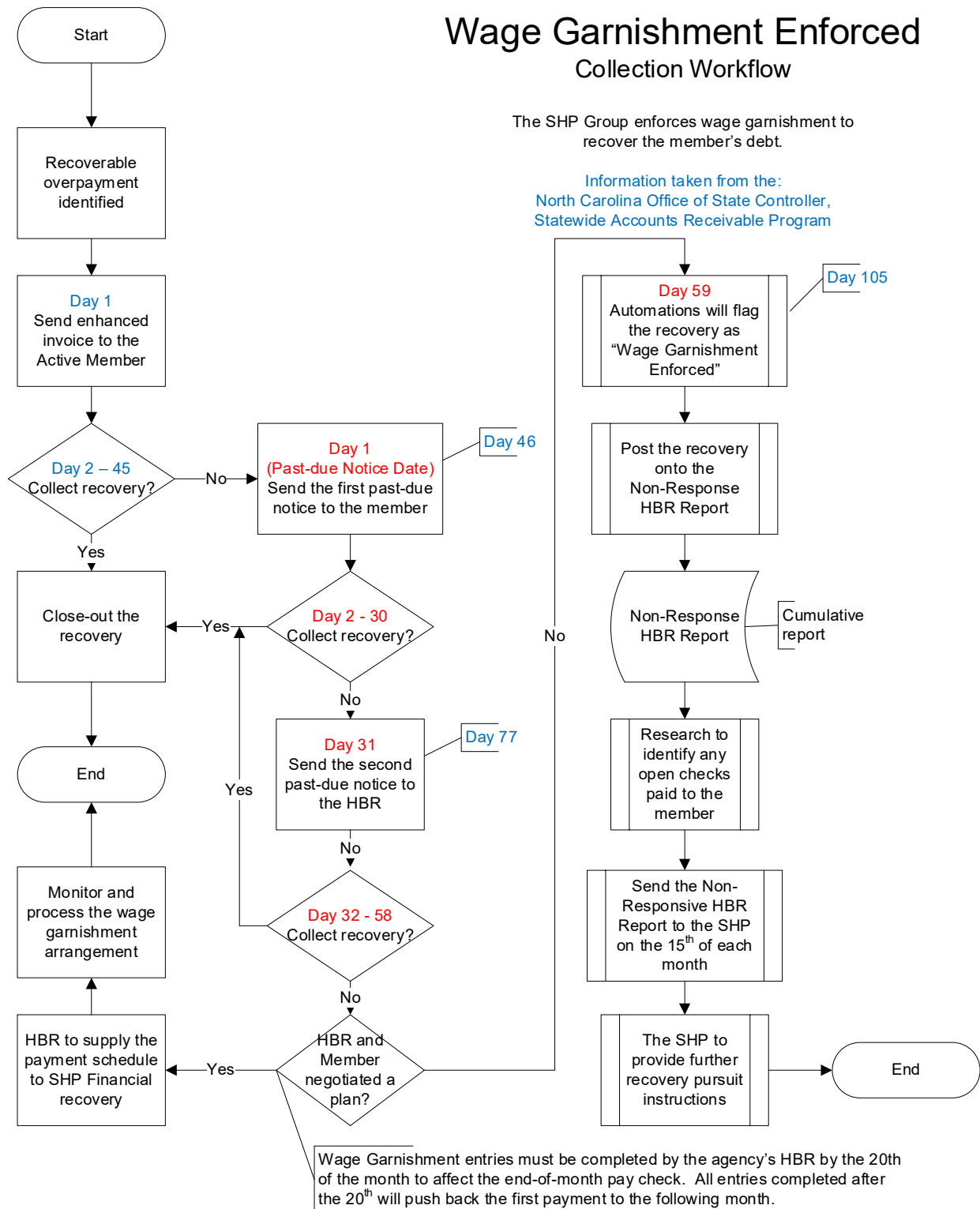
16-Aug-13

Active Member Workflow

## Active Member Wage Garnishment Enforced Collection Workflow

The SHP Group enforces wage garnishment to recover the member's debt.

Information taken from the:  
North Carolina Office of State Controller,  
Statewide Accounts Receivable Program

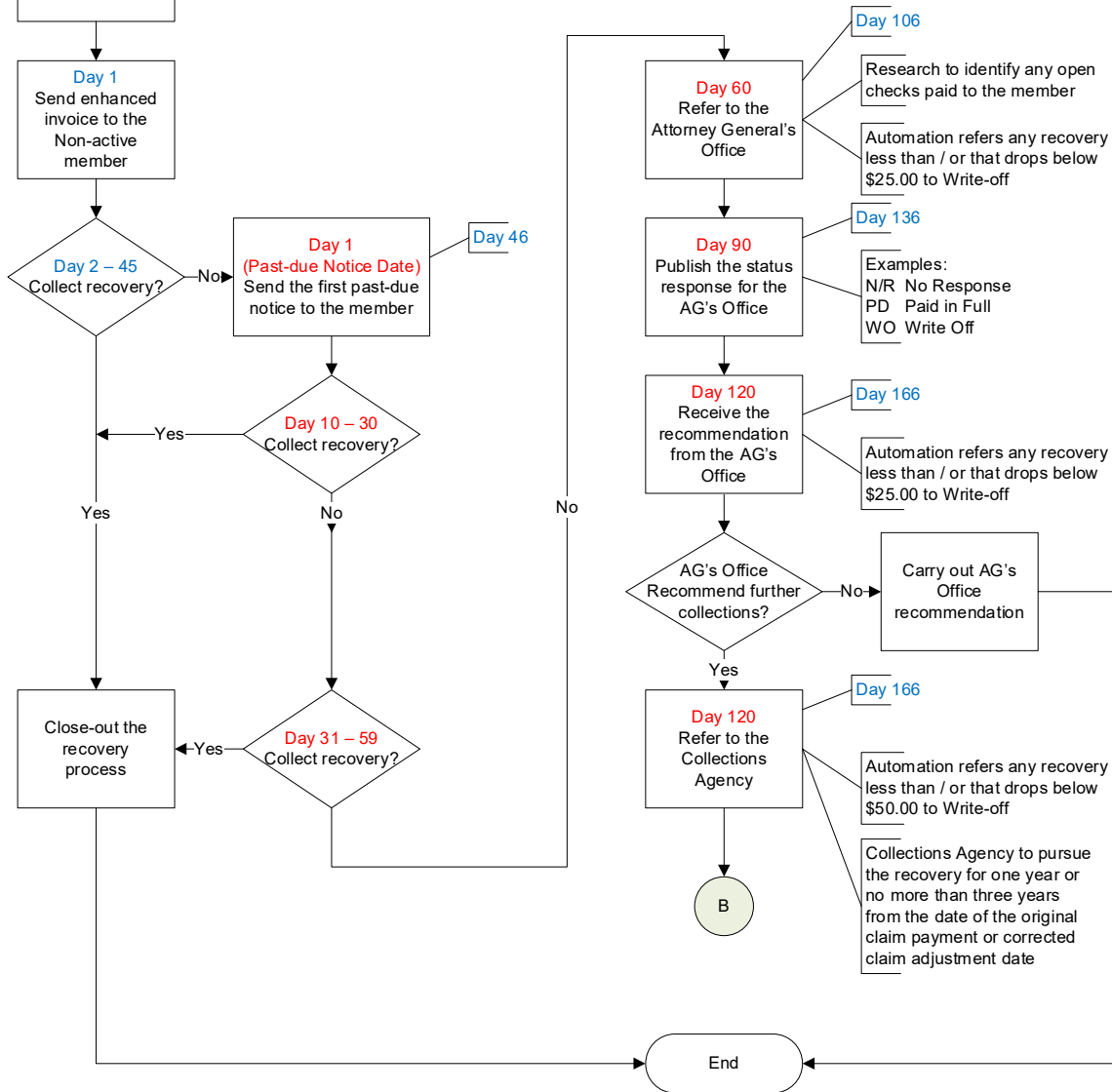


### Non-Active Member Workflow

# Non-Active Member

## Collection Workflow

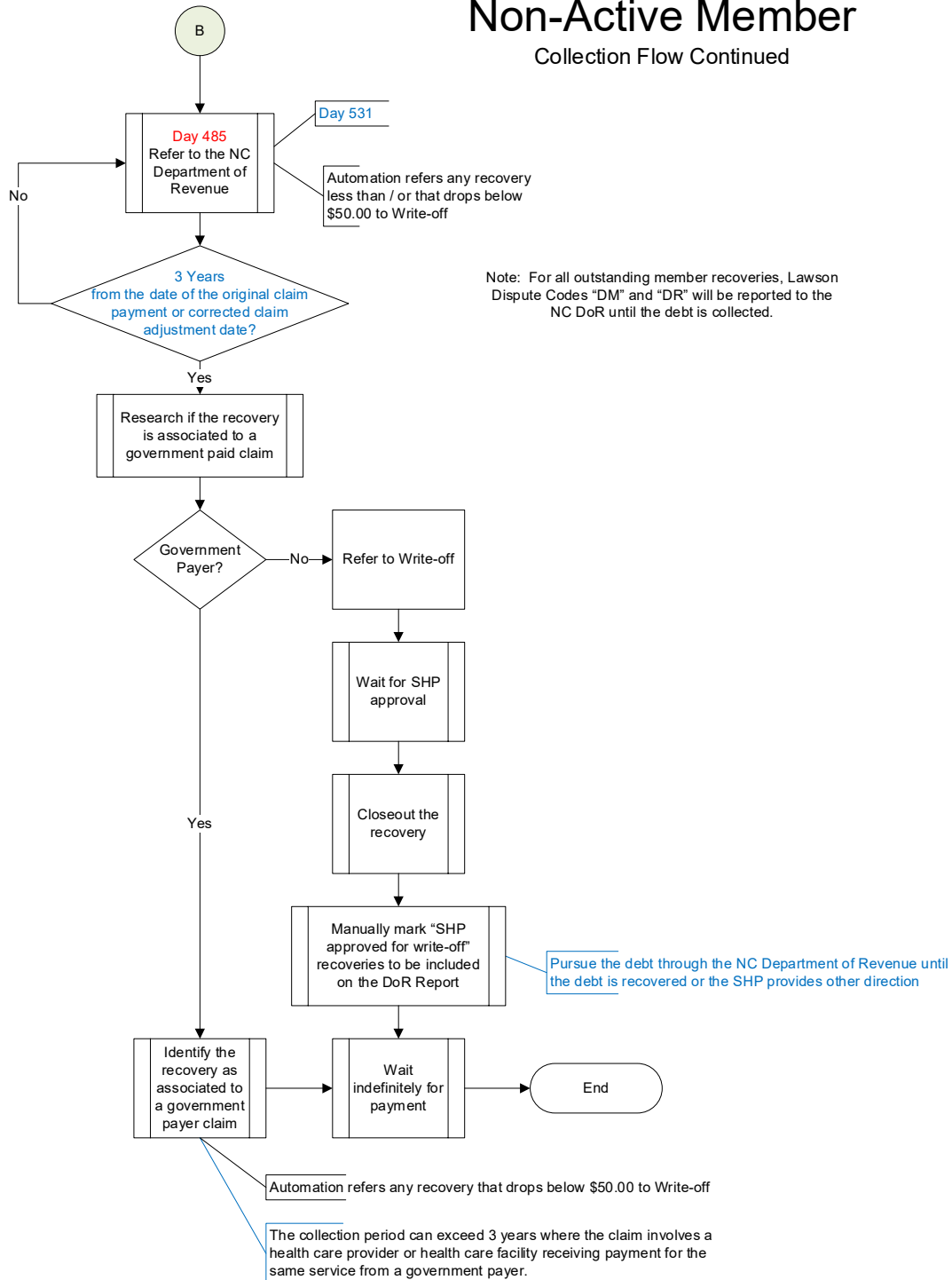
Information taken from the:  
North Carolina Office of State Controller,  
Statewide Accounts Receivable Program



Note: A member recovery will be referred to write-off at any point in the process flow if the recovery is greater than or equal to 3 years from the date of original claim payment or corrected claim adjustment date **and** the recovery does not involve a health care provider or health care facility receiving payment for the same service from a government payer.

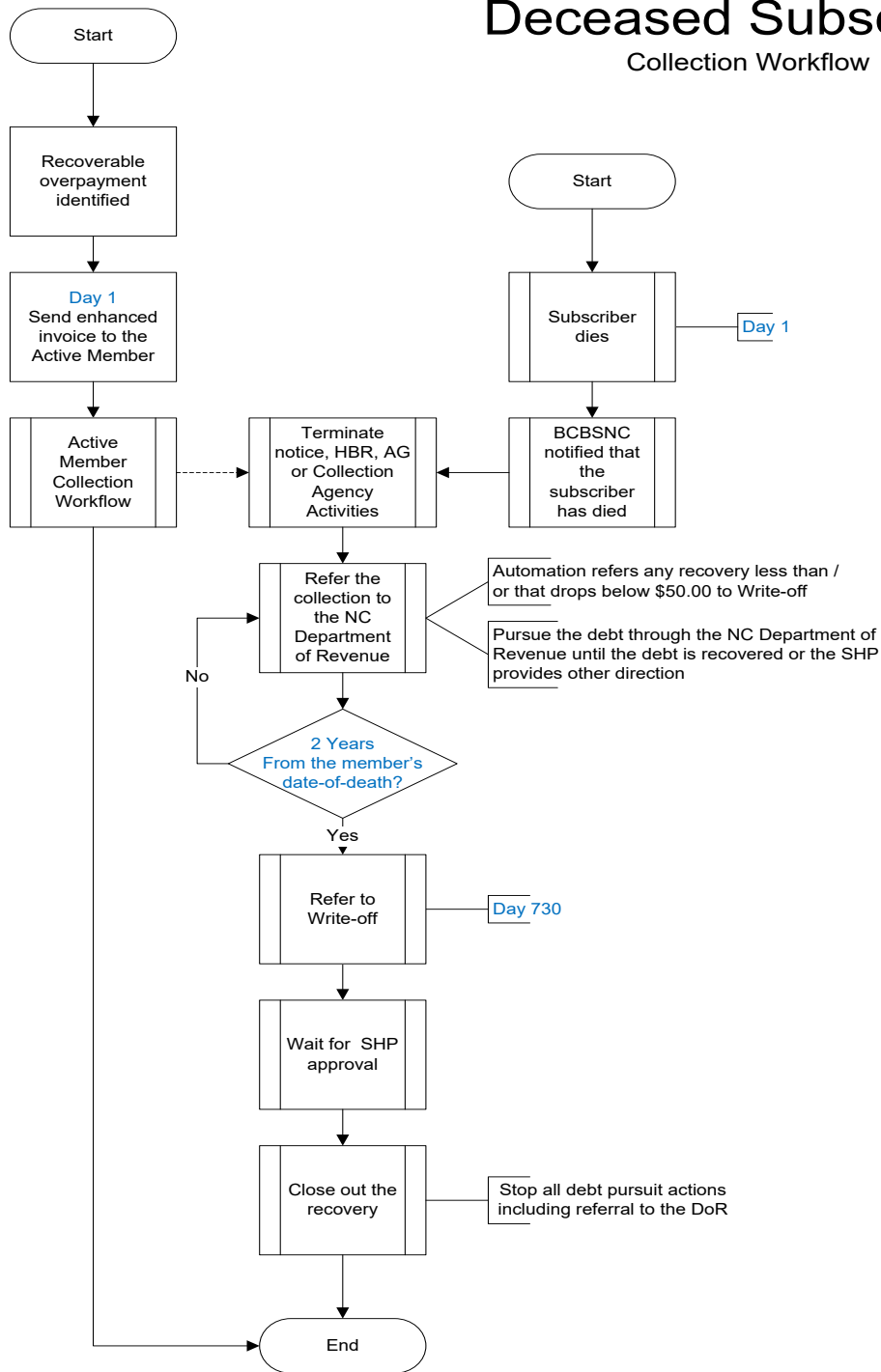
# Non-Active Member

## Collection Flow Continued



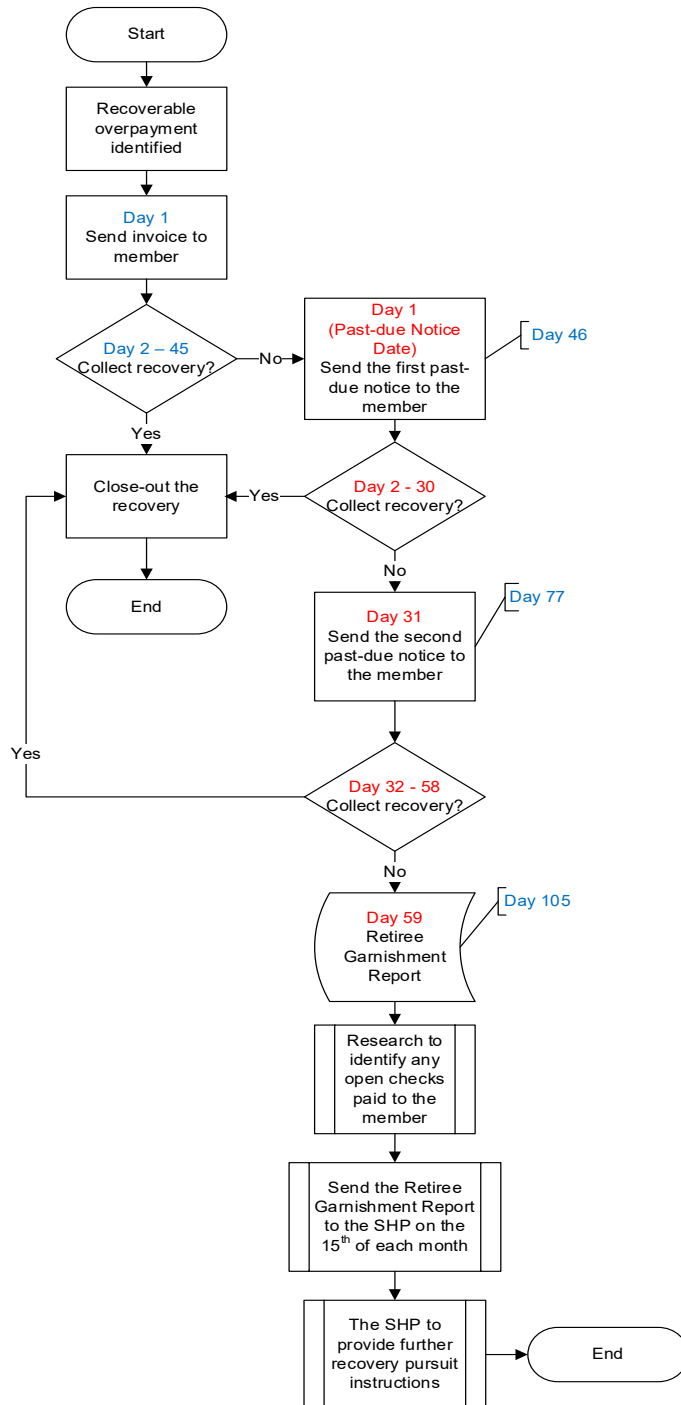
# Deceased Subscriber

## Collection Workflow



## Exhibit 10 State Health Plan Recovery Workflows

### Retiree Member Workflow



### Retiree Debt Offset Collection Workflow

Information taken from the:  
North Carolina Office of State Controller,  
Statewide Accounts Receivable Program

Note: A member recovery will be referred to write-off at any point in the process flow if the recovery is greater than or equal to 3 years from the date of original claim payment or corrected claim adjustment date **and** the recovery does not involve a health care provider or health care facility receiving payment for the same service from a government payer.

8-Sept-17

## Exhibit 11 Standard Reports

Number	Name	Frequency
<b>Claims Reports</b>		
CLM001	Processed Claims Report	Monthly-20 <sup>th</sup>
CLM002	Deductible & Out of Pocket Maximums by Plan and Month	Quarterly-due forty five (45) days after the end of each quarter
CLM003	Monthly COB Report	Monthly - 20 <sup>th</sup>
CLM004	Quarterly Summary of Denied Claims Report	Quarterly-due forty five (45) days after the end of each quarter
CLM005	High Claimant Report	Quarterly-due forty five (45) days after the end of each quarter
CLM006	Appeals Reports	Monthly-20 <sup>th</sup>
CLM007	Monthly Pharmacy Appeals Detail Report	Monthly-20 <sup>th</sup>
<b>Customer Experience Reports</b>		
CUS001	Operations Dashboard	Weekly-Thursday-End of Day
CUS002	Web Trends Report	Quarterly-due forty five (45) days after the end of each quarter
<b>Finance Reports</b>		
FIN001	Accounts Receivable Aging Report	Monthly-13 <sup>th</sup>
FIN002	Uncollectible Accounts Report	Quarterly-due forty five (45) days after the end of each quarter
FIN003	Prepaid Premiums Report	Monthly-15 <sup>th</sup>
FIN004	Daily Deposit Report	Daily-Receive by 10:00 a.m.
FIN005	Not Sufficient Funds Report	Daily-5:00 p.m.
FIN006	Misapplied Deposits and/or Collections Report	Monthly-20 <sup>th</sup>
FIN007	Net Disbursement Reporting Package	Weekly-due by 9:30 a.m.-1st State Business day of week
FIN008	Deposit Reconciliation Report	Monthly-5 <sup>th</sup>
FIN009	Reconciliation of Claims and Other Disbursements Report	Monthly-13 <sup>th</sup>
FIN010	Escheats	Annually and as Otherwise Needed- no less than 20 calendar days prior to Vendor's planned date for escheating funds to the state based on the State's required deadline
FIN011	PPO Summary of Billed Charges by State Fiscal Year Report	Monthly-20 <sup>th</sup>
FIN012	Statement of Account (SOA) by State Fiscal Year Report	Monthly-20 <sup>th</sup>
<b>Financial Performance Reports</b>		
FP001	Performance Guarantee Report	Monthly-20 <sup>th</sup>

FP002	Performance Guarantee Report	Quarterly-due forty five (45) days after the end of each quarter
FP003	Performance Guarantee Report	Annually - due forty five (45) days after the end of the calendar year
FP004	Triangulation Report by Plan Option	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
FP005	Triangulation Report by Service	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
FP006	Prompt Pay Interest Report	Monthly-20 <sup>th</sup>
FP007	Open Invoice Report	Weekly-Thursday-End of Day
<b>Matrix Reports</b>		
MAT001	Charge Summary Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT002	Charge Summary Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT003	Charge Summary Trend Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT004	Charge Summary Trend Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT005	Coinsurance & Deductible, Full Population-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT006	Coinsurance & Deductible, Full Population-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT007	Coinsurance & Deductible, Closed Population-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT008	Coinsurance & Deductible, Closed Population-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT009	Copay-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT010	Copay-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT011	Copay--Incurred (Claims Runout) Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT012	Claims Experience Summary by Age and Sex-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT013	Claims Experience Summary by Age and Sex-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th



MAT014	Financial Summary-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT015	Financial Summary-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT016	Financial Reconciliation-Paid Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT017	Financial Reconciliation-Incurred Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
MAT018	Member Utilization and Cost-Share by Type of Service Report	Monthly-20 <sup>th</sup> - Except the fiscal year end report (June) which must be received by July 15th
<b>Membership Reports</b>		
MEM001	Monthly Member Reporting Package	Monthly-15 <sup>th</sup>
<b>Operations Reports</b>		
OPS001	Weekly Membership report	Weekly-due by 10:00 a.m.-1st State Business day of week
OPS002	PCP Election Report	Monthly-20 <sup>th</sup>
<b>Network Management Reports</b>		
NM001	GeoAccess Report	Quarterly-due forty five (45) days after the end of each quarter
<b>Pharmacy Reports</b>		
PHM001	Specialty Pharmacy Rebates Report	Quarterly-due forty five (45) days after the end of each quarter
<b>Medical Management Reports</b>		
MM001	Medical Costs and Clinical Outcomes	Quarterly-to coincide with the Program Performance Meeting
MM002	Case Management Clinical Outcomes	Quarterly-to coincide with the Program Performance Meeting
MM003	Preventive Care Services Utilization	Quarterly-to coincide with the Program Performance Meeting
MM004	Utilization Management	Quarterly-to coincide with the Program Performance Meeting
MM005	Utilization Management	Annually-to coincide with the fourth-quarter Program Performance Meeting
MM006	Clinical Quality Improvement	Quarterly-to coincide with the Program Performance Meeting
MM007	Annual Medical Policy Change Review Report	Annually - Due in October for Plan's review and approval for January 1 implementation
<b>Recovery and SIU Reports</b>		
REC001	Recovery Reporting Package	Monthly-20th
REC006	Special Investigation Reporting Package	Monthly-20th

REC007	Audit Repayment Reporting Package	Thirty (30) days after the final medical cliams audit report is issued

**Exhibit 12**  
**Matrix**  
**Reports**

**MATRIX #1**

**State Health Plan for Teachers and State Employees**  
**Charge Summary - Paid**  
**Report Period: Claims Paid**  
**Active Employee Groups- Traditional (See Note Below)**

	QTD			CYTD			
	Paid April 1 through June 30, 2016			Paid January 1 through June 30, 2016			
	Employees	Dependents	Totals	Employees	Dependents	Totals	*Percent
1. Billed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
2. Non Covered	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
3. Allowed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
4. Member Liability							
A. Member Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
B. Member Coinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
C. Member Copay	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
<b>Total Member Liability</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0 NA</b>
5. Coordination of Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
6. Financial Adjustments	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
7. Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA

**\*PERCENTAGE OF ALLOWED CHARGES**

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #2**

**State Health Plan for Teachers and State Employees**  
**Charge Summary - Incurred**  
**Report Period: Claims Incurred**  
**Active Employee Groups- Traditional (See Note Below)**

	QTD			CYTD			
	Incurred April 1 through June 30, 2016			Incurred January 1 through June 30, 2016			
	Employees	Dependents	Totals	Employees	Dependents	Totals	*Percent
1. Billed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
2. Non Covered	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
3. Allowed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
4. Member Liability							
A. Member Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
B. Member Coinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
C. Member Copay	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
Total Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
5. Coordination of Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
6. Financial Adjustments	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA
7. Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0 NA

**\*PERCENTAGE OF ALLOWED CHARGES**

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #3**

**State Health Plan for Teachers and State Employees**  
**Trend Paid**  
**Report Period: Claims Paid January 1 through June 30, 2016**  
**Active Employee Groups- Traditional (See Note Below)**

Fiscal Quarter                2

Month/Year	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
January 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
February 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
March 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
April 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
May 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
June 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
July 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
August 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
September 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
October 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
November 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
December 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Totals</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>QTD Totals</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #4**

**State Health Plan for Teachers and State Employees**  
**Trend Incurred**  
**Report Period: Claims Incurred January 1 through June 30, 2016**  
**Active Employee Groups- Traditional (See Note Below)**

Fiscal Quarter            **2**

Month/Year	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
January 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
February 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
March 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
April 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
May 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
June 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
July 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
August 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
September 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
October 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
November 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
December 2016	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Totals</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>QTD Totals</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

## MATRIX #5

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
**Traditional Actives (See Note Below) - Full Population**  
**Report Period: Claims Paid January 1 through June 30, 2016**

Allowed Band	Claimants	Non Covered	Allowed Charges	Member Copay	Net Allowed	Member Deductible	Member Coinsurance	COB	Financial Adjustments	Payments	Reduction	% Diff
LESS_THAN_\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0.01_\$100.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$100.01_\$200.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$200.01_\$300.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$300.01_\$400.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$400.01_\$500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$500.01_\$600.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$600.01_\$700.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$700.01_\$800.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$800.01_\$900.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$900.01_\$1,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,000.01_\$1,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,500.01_\$2,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,000.01_\$2,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,500.01_\$3,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$3,000.01_\$5,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$5,000.01_\$10,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$10,000.01_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
OVER_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
<b>TOTAL</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.00%</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #5 (continued)

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
*Traditional Actives - Full Population*  
**Report Period: Claims Paid January 1 through June 30, 2016**

	Avg Allowed Charges	Avg Member Copay	Avg Net Allowed	Avg Member Deductible	Avg Member Coinsurance	Avg COB	Avg Payments
LESS_THAN_\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$.01_\$100.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$100.01_\$200.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$200.01_\$300.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$300.01_\$400.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$400.01_\$500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$500.01_\$600.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$600.01_\$700.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$700.01_\$800.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$800.01_\$900.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$900.01_\$1,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,000.01_\$1,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,500.01_\$2,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,000.01_\$2,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,500.01_\$3,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$3,000.01_\$5,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$5,000.01_\$10,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$10,000.01_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OVER_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$0	\$0	\$0	\$0	\$0	\$0	\$0



## MATRIX #6

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
**Traditional Actives (See Note Below) - Full Population**  
**Report Period: Claims Incurred January 1 through June 30, 2016**

Allowed Band	Claimants	Non Covered	Allowed Charges	Member Copay	Net Allowed	Member Deductible	Member Coinsurance	COB	Financial Adjustments	Payments	Reduction	% Diff
LESS_THAN_\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0.01_\$100.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$100.01_\$200.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$200.01_\$300.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$300.01_\$400.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$400.01_\$500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$500.01_\$600.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$600.01_\$700.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$700.01_\$800.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$800.01_\$900.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$900.01_\$1,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,000.01_\$1,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,500.01_\$2,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,000.01_\$2,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,500.01_\$3,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$3,000.01_\$5,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$5,000.01_\$10,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$10,000.01_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
OVER_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
<b>TOTAL</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.00%</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #6 (continued)

## State Health Plan for Teachers and State Employees

### Coinsurance & Deductible Levels

### Traditional Actives - Full Population

Report Period: Claims Incurred January 1 through June 30, 2016

	Avg Allowed Charges	Avg Member Copay	Avg Net Allowed	Avg Member Deductible	Avg Member Coinsurance	Avg COB	Avg Payments
LESS_THAN_\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$.01_\$100.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$100.01_\$200.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$200.01_\$300.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$300.01_\$400.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$400.01_\$500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$500.01_\$600.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$600.01_\$700.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$700.01_\$800.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$800.01_\$900.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$900.01_\$1,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,000.01_\$1,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,500.01_\$2,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,000.01_\$2,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,500.01_\$3,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$3,000.01_\$5,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$5,000.01_\$10,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$10,000.01_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OVER_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$0	\$0	\$0	\$0	\$0	\$0	\$0

## MATRIX #7

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
**Traditional Actives (See Note Below) - Closed Population**  
**Report Period: Claims Paid January 1 through June 30, 2016**

Allowed Band	Claimants	Non Covered	Allowed Charges	Member Copay	Net Allowed	Member Deductible	Member Coinsurance	COB	Financial Adjustments	Payments	Reduction	% Diff
LESS_THAN_\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0.01_\$100.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$100.01_\$200.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$200.01_\$300.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$300.01_\$400.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$400.01_\$500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$500.01_\$600.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$600.01_\$700.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$700.01_\$800.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$800.01_\$900.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$900.01_\$1,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,000.01_\$1,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,500.01_\$2,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,000.01_\$2,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,500.01_\$3,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$3,000.01_\$5,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$5,000.01_\$10,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$10,000.01_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
OVER_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
<b>TOTAL</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.00%</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #7 (continued)

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
*Traditional Actives - Closed Population*  
**Report Period: Claims Paid January 1 through June 30, 2016**

	Avg Allowed Charges	Avg Member Copay	Avg Net Allowed	Avg Member Deductible	Avg Member Coinsurance	Avg COB	Avg Payments
LESS_THAN_\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$.01_\$100.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$100.01_\$200.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$200.01_\$300.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$300.01_\$400.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$400.01_\$500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$500.01_\$600.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$600.01_\$700.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$700.01_\$800.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$800.01_\$900.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$900.01_\$1,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,000.01_\$1,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,500.01_\$2,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,000.01_\$2,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,500.01_\$3,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$3,000.01_\$5,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$5,000.01_\$10,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$10,000.01_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OVER_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$0	\$0	\$0	\$0	\$0	\$0	\$0

## MATRIX #8

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
***Traditional Actives (See Note Below) - Closed Population***  
**Report Period: Claims Incurred January 1 through June 30, 2016**

Allowed Band	Claimants	Non Covered	Allowed Charges	Member Copay	Net Allowed	Member Deductible	Member Coinsurance	COB	Financial Adjustments	Payments	Reduction	% Diff
LESS_THAN_\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$0.01_\$100.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$100.01_\$200.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$200.01_\$300.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$300.01_\$400.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$400.01_\$500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$500.01_\$600.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$600.01_\$700.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$700.01_\$800.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$800.01_\$900.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$900.01_\$1,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,000.01_\$1,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$1,500.01_\$2,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,000.01_\$2,500.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$2,500.01_\$3,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$3,000.01_\$5,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$5,000.01_\$10,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
\$10,000.01_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
OVER_\$20,000.00	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	0.00%
<b>TOTAL</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.00%</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #8 (continued)

**State Health Plan for Teachers and State Employees**  
**Coinsurance & Deductible Levels**  
*Traditional Actives - Closed Population*  
**Report Period: Claims Incurred January 1 through June 30, 2016**

	Avg Allowed Charges	Avg Member Copay	Avg Net Allowed	Avg Member Deductible	Avg Member Coinsurance	Avg COB	Avg Payments
Allowed Band							
LESS_THAN_\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$.01_\$100.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$100.01_\$200.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$200.01_\$300.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$300.01_\$400.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$400.01_\$500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$500.01_\$600.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$600.01_\$700.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$700.01_\$800.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$800.01_\$900.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$900.01_\$1,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,000.01_\$1,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,500.01_\$2,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,000.01_\$2,500.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$2,500.01_\$3,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$3,000.01_\$5,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$5,000.01_\$10,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$10,000.01_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OVER_\$20,000.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL	\$0	\$0	\$0	\$0	\$0	\$0	\$0

## MATRIX #10

**State Health Plan for Teachers and State Employees**  
**Copay Report - Paid Claims**  
**CYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of	Number of	Billed	Non	Allowed	Member	Member	Member	Financial		
EMPLOYEE - QTD	Claimants	Visits	Charges	Covered	Charges	Deductible	Coinsurance	Copay	COB	Adjustments	Payments
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Type of Service:											
DEPENDENT - QTD											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Type of Service:											
TOTAL - QTD											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #10 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Paid Claims**  
**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
<b>EMPLOYEE - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>DEPENDENT - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>TOTAL - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.



MATRIX #10 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Paid Claims**  
**CYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>DEPENDENT - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>TOTAL - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #10 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Paid Claims**  
**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>DEPENDENT - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>TOTAL - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

## MATRIX #11

**State Health Plan for Teachers and State Employees**  
**Copay Report - Incurred Claims**  
**CYTD= January 1 through June 30, 2016    QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
<b>EMPLOYEE - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>DEPENDENT - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>TOTAL - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #11 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Incurred Claims**  
**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
<b>EMPLOYEE - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>DEPENDENT - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>											
<b>TOTAL - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #11 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Incurred Claims**  
**CYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
*Traditional - Actives (See Note Below)*

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>DEPENDENT - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>TOTAL - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #11 (continued)

**State Health Plan for Teachers and State Employees**  
**Copay Report - Incurred Claims**  
**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
*Traditional - Actives (See Note Below)*

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>DEPENDENT - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

<b>Type of Service:</b>									
<b>TOTAL - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

**State Health Plan for Teachers and State Employees**  
**Claims Experience by Age and Sex**  
***Traditional Actives (See Note Below)***  
**Total Payments**  
**Report Period: Claims Incurred January 1 through June 30, 2016**

Age Band	Employees		Dependents		Total		Total
	Male	Female	Male	Female	Male	Female	
0 - 4	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5 - 9	\$0	\$0	\$0	\$0	\$0	\$0	\$0
10 - 14	\$0	\$0	\$0	\$0	\$0	\$0	\$0
15 - 19	\$0	\$0	\$0	\$0	\$0	\$0	\$0
20 - 24	\$0	\$0	\$0	\$0	\$0	\$0	\$0
25 - 29	\$0	\$0	\$0	\$0	\$0	\$0	\$0
30 - 34	\$0	\$0	\$0	\$0	\$0	\$0	\$0
35 - 39	\$0	\$0	\$0	\$0	\$0	\$0	\$0
40 - 44	\$0	\$0	\$0	\$0	\$0	\$0	\$0
45 - 49	\$0	\$0	\$0	\$0	\$0	\$0	\$0
50 - 54	\$0	\$0	\$0	\$0	\$0	\$0	\$0
55 - 59	\$0	\$0	\$0	\$0	\$0	\$0	\$0
60 - 64	\$0	\$0	\$0	\$0	\$0	\$0	\$0
65 - 69	\$0	\$0	\$0	\$0	\$0	\$0	\$0
70 - 74	\$0	\$0	\$0	\$0	\$0	\$0	\$0
75 - 79	\$0	\$0	\$0	\$0	\$0	\$0	\$0
> 79	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Unknown	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #12 (continued)

**State Health Plan for Teachers and State Employees**  
**Claims Experience by Age and Sex**  
*Traditional Actives (See Note Below)*  
**Average Monthly Membership**  
**Report Period: Claims Incurred January 1 through June 30, 2016**

Age Band	Employees		Dependents		Total		Total
	Male	Female	Male	Female	Male	Female	
0 - 4	0	0	0	0	0	0	0
5 - 9	0	0	0	0	0	0	0
10 - 14	0	0	0	0	0	0	0
15 - 19	0	0	0	0	0	0	0
20 - 24	0	0	0	0	0	0	0
25 - 29	0	0	0	0	0	0	0
30 - 34	0	0	0	0	0	0	0
35 - 39	0	0	0	0	0	0	0
40 - 44	0	0	0	0	0	0	0
45 - 49	0	0	0	0	0	0	0
50 - 54	0	0	0	0	0	0	0
55 - 59	0	0	0	0	0	0	0
60 - 64	0	0	0	0	0	0	0
65 - 69	0	0	0	0	0	0	0
70 - 74	0	0	0	0	0	0	0
75 - 79	0	0	0	0	0	0	0
> 79	0	0	0	0	0	0	0
Unknown	0	0	0	0			
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.



MATRIX #12 (continued)

**State Health Plan for Teachers and State Employees**  
**Claims Experience by Age and Sex**  
*Traditional Actives (See Note Below)*  
**Average Payment PMPM**  
**Report Period: Claims Incurred January 1 through June 30, 2016**

Age Band	Employees		Dependents		Total		Total
	Male	Female	Male	Female	Male	Female	
0 - 4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5 - 9	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
10 - 14	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
15 - 19	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
20 - 24	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25 - 29	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
30 - 34	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
35 - 39	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
40 - 44	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
45 - 49	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
50 - 54	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
55 - 59	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
60 - 64	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
65 - 69	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
70 - 74	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
75 - 79	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
> 79	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Unknown							
<b>TOTAL</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**State Health Plan for Teachers and State Employees  
Claims Experience Summary- Incurred**

**Active Employee Groups - Traditional (See Note Below)**

**Quarter to Date- Apr 1 through Jun 30, 2016**

**Calendar Year to Date- Jan 1 through Jun 30, 2016**

Place of Service	Type of Provider	Type of Service	QTD Emps	QTD Deps	QTD Total	% of QTD Grand Total	YTD Emps	YTD Deps	YTDTotal	% of YTD Grand Total
1 Inpatient	1 Institutional	Inpatient Maternity - Mother	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Maternity - Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Maternity - Well Newborn	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Psychiatric - Alcohol and Drug	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Psychiatric - Non Alcohol Non Drug	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Inpatient Surgical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	1 Institutional	Skilled Nursing Facility	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Anesthesia - Excluding Maternity	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Anesthesia - Maternity Cesarean Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Anesthesia - Maternity Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Anesthesia - Maternity Normal Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Assistant Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Cardiovascular	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

1 Inpatient	2 Professional	Consults	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Dialysis	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Hearing/Speech Exams	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Inpatient Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Maternity - Cesarean Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Maternity - Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Maternity - Normal Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Observation Physicians Visit	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Physical Medicine	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Preventive Medicine - Physical Exam	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Professional Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Professional Radiology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Psychiatric - Alcohol and Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Psychiatric - Non Alcohol and Non Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	2 Professional	Therapeutic Injections	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient	3 Other Services	DME, Supplies and Equipment	\$0	\$0	\$0	%	\$0	\$0	\$0	%
1 Inpatient Total			\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Cardiovascular	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Emergency Room	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

2 Outpatient	1 Institutional	Outpatient Maternity	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Other	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Pharmacy and Blood	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Psychiatric	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient PT/OT/ST	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Radiology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	1 Institutional	Outpatient Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Allergy Testing	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Anesthesia - Excluding Maternity	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Anesthesia - Maternity Cesarean Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Anesthesia - Maternity Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Assistant Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Cardiovascular	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Chiropractic	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

2 Outpatient	2 Professional	Consults	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Dialysis	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Emergency Room Physicians Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Hearing/Speech Exams	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Maternity - Cesarean Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Maternity - Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Maternity - Normal Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Observation Physicians Visit	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Office/Home E&M Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Physical Medicine	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Preventive Medicine - Physical Exam	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Professional Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Professional Radiology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Prosthetics	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

2 Outpatient	2 Professional	Psychiatric - Alcohol and Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Psychiatric - Non Alcohol and Non Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Therapeutic Injections	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	2 Professional	Vision Exams	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	DME, Supplies and Equipment	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Outpatient Anesthesia	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Outpatient Other	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Outpatient Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Outpatient Pharmacy and Blood	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient	3 Other Services	Outpatient Residential Services	\$0	\$0	\$0	%	\$0	\$0	\$0	%
2 Outpatient Total			\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	1 Institutional	Outpatient Maternity	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	1 Institutional	Outpatient Other	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	1 Institutional	Outpatient Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

3 Other	2 Professional	Allergy Immunotherapy	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Allergy Testing	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Anesthesia - Excluding Maternity	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Assistant Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Cardiovascular	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Chiropractic	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Consults	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Dialysis	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Emergency Room Physicians Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Glasses/Contacts	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Hearing/Speech Exams	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Immunizations	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Maternity - Non Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Maternity - Normal Delivery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Office/Home E&M Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Physical Medicine	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Preventive Medicine - Physical Exam	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Preventive Medicine - Well Baby Exam	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Professional Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Professional Radiology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Prosthetics	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Psychiatric - Alcohol and Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #13

3 Other	2 Professional	Psychiatric - Non Alcohol and Non Drugs	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Surgery	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Therapeutic Injections	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Urgent Care Visits	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	2 Professional	Vision Exams	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Dental	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Dialysis	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	DME, Supplies and Equipment	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Medical	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Outpatient Other	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Private Duty Nursing	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Professional Ambulance	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Professional Pathology	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other	3 Other Services	Prosthetics	\$0	\$0	\$0	%	\$0	\$0	\$0	%
3 Other Total			\$0	\$0	\$0	%	\$0	\$0	\$0	%
Grand Total			\$0	\$0	\$0	%	\$0	\$0	\$0	%

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.



**MATRIX #14**

**State Health Plan for Teachers and State Employees**  
**Financial Summation Report- Paid Amounts**  
**Active Employees (See Note Below)**  
**Claims Paid January 1 through June 30, 2016**

	QUARTER TO DATE			YEAR TO DATE			
	Employees	Dependents	Total QTD	Employees	Dependents	Total YTD	*Percent
<b>Traditional</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>Enhanced</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>CDHP</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>All Products</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>

\* Percent of Total Claims

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #15**

**State Health Plan for Teachers and State Employees**  
**Financial Summation Report- Paid Amounts**  
**Active Employees (See Note Below)**  
**Claims Incurred January 1 through June 30, 2016**

	QUARTER TO DATE			YEAR TO DATE			
	Employees	Dependents	Total QTD	Employees	Dependents	Total YTD	*Percent
<b>Traditional</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>Enhanced</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>CDHP</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>
	<b>Employees</b>	<b>Dependents</b>	<b>QTD Totals</b>	<b>Employees</b>	<b>Dependents</b>	<b>YTD Totals</b>	<b>*Percent</b>
<b>All Products</b>							
A - Claims Subject to Copays	\$0	\$0	\$0	\$0	\$0	\$0	N/A
B - Claims Subject to Coinsurance and Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
C - Claims Included in Both (Overlap)	\$0	\$0	\$0	\$0	\$0	\$0	N/A
D - Claims Not Subject to Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	N/A
<b>Total Claims (A+B-C+D)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>0.0%</b>

\* Percent of Total Claims

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #16**

**State Health Plan for Teachers and State Employees  
Financial Reconciliation Report- Paid  
Report Period: Claims Paid January 1 through June 30, 2016  
Active Employee Groups- Traditional (See Note Below)**

	QUARTER-TO-DATE Paid April 1 through June 30, 2016					YEAR-TO-DATE Paid January 1 through June 30, 2016				
	A Claims Subject to Copay	B Claims Subject to Coinsurance and Deductible	C Overlap	D Claims Not Subject to Member Liability	E=A+B-C+D Total	A Claims Subject to Copay	B Claims Subject to Coinsurance and Deductible	C Overlap	D Claims Not Subject to Member Liability	E=A+B-C+D Total
1. Billed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Non Covered	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Allowed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4. Member Liability										
A. Member Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
B. Member Coinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
C. Member Copay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal - Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5. Coordination of Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6. Financial Adjustments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7. Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

**MATRIX #17**

**State Health Plan for Teachers and State Employees  
Financial Reconciliation Report- Incurred  
Report Period: Claims Incurred January 1 through June 30, 2016  
Active Employee Groups- Traditional (See Note Below)**

	QUARTER-TO-DATE Paid April 1 through June 30, 2016					YEAR-TO-DATE Paid January 1 through June 30, 2016				
	A Claims Subject to Copay	B Claims Subject to Coinsurance and Deductible	C Overlap	D Claims Not Subject to Member Liability	E=A+B-C+D Total	A Claims Subject to Copay	B Claims Subject to Coinsurance and Deductible	C Overlap	D Claims Not Subject to Member Liability	E=A+B-C+D Total
1. Billed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Non Covered	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Allowed Charges	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4. Member Liability										
A. Member Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
B. Member Coinsurance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
C. Member Copay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal - Member Liability	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5. Coordination of Benefits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6. Financial Adjustments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7. Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

*Note:* Identical report must be provided for each plan option and employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee) and then aggregated for each plan option and each employee group, including an overall total for the population.

## MATRIX #18

**State Health Plan for Teachers and State Employees**  
**All Paid Claims**  
**CYTD= January 1 through June 30, 2016    QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copoly	COB	Financial Adjustments	Payments
<b>EMPLOYEE - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>DEPENDENT - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>TOTAL - QTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #18 (continued)

**State Health Plan for Teachers and State Employees**  
**All Paid Claims**  
**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**  
**Traditional - Actives (See Note Below)**

Type of Service:	Number of Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copoly	COB	Financial Adjustments	Payments
<b>EMPLOYEE - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>DEPENDENT - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>TOTAL - CYTD</b>											
Office											
Primary	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #18 (continued)

**State Health Plan for Teachers and State Employees**

**All Paid Claims**

**CYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**

**Traditional - Actives (See Note Below)**

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - QTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Type of Service:  
DEPENDENT - QTD**

Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Type of Service:  
TOTAL - QTD**

Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.

MATRIX #18 (continued)

**State Health Plan for Teachers and State Employees**

**All Paid Claims**

**FYTD= January 1 through June 30, 2016 QTD= April 1 through June 30, 2016**

**Traditional - Actives (See Note Below)**

Type of Service:	Avg Visits per Member	Avg Billed Charge	Avg Non Covered	Avg Allowed Charge	Avg Member Deductible	Avg Member Coinsurance	Avg Member Copay	Avg COB	Avg Payment
<b>EMPLOYEE - CYTD</b>									
Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Type of Service:  
DEPENDENT - CYTD**

Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**Type of Service:  
TOTAL - CYTD**

Office									
Primary	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Mid Level	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Urgent Care	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Inpatient	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
ER	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Routine Eye	0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>0.00</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Note: Identical report must be provided for each plan option and employee status and then aggregated for each plan option and each employee group, including an overall total for the population.