STATE OF NORTH CAROLINA

THE NORTH CAROLINA STATE HEALTH PLAN

FOR TEACHERS AND STATE EMPLOYEES

Request for Proposal #: 270-20191001TPAS

THIRD PARTY ADMINISTRATIVE SERVICES

Date of Issue: October 1, 2019

Proposal Opening Date: January 3, 2020

At 02:00 PM ET

Direct all inquiries concerning this RFP to:

Sharon L. Smith

Manager of Contracting & Compliance

Email: Sharon.Smith@nctreasurer.com
SHPContracting@nctreasurer.com

Phone: 919-814-4432

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

STATE OF NORTH CAROLINA

Request for Proposal # 270-20191001TPAS

For internal State agency processing, including tabulation of proposals 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 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

STATE OF NORTH CAROLINA
North Carolina Department of State Treasurer

Refer *ALL* Inquiries regarding this RFP to: ***Sharon L. Smith, Manager of Contracting and Compliance*** ***sharon.smith@nctreasurer.com with a copy to SHPContracting@nctreasurer.com***	**Request for Proposal # 270-20191001TPAS**
	Proposals will be publicly opened: January 3, 2020, 2:00 p.m. ET
	Contract Type: Open Market
	Commodity No. and Description: 948 – Health Related Svcs.
	Using Agency: The North Carolina State Health Plan for Teachers and State Employees
	Requisition No.: 270-20191001TPAS

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 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 NC 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. 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 the 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).

FOR STATE USE ONLY: Offer accept 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).

Table of Contents

1.0 VISION AND OVERVIEW OF THE STATE HEALTH PLAN

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 services. The Vendor must be willing to work with the Plan in meeting the mission and priorities set by the Treasurer and the Board of Trustees. 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, the Plan is currently undertaking an initiative called the Clear Pricing Project to provide affordable, quality care and increase transparency, predictability, and value for Plan Members. In the first phase of this project, the Plan has begun to build its own network of North Carolina providers, with reimbursement rates that are referenced to Medicare rates. There are currently approximately 25,000 providers, including 3 hospitals, who have committed to participate in this network. During this initial phase, this network will be supplemented by the TPA's network in order to provide adequate access for Plan Members. It is the Plan's intent in the next phase of this project to further partner with these providers by designing alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation. In the future, the Plan hopes to secure partnerships with additional providers in order to expand the size of this network and eliminate the need for a supplemental network from the TPA.

In fulfilling its mission and vision, the Plan seeks to focus on the key principles of Member education, 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 selected Vendor will possess the following traits at a minimum:

- Flexible and Adaptable
- Confident and Committed
- Responsive and Capable
- Provide superior administrative and technical services
- Model, design, and implement alternative provider payment models
- Put financial performance guarantees in place
- Demonstrate dedication to providing a superior customer experience
- Provide quality services
- Collaborate with other Plan vendors to integrate data across the Plan

The Vendor must also 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. The 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, the Vendor must show a dedication to providing 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, the Vendor must provide comprehensive staff training, deploy appropriate operational controls, conduct frequent audits, and accept appropriate performance guarantees to measure the success of these services.

1.2 OVERVIEW OF THE STATE HEALTH PLAN

Background

The Plan operates as a division of the Department of State Treasurer. The Treasurer is responsible for administering and operating the Plan as described in Article 3B of Chapter 135 of the North Carolina General Statutes subject to certain approvals by and consultations with the Board of Trustees. An Executive Administrator oversees the day-to-day

operations of the Plan. The State Treasurer, Board of Trustees, and Executive Administrator are required to carry out their duties and responsibilities as fiduciaries for the Plan. The Plan employs approximately forty (40) staff members.

There are over four hundred (400) Employing Units whose employees are eligible to receive benefits from the Plan. Employing Units include State agencies and departments, universities, public school systems, local community colleges, and the retirement system. In addition, a number of local government entities and charter schools receive benefits under the Plan. In total, the Plan provides benefits for approximately seven hundred thirty-four thousand (734,000) lives. Members reside in all of North Carolina's one hundred (100) counties, all fifty (50) states, and other countries.

The Plan is exempt from the Employee Retirement Income Security Act of 1974 (ERISA) pursuant to 29 U.S.C.S. § 1003 as it is a self-funded state government health benefit program established for the benefit of State employees. Benefits, premium rates, copays, deductibles, and coinsurance maximums are set by the State Treasurer as approved by the Board of Trustees. Refer to the Plan's website at www.shpnc.org for a complete overview of benefits.

In State fiscal year 2017-2018, Plan expenditures were approximately $3.33 billion including $2.30 billion in medical claims, $669.6 million in net pharmacy claims, $211.1 million in premium payments for fully insured Medicare Advantage plans, and $146.0 million in administrative costs.

Membership Statistics

As of July 2019, the Plan's membership consisted of 734,057 teachers, State Employees, retirees, current and former lawmakers, state university and community college personnel, and their Dependents.

Among total membership, there are:

- 498,446 active Employees and their Dependents.
- 1,362 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 Plan pursuant to Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300bb-1 through 300bb-8.
- 231,326 Medicare and non-Medicare retirees and disabled Members and their Dependents.
- 2,923 Members and their Dependents who are eligible for the Plan on a fully contributory basis who are invoiced for their premiums (Direct Bill Members) on a monthly basis.

Plan Offerings

The Plan offers two (2) Preferred Provider Organization (PPO) plans to 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 Blue Shield of North Carolina's (BCBSNC) Blue Card network.

- The 82/20 PPO Plan has higher premiums in exchange for lower copays, coinsurance, and deductibles. This plan includes the ability for the Subscriber to lower the monthly Subscriber premium by attesting to be a non-tobacco user or a tobacco user willing to complete a tobacco cessation program. As of July 2019, the 80/20 PPO Plan accounted for 333,768 Members.

- The 70/30 PPO Plan has lower premiums in exchange for higher copays, coinsurance, and deductibles. Like the 80/20 PPO Plan, the 70/30 PPO Plan includes the ability for the Subscriber to lower the monthly Subscriber premium by attesting to be a non-tobacco user or a tobacco user willing to complete a tobacco cessation program. As of July 2019, the 70/30 PPO Plan accounted for 221,631 Members.

In 2019, the State Health Plan offered three (3) health plan options for Medicare Primary Members. These plans include the 70/30 PPO Plan, which is also offered to Non-Medicare primary Members and administered through BCBSNC, and two (2) Group Medicare Advantage (PPO) Plan options — offered through UnitedHealthcare — which

include benefits and services such as access to the SilverSneakers® Fitness Program, a nurse help line, and disease and case management services.

- UnitedHealthcare Group Medicare Advantage PPO Base Plan – 131,278 Members
- UnitedHealthcare Group Medicare Advantage PPO Enhanced Plan – 22,020 Members
- 70/30 PPO Plan – 24,928 Members

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 who do 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.

- 432 HDHP Members

Plan Vendors

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

- BCBSNC is the current Third Party Administrator (TPA) for Claims and Related Services for the Plan's three (3) self-funded plan options.
- The two (2) fully insured Medicare Advantage Plan designs are provided by UnitedHealthcare.
- CVS/Caremark is the Pharmacy Benefit Manager (PBM).
- Benefitfocus is the Plan's eligibility and enrollment services (EES) vendor.
- iTEDIUM provides COBRA administration and billing services.

A full list of the Plan's contracted vendors (Plan vendors) is available on the Plan's website at www.shpnc.org.

2.0 GENERAL INFORMATION

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 the 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 the 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, the 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. 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	October 1, 2019
Vendor Deadline for Submission of Written Minimum Requirements Questions	Vendor	October 8, 2019
Plan Responds to Minimum Requirements Questions (Posted on IPS)	Plan	October 14, 2019
Deadline to Submit Minimum Requirements Proposals including executed Attachment I	Vendor	October 21, 2019
Notify Vendors if Minimum Requirements Met		October 29, 2019
Issue Vendor's designated recipient, a link to Secure File Transfer Protocol (SFTP) system for attachments and Data Files	Plan	October 29-31, 2019
Vendor Deadline for Submission of All Written Questions	Vendor	November 7, 2019
Plan Responds to Questions (Posted on IPS)	Plan	November 15, 2019
Opening of Proposals by Plan (Bid Closes)	Vendor	January 3, 2020
Evaluation Period (Review of Proposals and Finalist Presentations)	Plan	January 15-28, 2020
Proposed Finalist Presentations	Vendor	February 6-10, 2020
Best and Final Offer (BAFO)	Plan	February 11-14, 2020
Plan Seeks Approval from the Attorney General's Office	Plan	February 17-26, 2020
Present award recommendation to the Board	Plan	February 27-28, 2020
Award of the Contract	Plan & Vendor	February 28, 2020
Implementation Period	Plan & Vendor	March 1, 2020 through December 31, 2021
Services Begin	Vendor	January 1, 2022

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 Sharon.Smith@nctreasurer.com with a copy to SHPContracting@nctreasurer.com by the date and time specified above. When submitting Minimum Requirements questions, Vendors should enter "RFP # *270-20191001TPAS:* Minimum Requirements Questions" as the subject for the email. When submitting all other questions, Vendors should enter "RFP # *270-20191001TPAS* Questions." Question submittals should include a reference to the applicable RFP section and be submitted in the format shown below:

Reference	Vendor Question
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 to the Interactive Purchasing System (IPS), http://www.ips.state.nc.us, in the form of an Addendum to this RFP. 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 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 Nondisclosure Agreement, Attachment I, will be provided a de-identified medical claims file for repricing. 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 the Vendors that meet the Minimum Requirements and each Vendor's designated recipient.
   ii. Segal will send each Vendor's designated recipient a link to the SFTP system, the appropriate data dictionary(s), file layouts, and reference tables.
   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: *270-20191001TPAS* NC Department of State Treasurer State Health Plan Division 3200 Atlantic Avenue Raleigh, NC 27604 Attention: Sharon Smith, Manager of Contracting and Compliance

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 the Vendor. It is the sole responsibility of the 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, thirteen (13) photocopies, one (1) photocopy of the Minimum Requirements Proposal redacted in accordance with Chapter 132 of the 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 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 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 the 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 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 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 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 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. If Vendor is submitting more than one (1) proposal, each proposal shall be submitted in separate sealed envelopes and marked accordingly. 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.

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 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.”

e) 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 the 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 the 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).
c) ATTACHMENT C: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS.
d) Completed version of ATTACHMENT D: LOCATION OF WORKERS UTILIZED BY VENDOR.
e) Completed and signed version of ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION.
f) Completed and signed version of ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT.
g) Completed and signed version of ATTACHMENT H: HIPAA QUESTIONNAIRE.
h) 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 the 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) Technical Response (RFP Sections, 4.6, 4.10, 5.2, & 6.3).

c) Completed version of ATTACHMENT A: PRICING.

d) ATTACHMENT B: INSTRUCTIONS TO VENDORS.

e) 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 the 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 the 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 the 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 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 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 retro-activity, 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 the Vendor's proposal response.

m) **CLOSE-OUT DOCUMENT:** A document developed by the 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) **COBRA PARTICIPANTS:** Any Members of the Plan covered under COBRA.

q) **CONFLICT OF INTEREST:** Situations or circumstances through which the Vendor, or entities or individuals closely affiliated with the 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, the Vendor's ability to perform this Contract in the best interests of the State.

r) **CONTRACT ADMINISTRATOR:** Representative of the Plan who will administer this Contract for the State.

s) **CONTRACT MANAGER:** Representative of the Plan who corresponds with potential Vendors regarding this RFP.

t) **COVERAGE TIER:** The type of coverage (Employee only, Employee + spouse, Employee + child(ren), and Employee + family) the Subscriber has elected.

u) **CUSTOMER:** For the purposes of this RFP, any entity for which a service is provided such as Providers, Plan Members, Health Benefit Representatives (HBRs), and Plan Staff.

v) **CUSTOMER EXPERIENCE:** The service experience of Customers.
w) **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.
x) **DATA FILE:** An electronic file containing data.
y) **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. Essential components of a Data Warehouse include the means to (1) retrieve, extract, transform, and load data from different sources for access and analysis, (2) processes to cleanse the data from the operational systems to ensure data quality before it is used for analytics and reporting, (3) maintain, catalogue, and utilize associated metadata including the data dictionary and reference code sets, (4) analyze data, and (5) operate across very large amounts of data. A Data Warehouse differs from a database. A database is used to capture and store data from a limited set of transactional systems (or one), its schema is normalized, and it is not designed to run across very large data sets. A Data Warehouse differs from a data lake. A data lake is a central repository for all types of raw data, whether structured or unstructured, from multiple sources, and its schema is undefined.
z) **DELIVERABLE:** Refers to any service, duty, performance, or other contractual obligation of the Vendor.
aa) **DEPENDENT:** An eligible Plan Member other than the Subscriber.
bb) **DEPENDENT CHILD:** Natural, legally adopted, or foster child or children of the Employee and/or spouse, up to the first of the month following his/her 26th birthday, whether or not the child is living with the Employee.
cc) **DEPLOYMENT PLAN:** A document developed by the Vendor to outline the sequence of operations or steps that must be carried out to deploy new functionality or processes.
dd) **DIRECT BILL MEMBERS:** Members who are invoiced directly for their premium contributions by the Plan's billing vendor. This includes, but is not limited to, individuals on COBRA or leave of absence, retirees for whom the State of North Carolina makes partial contributions, former Employees who have elected to continue reduction in force benefits beyond the initial twelve (12) months, and surviving Dependents. Any Member in this population could be enrolled in and invoiced for multiple benefits.
ee) **ELECTRONIC DATA INTERFACE (EDI):** Standard format for exchanging business data.
ff) **EMPLOYEE OR STATE EMPLOYEE:** Any individual eligible for coverage pursuant to their employment with a qualifying Employing Unit as described in Article 3B of Chapter 135 of the North Carolina General Statutes, as may be amended from time to time.
gg) **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 Statues 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.
hh) **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.
ii) **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.
jj) **E-PROCUREMENT SERVICES:** The program, system, and associated Services through which the State conducts electronic procurement.

kk) **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.

ll) **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. **Billing Files –** A Full File that provides all records/transactions required to successfully deduct premiums including, but not limited to, enrollment (i.e., demographics and Member categories) and coverage periods (i.e., effective and expiration dates across plan years, plan, and Group).
c. **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).
d. **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.

mm) **FUNTIONAL REQUIREMENTS DOCUMENT:** The document developed by the Vendor to ensure the technical specifications are in alignment with the Business Requirements. This document may also be called a Solutions Document.

nn) **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.

oo) **GROUP:** The entity through which Members are "grouped" to enroll and be invoiced (i.e. Employing Units, Retirement Systems, Direct Bill, and COBRA).

pp) **GROUP PREMIUM INVOICE:** Monthly Invoice provided to the Employing Unit and/or Entity responsible for paying the monthly health benefit premiums.

qq) **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 State Retirement System is the HBR for retired State Employees.

rr) **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.

ss) **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.

tt) **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).

uu) **INTERACTIVE VOICE RESPONSE (IVR):** A technology that allows a computer to interact with humans through the use of voice and keypad inputs.

vv) **MAY:** Denotes that which is permissible, not mandatory

ww) **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.

xx) **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.

yy) **N.C.G.S.:** North Carolina General Statutes.

zz) **PARTIES TO THE CONTRACT:** The Parties (Parties) to this Contract are the Plan and the Vendor(s) selected through the RFP process.

aaa) **PARTNER:** State sister agencies or other governmental units including BEACON, the State Retirement Systems, the University system, community college system, and public school systems.

bbb) **PERFORMANCE GUARANTEE:** A contractual obligation or performance standard the Vendor must comply with or be subject to contractual fee reductions, payments to the Plan, or legal remedies.

ccc) **PLAN YEAR:** A twelve-month period which runs from January 1 through December 31.

ddd) **PLAN'S AUDITORS:** Includes external audit Vendors engaged by the Plan, internal Plan auditors, and Certified Public Accountants.

eee) **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: 80/20, 70/30, and the HDHP.

fff) **PRIOR AUTHORIZATION:** The process of obtaining certification or authorization from the PBM or TPA for specified medications or specified quantities of medications or certain medical claims. The process involves clinical appropriateness review against pre-established criteria. Failure to obtain Prior Authorization when required may result in non-payment of claims by the Plan.

ggg) **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 different Products: Preferred Provider Organizations (PPO) and Medicare Advantage Plans.

hhh) **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.

iii) **QUALIFIED PROPOSAL:** A responsive proposal submitted by a responsible Vendor.

jjj) **REBATES:** The amounts paid to the 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 the 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.

kkk) **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.

lll) **REDUCTION IN FORCE (RIF):** The act of suspending or dismissing an employee, for lack of work or because of corporate reorganization.

mmm) **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.

nnn) **SECURE File Transfer Protocol (SFTP):** Secure file transfer protocol in which a standard network protocol is used to exchange files over a TCP/IT based network.

ooo) **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.

ppp) **SERVICES:** The tasks and duties undertaken by the Vendor to fulfill the requirements and specifications of this RFP.

qqq) **SHALL OR MUST:** Denotes that which is a mandatory requirement.

rrr) **SHOULD:** Denotes that which is recommended or preferred, but not mandatory.

sss) **SPECIALTY DRUGS:** Medications classified by the Plan as having unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider and exceed four hundred dollars ($400) cost to the Plan per prescription.

ttt) **SPLIT CONTRACT:** Retiree who is Medicare Primary with one or more Dependents that are Non-Medicare Primary or vice versa.

uuu) **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, identify overpayments, and prepare the State's Comprehensive Annual Financial Report (CAFR).

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

www) **STATE AGENCY:** Any of the more than 400 sub-units within the executive branch of the State, including its departments, boards, commissions, institutions of higher education, and other institutions.

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

yyy) **SUBSCONTRACTOR:** 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 [the Vendor's] obligations under the contract, including payment to the Subcontractor. The Subcontractor has no contractual relationship with the Plan, only with the Vendor.

zzz) **SUBSCRIBER:** The primary health benefit plan contract holder.
aaaa) **TEST PLAN:** The document or tool developed by the Vendor to manage, organize and track test cases.
bbbb) **TIER 1 PROVIDER:** In-Network provider that meets the established high quality and low cost criteria.
cccc) **TIER 2 PROVIDER:** In-Network provider that does not meet the Tier 1 provider quality and/or cost criteria.
dddd) **THIRD PARTY ADMINISTRATOR (TPA):** A firm that provides administrative services and assumes responsibility for administering health benefit plans including claims processing without assuming financial risk for claims payments.
eeee) **THIRD PARTY ADMINISTRATIVE (TPA) SERVICES:** Services provided by the Third Party Administrator.
ffff) **UNIT TESTING:** Testing performed in isolation of interdependencies.
gggg) **VENDOR:** Supplier, bidder, proposer, company, firm, corporation, partnership, individual, or other entity submitting a response to this RFP.

3.0 METHOD OF AWARD AND PROPOSAL EVALUATION PROCESS

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 the 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 the 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 the 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 the Vendor and its staff, and cost(s). Specific evaluation criteria are listed in 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 the 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 oral presentations during the evaluation process. However, all decisions regarding scoring and the final award 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

- Written Technical Proposal
- Oral Presentations (if deemed necessary by the Plan)

2: Evaluation of Cost Proposal

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

c) Approval for Contract Award

The Plan's Executive Administrator will award the Contract after approval by the Plan's Board of Trustees and Attorney General's Office, if applicable. 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. 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	60%
Cost Proposal	40%
Total:	**100%**

Continues on next page.

b) Technical Requirements & Specifications:

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

TECHNICAL AREAS	POINTS
Section 5.2.2 Account Management	1,000
Section 5.2.3 Finance and Banking	1,100
Section 5.2.4 Network Management	1,200
Section 5.2.5 Medical Management & Health Care Support	600
Section 5.2.6 Pharmacy Management	400
Section 5.2.7 Enrollment & Group Set-Up	900
Section 5.2.8 Group Billing & Collection	900
Section 5.2.9 Data & Technology	900
Section 5.2.10 Customer Experience	700
Section 5.2.11 Product Management	400
Section 5.2.12 Claims Processing & Appeals	300
Section 5.2.13 Audit	500
Section 5.2.14 Recovery and Investigations	600
Section 5.2.15 Initial and Ongoing Implementations	500
Total for Technical Areas	**10,000**

c) Cost Proposal:

Cost Proposals will be scored based upon the assumption that the Vendor's broad network described in Section 5.2.4.3 and priced in Attachment A will be used as a wrap-around to supplement the Plan's custom network. The maximum number of total points will be awarded to the Vendor offering the lowest total cost with others receiving points proportionately. A Vendor's total cost will include the projected claims costs associated with the Vendor's broad network providers, excluding North Carolina State Health Plan Network providers, based upon information from Attachment A and the Vendor's administration fees priced in Attachment A-7.

The following calculations will be used:

i. The Vendor with lowest total cost will be awarded the maximum number of 10,000 points allocated for this component.
ii. The Vendor with next lowest cost and remaining bids will be given a pro-rata share of the total number of points allocated for this component = (lowest bid/bid being evaluated).

Costs associated with other network combinations may be calculated for informational purposes only, but will not factor into any scoring associated with this RFP.

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 the 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 Request for Proposal serves two 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 Request for Proposal shall be enforceable as contract terms in accordance with Attachment C: North Carolina General Contract Terms and Conditions. The use of phrases "shall" and "must" create enforceable contract obligations. 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 solutions that will satisfy the State's needs as described in the Request for Proposal. Except as specifically stated in the Request for Proposal, 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

This Section lists the requirements related to this RFP. By submitting a proposal, the 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, the 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 Sections 4.6 and 4.10 in accordance with Section 2.7.2.b).

4.1 CONTRACT TERM

The Contract shall have an initial term of fifty-eight (58) months, including twenty-two (22) months for implementation, beginning March 1, 2020 through December 31, 2024. The Vendor shall begin providing services on January 1, 2022.

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 additional one-year terms beginning January 1, 2025 through December 31, 2025 and January 1, 2026 through December 31, 2026. The State will give the 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 FORM and include in Proposal.

4.3 INVOICES

4.3.1 Administrative Fees

a) The 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 fifteen (15) days of execution of the Contract. This form can be accessed at the following link: https://www.osc.nc.gov/vendor-resources.

b) The 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 the 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 the Vendor and the Plan."

e) The 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 the Vendor by the Plan or the Plan's EES vendor by the 10th State Business day of the month. The 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 thirty (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, the Vendor shall be required to submit a corrected invoice, in which case payment shall be made within thirty (30) calendar days of receipt of the corrected invoice.

k) The 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 party 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) The 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) The Vendor shall submit a weekly reporting package of disbursements as required in Section 5.2.3 et seq., no later than 9:30 a.m. ET on the first State Business day of each week.

c) The 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 the Vendor of funding availability no later than noon on the second State Business day of each week.

d) The Plan reserves the right to validate any reporting package of disbursements submitted for funding and shall have access to the Vendor's or Subcontractors' supporting documentation as necessary to validate the funding request.

e) 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

The Vendor will be compensated at the rates quoted in the 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, the Vendor shall notify the State within thirty (30) days of any occurrence or condition that materially alters the truth of any statement made in this Certification.

4.6 REFERENCES

Vendors shall provide at least three (3) references for which they have provided Services of similar size and scope to those proposed herein. The State may contact these users to determine whether the Services provided were substantially similar in scope to those proposed herein and whether the Vendor's performance has been satisfactory. The information obtained may be considered in the evaluation of the proposal.

COMPANY NAME	CONTACT NAME	TELEPHONE NUMBER

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 thirty (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 the 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.

Continued on next page.

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, 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

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

Sharon Smith
Manager of Contracting and Compliance
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, NC 27604
Phone (919) 814-4432
Email: Sharon.Smith@nctreasurer.com

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

Chris Almberg
HIPAA Privacy and Security 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

Continues on next page.

b) The 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: _____

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), the Vendor shall maintain the confidentiality of all Plan Member information, in whatever form, and however it is obtained. The 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 the 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 the 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 ten (10) calendar days of the Contract execution date, the Vendor must begin the process of executing Confidentiality Agreements with Plan vendors as determined by the Plan. The Vendor must complete the execution of Confidentiality Agreements within forty-five (45) calendar days of the Contract execution date. The Plan will provide the 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 the Vendor. If requested by the Plan, the 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) The Vendor's Minimum Requirements Proposal including clarifications and supplemental documentation;

d) The Vendor's Technical and Cost Proposal including clarifications, supplemental documentation, and written information from oral presentations; 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

The 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 the Vendor solely for the purposes described in this Contract. Under no circumstances shall the 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 conflict in any manner or degree with the performance of its services during the term of the Contract.

The Vendor shall:

a) Disclose any relationship to any business or associate with whom the 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 the Vendor, any firm principal, staff member or subcontractor, known by the 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.

d) Provide written notice to the Plan of any actual or imminent legal matters or regulatory compliance actions involving the 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 the 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, the 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 the Vendor has been involved within the past five (5) years. If any, please provide a detailed explanation.

f) Notify the Plan in writing within fifteen (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

The 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 the Vendor's proposal, and executing future contractual documents.

b) Notify the Plan in writing within fifteen (15) calendar days of any changes in those individuals identified as having authority to bind the firm.

4.17 DEBARRED, SUSPENDED OR EXCLUDED VENDORS

The Vendor shall:

a) Notify the Plan in writing within fifteen (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 the Vendor be a recipient of the contract award.

4.18 REGISTRATION AND CERTIFICATION

The 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 fifteen (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

The 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 eighteen (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

5.1 MINIMUM REQUIREMENTS:

This procurement is open to qualifying Vendors that satisfy the Minimum Requirements described in this section. Vendors must meet all Minimum Requirements for technical responses to be evaluated for possible Contract award. The Plan reserves the right to reject proposals deemed incomplete or non-compliant with these Minimum Requirements.

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

Vendors shall respond to all questions and confirmation/certification/description requests that are described herein in their Minimum Requirements response using the same RFP numbering sequence. Vendors are cautioned to provide sufficient detail for the Plan to validate their responses.

TPA MINIMUM REQUIREMENTS TABLE		
	Requirement	**RFP Section Number and Page Number of Response**
1	Vendor must agree to a carve-out of Pharmacy Benefit Manager (PBM) services.	
2	Vendor must have worked with at least one (1) public or private client with more than one hundred thousand (100,000) covered lives for whom the Vendor provided services. Provide documentation to support experience requirement.	
3	Vendor must have experience managing split contracts where members of the same family (contract) can be enrolled in different Products or Plan designs. (Example: one (1) or more member(s) of the family is enrolled in a Medicare Primary 70/30 Plan and other family members are enrolled in the 80/20 Plan.) Provide documentation to support experience requirement.	
4	Vendor must 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 Board of Trustees.	
5	Vendor must comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan, and confirm agreement that all premium receipts and other moneys belonging to the Plan that are collected or received by the Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan. Provide documentation that supports the Vendor's understanding of the requirement and ability to comply.	
6	Vendor must 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/fod/Resources/BankingHandbook.pdf. Vendor shall provide documentation that supports the Vendor's understanding of the requirement and ability to comply.	
7	If Vendor will be disbursing funds from Plan 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 electronic funds transfers (EFT) 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 thirty (30) days prior to January 1, 2022.	

	If Vendor will not be disbursing funds from the Plan bank accounts, the Vendor should insert N/A in the last column.	
8	Vendor must agree to manage the part of the network that is "owned" by the Plan. Management may include handling provider credentialing, provider maintenance, and providing a provider search tool that integrates the Plan's network with the Vendor's network, needed to support Plan Members that reside in North Carolina and throughout the United States.	
9	Vendor must be able to support the Plan's Group Billing requirements as described in Section 5.2.8. Vendor shall provide documentation that supports the Vendor's understanding of the requirement and the ability to comply.	
10	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. 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 financial statements and such other evidence of its own financial stability identified above.	
11	Vendor shall certify, without exception: i. The sufficiency of its security standards, tools, technologies, and procedures in providing Services under this Contract. ii. That any Cloud Infrastructure as Service (IaaS), Platform as a Service (PaaS), and Software as a Service (SaaS) solutions system(s) used to provide the Services under this Contract and that contain Plan Data has, and will maintain, a third party security assertion with a favorable opinion for the proposed system that is consistent with the data classification level and security controls appropriate for moderate information system(s) per the National Institute of Standards and Technology NIST 800-53 revision 4.The current and favorable third-party security assertions will be verified yearly, and the Vendor will be required to provide an updated report or a bridge letter verifying that the system environment and functions have not changed since the last Security Assertion report was produced (bridge letter option only valid for two years after full third-party assessment). iii. It is the Plan's preference for the Vendor to provide a full SOC2, Type 2 security assessment report. If the Vendor maintains that any information contained in such report is proprietary or otherwise confidential, the Vendor shall redact these portions of the report, and supply the un-redacted portions for review. Alternatively, the Vendor may submit any of the following for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). All component names and types shall be clearly defined and outlined.	

	1. The Opinion Letter from the third party that performed the assessment stating that the SOC2, Type 2 report shows a favorable opinion; or 2. A signed letter from the Vendor's highest ranking officer attesting that the Vendor has passed as SOC2, Type 2 security assessment within the last year with a favorable opinion; or 3. A SOC3 showing that the Vendor maintained effective controls over its systems for the last year. iv. A third-party SOC2, Type 2 security assessment report is preferred, but assessment reports performed under other security frameworks will be considered as a substitute as long as the security controls can be cross-walked to the appropriate NIST-800-53 security control requirements (e.g. ISO 27001, HITRUST). The State reserves the right to independently evaluate, audit, and verify such requirements, including requesting the performance of a penetration test with satisfactory results. The Vendor shall include the full version of any substitute third party assessment report(s) as part of its submission. If the Vendor maintains that any information contained in such report(s) is proprietary or otherwise confidential, the Vendor shall redact these portions of the report, and supply the un-redacted portions for review. The Vendor shall supply a third-party security assertion for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). The report shall clearly define the service type(s) included in the assertion. v. If the Vendor submits a substitute security framework, the State reserves the right to, based upon its evaluation, request that the Vendor provide a suitable amount of cyber breach liability insurance coverage and/or commit to obtaining a favorable SOC2, Type 2 security assessment within a specified time period as a condition of Contract award. The Vendor shall list the amount of cyber breach liability insurance that it currently carries for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). If the Vendor is currently undergoing a SOC2, Type 2 assessment, the Vendor shall list the expected date for completion.	
12	Vendor must agree to Attachment C: North Carolina General Terms and Conditions without exception. Refer to Section 2.3.	
13	Vendor shall complete and submit, without exception, Attachment D: Location of Workers Utilized by Vendor.	
14	Vendor shall complete, sign and submit, without exception, Attachment E: Certification of Financial Condition	
15	Vendor shall complete, sign, and submit Attachment G: Business Associate Agreement (BAA).	
16	Vendor shall be HIPAA compliant; and shall complete, sign, and submit Attachment H: HIPAA Questionnaire and supply copies of and sign the Vendor's HIPAA privacy and security policies. If the Vendor maintains that any information contained in the HIPAA privacy and security policies is proprietary or otherwise confidential, the Vendor may redact these portions and supply the un-redacted portions for review.	
17	Vendor shall complete, sign and submit Attachment I: Nondisclosure Agreement.	
18	Vendor must complete, sign and submit Attachment J: Minimum Requirements Submission Information	

5.2 TECHNICAL PROPOSAL REQUIREMENTS AND SPECIFICATIONS

5.2.1 General

The Plan requires a Vendor with a robust suite of services, a dedication to quality, a commitment to providing a superior Customer Experience, and staff with the expertise to support the Plan's strategic goals. For consideration, each proposal must clearly demonstrate **all of the requirements** in this section. The Plan reserves the right to reject proposals deemed incomplete, non-responsive, or non-compliant with RFP requirements.

The Vendor shall respond to all questions and confirmation/certification/description requests that are described herein in its proposal response using the same RFP numbering sequence. The Plan is not interested in generalized responses. The nature of this RFP is detailed, and the Plan's expectation is to receive detailed and direct responses to all questions and confirmation/certification/description requests. The following directives are used throughout this RFP:

- **Provide –** The Plan's expectation is that the Vendor will provide a sample or copy of the requested material or information.
- **Describe –** The Plan's expectation is that the Vendor will provide a detailed narrative description of the requested information.
- **Confirm –** The Plan's expectation is that the Vendor will affirm a requirement by, at a minimum, inserting the word CONFIRM.
- **Limitations –** The Plan's expectation is that the Vendor will describe in detail any limitations impacting its ability to perform the applicable requirement(s) or specification(s). If limitations are not requested regarding a specific requirement or specification, or if the Vendor does not identify any limitations in response to a request, then the Vendor shall perform as described in the requirement or specification. Any limitations identified by the Vendor will be considered during scoring of the Vendor's proposal. Failure to agree to any requirement may result in disqualification of the Vendor's proposal.

5.2.2 Account Management

5.2.2.1 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. The Vendor must be transparent when partnering with the Plan on initiatives or providing internal processes, data, or other information, as requested by the Plan. The Vendor must also show a willingness to develop custom networks, products, or processes to support the Plan. Finally, the Vendor must be responsive and have the resources to support Plan operations, implementations, and ongoing data needs. The Plan prefers a Vendor with resources in North Carolina. In this section, the Plan seeks to determine the level of experience, expertise, transparency, and in some cases, the specific resources, and the location of the resources, that will be utilized to support this Contract.

Objectives

a. Ensure the Vendor will dedicate the appropriate leadership resources to support the Plan during implementation and on an ongoing basis.

b. Partner with a Vendor that shares the Plan's desire to be transparent when it comes to provider contracting and provider data.

c. Ensure the Vendor has the experience and systems required to support the Plan.

5.2.2.2 Experience

The Plan requires a Vendor with a history of providing third party administrative (TPA) services for claims processing and related services and custom client networks.

The Vendor shall provide each of the following:

i. Description of the company, its operations and ownership.

ii. Description of any specific expertise in TPA services and how long the company has been providing TPA services.

iii. Description of the types of custom networks the Vendor has built for other clients.

iv. Description of the Vendor's experience administering plans which utilize networks built by an entity other than the Vendor (e.g., a custom network built by an employer).

v. Description of all processes and protocols involved with loading/building the custom network in the Vendor's claims system.

a. The Plan requires a Vendor with a proven track record of providing TPA services to clients of similar size and complexity to the Plan.

The Vendor shall confirm and describe each of the following:

i. The existence of one or more current or former administrative services only (ASO) clients with more than 100,000 members.

ii. The existence of one or more current or former ASO clients with more than 25,000 Medicare Primary members.

iii. The existence of one or more current or former ASO clients with more than 100,000 lives for which Vendor has managed the client's custom network.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements b.i. - iii., above.

c. The Plan prefers a Vendor with a proven track record of supporting at least two (2) clients with more than 500,000 members.

i. The Vendor shall provide the number of ASO clients in each size category and the name of the two (2) largest clients in each category in the table provided below:

Table 1 ASO/TPA Clients

Number of Members	Number of Clients	Largest clients for this Size Category (complete box with names of at least two (2) clients and number of current members for these clients).
100,000 – 250,000		
250,001 – 500,000		
> 500,000		

5.2.2.3 Resources

a. The Plan requires a Vendor that is willing to dedicate resources to the Plan during implementation and on an ongoing basis.

The Vendor shall provide each of the following:

i. Organizational chart of key executives, operational leaders, and technical leaders who will support the Plan during implementation and on an on-going basis.

ii. Short biography for each of the staff listed in the chart; clearly note the frequency the Plan will interact with each staff member.

b. The Plan requires certain resources be dedicated to the Plan and available to support the Plan on an ongoing basis.

The Vendor shall confirm it will provide a dedicated resource for each of the following roles. If the staff member assigned to fill the role is already known, Vendor shall include a brief biography of the specific resource:

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. **Member Services Manager –** Responsible for all customer service functions and reporting.

iii. **Claims Services Manager –** Responsible for claims payments and recoveries.

iv. **Enrollment, Group Set-Up, and Premium Billing Manager –** Responsible for all enrollment, enrollment files, premium billing, and reconciliation services.

v. **Operations Director –** Provides oversight of Members Services, Claims Services, Enrollment, Group Set-Up, and Premium Billing Manager.

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. If a different resource is needed to manage data exchanges than is needed to manage data analytics, modeling, and data requests, the Vendor shall provide information on both resources.

vii. **Network Operations Manager –** Provides oversight and leadership of the implementation and maintenance of the Plan's custom network, the North Carolina State Health Plan Network. This includes implementing and updating the tools required to maintain the reimbursement rates and methodologies outlined in Exhibit 1, North Carolina State Health Plan Network Participation Agreement: Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, and any current or future alternative payment arrangements.

viii. **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.

While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed.

The 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 objectives.

ii. **Actuary -** Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating 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.

iii. **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 ERISA. Responsible for maintaining internal controls to protect PHI and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.

iv. **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 the 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 the extent to which North Carolina Department of Insurance ("DOI") regulations apply to the Plan.

b. The Vendor shall describe any limitations and/or issues with meeting requirements b.- c. above.

c. The Plan prefers a Vendor with the resources named in 5.2.2.3.b. located in North Carolina.

The Vendor shall provide the following:

i. City and state for each office where resources named in 5.2.2.3.b. will be primarily located.

ii. City and state for each location that will provide support for the services included in this RFP (i.e., claims processing, customer services, medical management, data management, and implementation).

iii. Approximate number and type of staff for each location**.**

d. The Plan requires a Vendor that is both responsive and transparent.

The Vendor shall confirm and describe 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 forty-eight (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 twenty-four (24) hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.

v. 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.

vi. Vendor will provide the Plan detailed information, including direct access to contracts, relating to current and proposed provider payment arrangements. 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.

vii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.

viii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. - vii., above.

5.2.3 Finance and Banking

5.2.3.1 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 the processing, handling, tracking and reporting of group premium billing and collections, and claims processing and provider payments and recoveries. The Vendor must be able to accept electronic fund transfers and checks from multiple Employing Units and process and deposit receipts each day as well as batch claims and other disbursements on a weekly basis as required by the Plan. The 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.

It is important to understand the billing and payment hierarchy of the Plan.

- **Premium billing** – Billed to and paid by the Employing Units with oversight from the Plan
- **Claims funding** – Billed to and funded by the Plan
- **Administrative Services Fees** – Billed to and paid by the Plan

Objectives

a. Promote efficiency, accuracy, and a superior Customer Experience for the Plan and its Employing Units by selecting a Vendor with state-of-the-art business tools, processes and services.

b. Ensure accurate and timely processing and reporting of premium collections and deposits and related transactions.

c. Ensure accurate and timely processing and reporting of disbursements, including claims payments and related transactions.

d. Ensure all applicable policies and regulations of the Office of State Controller and the Department of State Treasurer, including State banking requirements, are supported and followed.

5.2.3.2 Services

a. The Plan requires a Vendor that can support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:

- State banking: https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf
- Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
- Escheats: https://www.nccash.com/holder-information-and-reporting
- High level daily deposits and disbursements of state funds workflows: Exhibit 2

The Vendor shall confirm and describe each of the following:

i. Vendor will comply with all State banking requirements, cash management policies, escheat regulations and any other related requirements for handling the Plan's financial transactions.

ii. Vendor will provide detailed, accurate and timely financial reporting related to all financial processes completed on behalf of the Plan.

iii. Vendor will manage multiple bank accounts for deposits, and if applicable, disbursements under the Department of State Treasurer, if required.

iv. Vendor will complete bank reconciliations for all disbursing accounts, if required.

v. Vendor will complete the escheat process for warrants/checks generated by the Vendor and issued against the Plan's bank account(s) or against the Vendor's bank accounts as prescribed by State guidelines and regulations. Refer to Exhibit 3 for TPA Escheats Process.

vi. Vendor will track and report receivables as well as earned and unearned revenue on behalf of the Plan.

vii. Vendor will provide access to up to three (3) years of historical premium billing and receipts and claims funding data.

viii. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-vii., above.

The Vendor shall describe the process for each of the following:

ix. Receiving and depositing, on a daily basis, premiums, refunds, and other receipts in the form of checks, automatic clearing house (ACH) drafts and wires in the Plan's bank account with the State Treasurer in accordance with N.C.G.S. § 147-77.

x. Determining and notifying the Plan of funding requirements for claims and other disbursements and the submission of backup documentation.

xi. Reviewing and issuing refunds as appropriate. Include turn-around time.

xii. Handling and reporting of any type of returns on deposited receipts.

xiii. Detecting, correcting, and reporting misapplied deposits and collections.

xiv. Tracking, reporting, and collecting receivables including delinquent accounts.

xv. Determining uncollectible accounts for debt write-off, including criteria.

xvi. Tracking and reporting prepaid premiums.

xvii. Tracking, handling, and reporting recoveries.

xviii. Handling returned provider payments.

b. The Plan requires a Vendor with state-of-the-art business software and processes to conduct the activities and services within the scope of the Contract.

The Vendor shall confirm and describe each of the following:

i. The Vendor will provide electronic submission of deposit reports, disbursement funding requirements, and detailed back up documentation in support of all financial transactions.

ii. The Vendor will provide electronic submission of invoices and back up documentation for administrative fees.

iii. The Vendor will accept and apply electronic Data Files containing multiple group premium payments from the State or another vendor and upload into the premium billing system within twenty-four (24) hours of receipt. (e.g., One vendor submits premium payments on one file for multiple state agencies.)

iv. The Vendor will provide historical check register detail and premium billing and receipts as well as claims funding data at the Plan level.

v. The Vendor shall describe any limitations and/or issues with meeting requirements b.i. – iv., above.

The Vendor shall describe each of the following:

vi. The integration between the premium billing, collection, claims processing, auditing, and recovery systems and financial reporting systems.

vii. Number of years beyond three (3) years for which historical data is available, the level of detail, and reporting capabilities.

c. The Plan requires a Vendor that will ensure that all deposits and disbursements are accurate and that proper financial controls are in place.

The Vendor shall confirm and describe each of the following:

i. The existence of an internal quality control program and audits that will ensure the accuracy of all financial reporting to the Plan.

ii. The existence of a monthly reconciliation process for medical claims; all receipts including but not limited to regular deposits, ACHs/drafts, claims refunds, and recoveries; bank accounts including returned payments and nonsufficient funds (NSF).

iii. The Vendor shall describe any limitations and/or issues with meeting requirement c.i.-ii., above.

The Vendor shall provide each of the following:

iv. Accuracy standards and internal audit results relative to processing deposits and disbursements on behalf of ASO clients from each of the last two (2) years.

v. A description of the internal quality control program and audits.

vi. A description of the process for reconciling bank accounts.

vii. A description of the process for reconciling claims payments and claims refunds.

viii. A description of the process for reconciling premium receipts.

ix. A description of the process for reconciling all deposits including regular deposits, ACHs/drafts, benefit/claim refunds, recoveries, etc.

d. The Plan requires a Vendor that can adhere to the requirements regarding weekly claims and other disbursements, daily deposits, and related financial processing and reporting. Refer to Exhibit 2 for Daily Deposits and Disbursements of State Funds Workflows.

The Vendor shall confirm and describe each of the following:

i. For Vendors disbursing funds from Plan bank accounts, or requesting reimbursement from the Plan for checks and ACH transactions from the Vendor's bank accounts that have been cashed or accepted, the Vendor will batch claims for payment from the Plan's bank account on a weekly basis as determined by the Plan.

ii. For Vendors disbursing funds from Plan bank accounts or requesting reimbursement from the Plan for checks and ACH transactions from the Vendor's bank accounts that have been cashed or accepted, the Vendor will issue any other disbursements, including refunds from the Plan's bank account on a weekly basis as determined by the Plan.

iii. The Vendor will hold payment of weekly claims and other disbursements until funding is authorized and requisitioned by the Plan.

iv. The Vendor will limit the aggregate dollar amount of claims paid each week if requested by the Plan to manage cash flow.

v. The Vendor will deposit checks received into the Plan's bank account within twenty-four (24) hours of receipt to comply with the State's banking and cash management requirements.

vi. The Vendor will provide a daily reporting package of deposited premiums and other receipts as required by the Plan (see reporting Section 5.2.16).

vii. The Vendor will provide a weekly reporting package of claims and other disbursements as required by the Plan (see reporting Section 5.2.16).

viii. The Vendor will customize the reporting of any deposits, disbursements, or other financial transactions as required by the Plan.

ix. The Vendor will notify and report on all warrants/checks to be escheated prior to submitting state filings, and if required by the Plan, adhere to a prior approval process for escheats.

x. The Vendor will recommend uncollectible accounts for write-off and adhere to a prior approval process.

xi. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. – x., above.

The Vendor shall provide the following:

xii. The Vendor's claims batching workflow.

e. The Plan requires a Vendor that will ensure financial and banking processes and reporting remain compliant over the term of the Contract.

The Vendor shall confirm and describe the following:

i. The Vendor will notify and consult with the Plan at least sixty (60) days in advance, or as soon as practicable, of any system or business process or system change as it relates to the handling, processing, or reporting of the Plan's financial transactions.

ii. The Vendor will notify the Plan when any system outage, defect, or other issue impacts the ability to meet any of the requirements in this section of the RFP.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements e.i. – ii., above.

The Vendor shall provide:

iii. A SOC 1, Type II, which reports on controls at the service organization relevant to user entities financial statements including the design and operating effectiveness of controls (testing of controls and results). If applicable, a bridge letter should be provided to attest that to the best of management's knowledge, controls have not materially changed since the last audit opinion.

The Vendor shall confirm the following:

iv. The Vendor will provide an annual SOC 1, Type II report upon request by the Plan.

v. The Vendor shall describe any limitations and/or issues with meeting requirements e.iv., above.

f. The Plan requires a Vendor that will process ad hoc checks, such as settlement checks to Members, as requested by the Plan. The funding of these checks will be included as part of the weekly disbursement.

The Vendor shall confirm and describe the following:

i. The Vendor will process ad hoc checks to Plan Members and other entities, as requested by the Plan.

ii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i., above.

5.2.4 Network Management

5.2.4.1 Overview and Expectations

The Plan seeks a Vendor that will support its provider reimbursement strategy which is the focal point of the Clear Pricing Project. This project has been designed to provide affordable, quality care and increase transparency, predictability, and value for Plan Members. To accomplish these goals, the Plan has begun to build its own network of North Carolina providers, the North Carolina State Health Plan Network ("custom network"), with reimbursement rates that are referenced to Medicare rates. The Vendor must load the Plan's custom network in the Vendor's system(s), and process claims based on the reimbursement methodology developed by the Plan. See Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy. While the Plan will contract directly with some providers, the Vendor must be able to supplement the Plan's custom network with other providers to ensure access to care standards are met throughout the state and provide supplemental contracts for services such as reference labs, durable medical equipment, and other commodity services. The Vendor must be flexible in this regard, including being able to accommodate the transition of more providers to the custom network in the future.

The Vendor also must be able to supplement the Plan's custom network with a national wrap-around network of providers located outside of North Carolina, as the Plan has Members in every state. During the initial phase of the Clear Pricing Project, providers outside of North Carolina will not be required to accept the Medicare-based reimbursement methodology.

The Plan shall partner with a Vendor that will work with the Plan during the implementation of the custom network to develop processes, payment policies, and ongoing network maintenance, to ensure that the integrity and ongoing viability of the custom network is maintained.

While phase one of the Clear Pricing Project is the establishment of a provider network whose reimbursement rate is referenced to Traditional Medicare, it is the Plan's intent in the next phase to strategically layer alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation, into the provider contracts where appropriate. The Plan shall partner with a Vendor with a shared vision to customize and implement these strategies, as needed, to meet the Plan's goals. A 'one size fits all' methodology will not meet the needs of a state so geographically diverse as North Carolina.

Finally, the Plan recognizes that the health care landscape is constantly changing; therefore, the Plan also seeks to partner with a Vendor that has the flexibility to meet changing needs which may include a full-service network offered

by the Vendor or a narrow network offered by the Vendor or designed specifically for the Plan. The Plan intends to evaluate the full breadth of provider services offered by the Vendor.

Objectives:

a. Partner with a Vendor who will support and supplement the Plan's custom network.

b. Engage a Vendor that has systems and processes that will easily administer and maintain the Plan's reference-based reimbursement methodology.

c. Provide a quality network to support Plan Members who reside in all one hundred (100) counties of North Carolina and throughout the United States.

d. Ensure that Plan Members living and traveling outside of North Carolina have access to a strong network.

e. Engage with a Vendor that will provide a full-service network or a narrow-network, if requested by the Plan.

f. Partner with a Vendor that has thought leadership around developing and implementing custom provider reimbursement strategies to the meet the future needs of the Clear Pricing Project.

g. Partner with a Vendor that has demonstrated experience implementing alternative payment models such as, but not limited to, Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), and two-sided risk.

h. Partner with a Vendor that will work with the Plan and other Plan vendors to develop and implement new alternative payment models such as bundled payment arrangements, risk sharing, and capitation.

5.2.4.2 Custom Network Services

a. The Plan requires a Vendor that will provide claims processing and related services utilizing a custom network that includes providers contracted by the Plan. While the Plan intends to contract directly with service providers in North Carolina, the Vendor will need to supplement the network with a national wrap-around network of providers located outside of North Carolina. The Vendor will also be asked to supplement the network with contracts for services such as reference labs, durable medical equipment, or other commodity services and other North Carolina providers, as needed, to ensure access to care standards are met.

The Vendor shall confirm and describe each of the following:

i. Vendor acknowledges that the Plan is a governmental payor.

ii. Vendor will accept and load a network of North Carolina providers contracted directly by the Plan. This includes loading the providers to facilitate claims processing and provider look-up via a provider search tool for Plan Members.

iii. Vendor will provide a portal for Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.

iv. Vendor will maintain an accurate and functional provider directory for the Plan, including providing a function in the portal through which providers can update their demographic information at regular intervals specified by the Plan.

v. Vendor will administer all provisions of the current North Carolina State Health Plan Network Participation Agreement ("NPA"), Exhibit 1 and Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy.

vi. Vendor will administer any future iterations of and changes to the NPA with the understanding that these are not subject to review by the North Carolina Department of Insurance ("DOI") since the Plan is self-funded and not subject to DOI regulations except for those specifically listed in N.C.G.S. § 135-48.51.

vii. Vendor will supplement the Plan's custom network with other providers contracted directly by the Vendor to ensure access to care standards are met in North Carolina.

viii. Vendor will supplement the Plan's custom network with other providers contracted directly by the Vendor for services such as, but not limited to, durable medical equipment, reference labs, or other commodity services. Vendor will allow the Plan will view these contracts upon request.

ix. Vendor will work with the Plan to develop and implement reimbursement strategies to reduce costs for services such as, but not limited to, specialty pharmacy.

x. Vendor will provide a national wrap-around network of providers located outside of North Carolina to support Members living and traveling around the country. The Plan has Members residing in all fifty states.

xi. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-x., above.

b. The Plan requires a Vendor that will administer the Plan's Medicare-based reimbursement methodology for in-network providers in the custom network that includes different reimbursement rates for professional, inpatient, and outpatient services. See Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy. There is also a delineation between rural, non-rural, and other facilities:

- **Non-Rural Inpatient – 175% of Medicare**
- **Non-Rural Outpatient – 225% of Medicare**
- **Professional – 160% of Medicare**
- **Rural Inpatient– 200% of Medicare**
- **Rural Outpatient – 235% of Medicare**

The Vendor shall confirm and describe each of the following:

i. Vendor will load, maintain, and adjudicate claims for in-network services rendered by providers contracted by the Plan in the custom network according to the Plan's Medicare-based reimbursement methodology at the in-network rates outlined above. Include in the description the specific repricing/pricing tools that will be used.

ii. Vendor will integrate with Optum Insight or a comparable tool to support and maintain the existing repricing/pricing structure if desired by the Plan.

c. The Plan requires a Vendor that will administer the Plan's Medicare-based reimbursement methodology for out-of-network providers as follows:

- **Non-Rural Inpatient – 125% of Medicare**
- **Non-Rural Outpatient – 150% of Medicare**
- **Professional – 130% of Medicare**
- **Rural Inpatient – 150% of Medicare**
- **Rural Outpatient – 180% of Medicare**

The Vendor shall confirm and describe each of the following:

i. Vendor will load, maintain, and adjudicate claims for non-network services according to the Plan's Medicare-based reimbursement methodology at the non-network rates outlined above.

ii. Vendor will reimburse Members, not providers, when services are rendered by an out-of-network provider.

d. While the Plan may contract directly with North Carolina providers in the custom network, the Plan requires a Vendor that will be responsible for the development, maintenance, and administration of medical and payment policies. In addition, the Vendor must be able to administer any Medicare medical and payment policies adopted by the Plan. Because the Plan's reimbursement methodology is indexed to

Medicare, some policies may need to be adjusted to better align with Medicare guidelines. In the future, the Plan may require the administration of medical or payment policies developed by other Plan vendors.

The Vendor shall confirm and describe:

i. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support the Plan's custom network.

ii. Vendor will administer any Medicare medical and payment policies adopted by the Plan.

iii. If necessary, Vendor will adjust its medical and payment policies to align with a Medicare-based reimbursement methodology and utilize these policies when administering benefits for the Plan.

iv. Vendor will administer any medical or payment policies developed by other Plan vendors in the future.

e. The Vendor shall describe any limitations and/or issues with meeting requirements b. – d. above.

f. While the Plan may contract directly with North Carolina providers, the Plan requires a Vendor that will be responsible for credentialing new providers that join the custom network.

The Vendor shall confirm and describe:

i. Vendor will evaluate and credential any new providers that wish to join the Plan's custom network.

ii. Vendor will reevaluate current Plan providers' credentials at the appropriate intervals.

iii. Vendor has a robust credentialing process in place to ensure timely completion of this function. Include in the description the Vendor's standard turnaround time for completing the credentialing process and the frequency with which the Vendor recredentials providers.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. – iii., above.

g. The Plan requires a Vendor that can follow access to care standards when there is not a specific provider available in a geographic area.

The Vendor shall provide the following:

i. Vendor's current access to care standards for North Carolina.

h. The Plan requires a Vendor that is flexible in its approach to handling "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).

The Vendor shall confirm and describe each of the following:

i. How "hidden providers" are addressed in the Vendor's provider contracts and/or payment policies.

ii. How "hidden providers" allowed amounts are determined by the Vendor.

iii. Whether "hidden providers" are paid at the in-network or out-of-network cost-shares.

iv. Vendor will customize "hidden provider" payment policies, as requested by the Plan.

v. Vendor will apply "hidden provider" rules as required by the Plan.

vi. The Vendor shall describe any limitations and/or issues with meeting requirements h.i. – v., above.

i. The Plan requires a Vendor that has demonstrated the ability and experience to design and implement transparent alternative payment and/or care delivery models. The Vendor must also integrate with other Plan vendors to support these arrangements.

The Vendor shall confirm and describe each of the following:

i. Experience and ability in designing or contributing to the design of each of the following alternative models of care or clinically integrated systems. Include details about the scale of each initiative, the population and the provider network involved.

1) Bundled/Episodic Payments.
2) Clinically Integrated Networks.
3) Patient-Centered Medical Homes.
4) Accountable Care Organizations.
5) Community Care Organizations.
6) Integrated Delivery Networks.
7) Physician-Hospital Organizations.
8) Shared Risk/Savings.
9) Pay-for-Performance.
10) Global Payment/Capitation.
11) Primary Care Incentives.

ii. 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.

iii. Vendor has the system capability to support capitated payments.

iv. Vendor has the capability to manage two-sided risk and upon request will implement a custom risk arrangement for the Plan.

v. Vendor has the tools to initiate a new clinical partnership, assign payment, and achieve physician engagement in new models of payment and care.

vi. The Vendor shall describe any limitations and/or issues with meeting requirements in i.i. – v., above.

The Vendor shall provide each of the following as examples of leadership, expertise, and capability to implement innovative provider payment models:

vii. Example of an implementation of an innovative engagement strategy that resulted in an increase in provider/patient engagement. Include details on the scale of the initiative and describe the population and the provider network involved.

viii. Description and examples of tools and actionable reports used for provider/network-level viewing of progress reports, such as dashboards.

ix. Description of the type of innovative alternative provider payment model(s) the Vendor would recommend be implemented for Plan Members inside and outside of North Carolina.

j. The Plan requires a Vendor with a provider call center to have hours of operation from at least 8:00 a.m. ET to 5:00 p.m. ET, each State Business Day, to respond to all provider inquiries, whether for the custom network or Vendor's supplemental network. The call center should be dedicated to the Plan with Plan-specific phone number and greeting.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide a dedicated provider call center for network and claims questions with a dedicated toll-free number with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to provider inquiries. Include the description of the anticipated number of resources that will be assigned to this call center.

ii. Vendor will accept and respond to provider emails.

iii. Vendor will answer the phones with a greeting that identifies the Vendor's representative as a member of the State Health Plan.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements in j.i. – iii., above.

The Vendor shall describe each of the following:

v. Any other non-web-based services provided to providers by the Vendor's Call Center.

vi. The method for handling complaints, for developing and implementing action plans to resolve complaints, and for reporting complaints and follow-up actions to the Plan.

vii. The training that will be provided to Vendor's Call Center resources, to educate them on the custom network.

5.2.4.3 Traditional Network Services

a. As stated throughout this RFP, one of the key principles for the Plan is to provide transparent pricing and high-quality care. This principle applies whether the Plan utilizes its own custom network, or a network provided by the Vendor. Therefore, the Plan requires a Vendor that offers traditional TPA services that include providing network solutions that are contracted and managed by the Vendor. In this regard, the Plan requires a Vendor that will provide a strong network in all one hundred (100) counties of North Carolina and throughout the United States. The Vendor's North Carolina network will be used, at the Plan's discretion, to supplement the Plan's custom network or as a stand-alone network.

The Vendor shall confirm and describe how it will:

i. Provide a network that will support the Plan's current Plan Designs for Members residing in all one hundred (100) counties in North Carolina and throughout the United States.

ii. Provide a network that will support the Plan's current Plan Designs for Members who live in or travel to one of the other forty-nine (49) states.

iii. Provide services to Members who travel outside the United States and have an urgent medical need.

iv. Support transparency by allowing the Plan, at its request, to directly view any contracts associated with this network.

v. The Vendor shall describe any limitations and/or issues with meeting requirements in a.i. – iv.

b. The Plan requires a Vendor with a robust provider management component.

The Vendor shall describe each of the following:

i. Organizational structure of the network management and/or provider development team(s). Include the names and job descriptions of the network management team members that will interact with the Plan to support ongoing network initiatives.

ii. Primary functions for network management/provider relations team(s).

iii. Network growth and development plans including how network gaps and deficiencies are evaluated and addressed.

iv. Approach for recruiting and selecting providers to participate in Vendor's network(s).

v. Process for collaborating with providers to address issues that may develop over time.

vi. Process for initiating and monitoring provider quality improvements.

vii. Process for collaborating with providers on new initiatives, models, or demonstrations. Provide a recent example.

viii. Frequency of provider office site visits.

ix. Provider education and retention activities and the frequency of each.

x. Process for responding to and investigating Member reported provider deficiencies.

xi. Process for responding to and investigating Member complaints about providers.

xii. Process for responding to and investigating Member reported provider fraud.

xiii. Payment models, other than fee for service, currently in use in North Carolina and nationally.

xiv. Basis for determining non-network claim allowed amounts when services required by Members are available in-network. (i.e. usual & customary, average contracted rate, percent of Medicare, billed charges).

xv. Basis for determining non-network claim allowed amounts when services required by Members are not available in-network. (i.e. usual & customary, average contracted rate, percent of Medicare, billed charges).

xvi. Criteria used to tier networks and to include/exclude providers, as well as a go forward strategy to move to risk-based reimbursements and how that will impact provider access.

xvii. How Centers of Excellence and transplant network services are developed. Include in the description the process for selection, evaluation, and ongoing performance measurement.

xviii. Strategy to reduce the cost variance on commodity services such as those listed below. Include in your description any cost variance opportunities based on site of service and/or reference based pricing.

1) Radiology.
2) Lab Services.
3) Durable Medical Equipment.
4) In office specialty medications.

xix. How the Plan will be informed of major contract disputes or potential network disruption to its Members.

xx. How the Vendor is moving towards transparency in provider contracting.

Continues on next page.

c. The Plan requires a Vendor that maintains high quality networks.

The Vendor shall complete:

i. The table below regarding physician credentialing for the Vendor's proposed network. Verified does not mean self-reported by the physician. It means the status is confirmed by the Vendor through some other data source.

Table 2. - Network Quality			
Vendor's Proposed Network	**Verified**	**Data Source Utilized?**	**Frequency of Re-credentialing?**
State License	☐ Yes		Every _____years
Medical School Grad	☐ Yes		Every _____years
DEA Current	☐ Yes		Every _____years
Residency Training Grad	☐ Yes		Every _____years
Board Certification	☐ Yes		Every _____years
Proof of Malpractice Insurance	☐ Yes		Every _____years
Malpractice History	☐ Yes		Every _____years
Hospital Standing	☐ Yes		Every _____years
Hospital Privileges	☐ Yes		Every _____years
National Databank Registration	☐ Yes		Every _____years
Federation of State Boards	☐ Yes		Every _____years
Review of Consumer Complaints	☐ Yes		Every _____years

ii. The table below that identifies the NCQA and/or URAC accreditation achieved by Vendor's commercial PPO business. Be specific about the accreditation status and corresponding dates.

Table 3. - Accreditation				
Type of Accreditation	**Date of Accreditation**	**Renewal Date**	**Date of last review**	**Outcome of Review**

iii. For Table 3 above, provide the following:

1) If accreditation was denied or highest accreditation available not received, provide the rationale.
2) If no review was held or scheduled, note the reason.
3) If Vendor's accreditation status changed between the initial review date and current status, indicate each status change and date of the change.

The Vendor shall provide each of the following:

iv. A GeoAccess report for Vendor's proposed network using the zip code census data for Plan membership. See Exhibit 8 for the State Health Plan for Teachers and State Employees 5 Digit ZIPcode report.

v. Based upon the data provided, identify any counties in North Carolina or in other states where the provider network may not have adequate capacity to meet potential Plan demand.

vi. Access to care standards.

vii. Description of how network adequacy, or access to care, is determined and monitored.

viii. Description of expansion plans in areas that do not meet access to care standards.

ix. For the state of North Carolina, provide a listing of all acute care North Carolina hospitals that are considered out-of-network hospitals in Vendor's proposed network.

x. A network directory for the Vendor's proposed network for all of North Carolina.

xi. A North Carolina map indicating participating counties and the process for enhancing networks as needed.

xii. Maps of Florida, South Carolina, Virginia, Georgia, and Tennessee indicating participating counties and the process for enhancing networks as needed.

xiii. Process for accessing care outside of the United States.

d. The Plan requires a Vendor that, upon request, will offer a "narrow" network of lower cost, high quality providers for the Plan's Members located in all 100 counties in North Carolina.

The Vendor shall confirm and describe how it will:

i. Offer a statewide "narrow" network of lower cost, high quality providers to be paired with a custom plan design, as requested by the Plan. This offering may be a full replacement or offered alongside other plan design options. Vendor should describe in which counties and/or cities the network is "narrowed" and which systems and large providers are in and out of the narrow network. Provide, along with the description, a GeoAccess report for Vendor's proposed narrow network using the zip code census data for Plan membership. See Exhibit 8, State Health Plan for Teachers and State Employees 5 Digit ZIPcode report.

ii. Build a custom narrow network at the regional or state level for the Plan. Include in the description the timeline to develop and deploy a custom network.

iii. Provide a strategy to ensure Plan Members have access to primary care providers, behavioral health providers, and specialists based on the size of the "narrow" network proposed.

iv. Support transparency by allowing the Plan, at its request, to view any contracts associated with this network.

v. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iv., above.

The Vendor shall describe the following:

vi. Custom network reimbursement options for Members who live and/or seek care outside of North Carolina.

The Vendor shall provide each of the following:

vii. Description of the types of "narrow network" products or Plan Designs currently available.

viii. Description of metrics utilized to qualify physicians and facilities for the "narrow network."

ix. Description of any other Network Specific Products or Plan Designs not already described that are available to the Plan.

x. All current network offerings available in North Carolina.

e. The Plan requires a Vendor that has strong transition of care policies to assist Members when their provider is no longer in the network or if they are admitted to a non-network facility.

The Vendor shall describe each of the following:

i. Process for notifying Members when their selected PCP is no longer in the network.

ii. The transition of care process and overall Member impact when a Member is admitted to a non-network facility on an emergency basis (i.e. admitted through the emergency room).

f. The Plan prefers a Vendor that supports the Plan's need to communicate Plan specific benefits, Plan Design, and programs to Providers.

The Vendor shall confirm and describe each of the following:

i. Availability of a provider portal and how Vendor will share Plan specific information with network providers via the portal.

ii. Other tools and resources available to the Plan to communicate directly with network providers about Plan specific benefits, Plan Designs, programs or other initiatives, as requested by the Plan.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. – ii., above.

5.2.5 Medical Management & Health Care Support Programs

5.2.5.1 Overview and Expectations

Medical Management - The Plan seeks a Vendor that demonstrates versatility and innovation in managing the complex medical environment. The 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. The Vendor must provide Medical Management services for physical and behavioral health diagnoses, including substance abuse diagnoses, highly acute and prevalent diagnoses, as well as new diagnoses or conditions that become of interest to the Plan in the future. The Vendor must be able to support the Plan in providing the right care, at the right time, delivered within the right place of service by the right provider at the right price to all Members in need of medical care.

Health Care Support Programs is the approach the Plan has adopted for supporting Members and managing all aspects of health, across the spectrum of wellness to chronic disease and end of life support. The Plan focuses on engaging Members in their own health and simultaneously improving the quality and coordination of care within the health care system. The goal has been and continues to be to maintain or improve the Member's health by providing them with benefits and a variety of resources that meet the Members where they are in their journey to better health and wellbeing.

Objectives

a. Ensure high quality, comprehensive, holistic Medical Management and Health Care Support Programs for Members' physical health, behavioral health, and substance abuse/misuse care, with the goal of reducing the overuse/ underuse of medical services and maximizing cost-effective options that result in optimal Member outcomes.

b. Partner with a Vendor that utilizes clinical quality indicators, including Healthcare Effectiveness Data and Information Set (HEDIS) and other national quality standards to monitor appropriateness, quality, effectiveness, and accessibility of care to minimize variations between practices and provider networks across the State.

c. Provide new and innovative Medical and Health Care Support Programs and initiatives to address needs and opportunities identified to meet the Plan's strategic priorities.

d. Identify Members that need assistance with the day to day management of their chronic conditions and provide the resources and support necessary to manage them.

5.2.5.2 Services

a. The Plan requires a Vendor that 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.

The Vendor shall confirm and describe each of the following:

i. The Vendor will provide Member-appropriate, cost efficient, and effective services for each of the following:

1) Prior-authorization (PA) programs.
2) Post-service medical reviews.
3) Utilization management programs.
4) Concurrent review programs.
5) Transition of care programs.
6) Service denial appeals.
7) Targeted case management (in-patient, transplant, extended length of stay, hip and knee replacements).
8) Benefit exception process.

ii. The Vendor will customize any of the Medical Management programs or policies, as requested by the Plan.

iii. Describe any limitations and/or issues with meeting requirements in a.i.-ii. above.

The Vendor shall provide each of the following:

iv. Process for evidence-based medical policy development and review schedule including process of offering coverage for new technologies and/or services.

v. Processes used to identify, propose, implement, and evaluate interventions to address Member patterns of overutilization or ineffective utilization of controlled substances, emergency department (ED), inpatient utilization, poly-pharmacy, and other high cost, inefficient, or ineffective services.

vi. A description of the online capacity for pre-certification submission and adjudication available to Providers, as well as any other electronic tools available to support Medical Management

b. The Plan requires a Vendor that will offer new and innovative Medical Management programs for Plan Members, and support the Plan's strategic interests.

The Vendor shall confirm and describe each of the following:

i. The Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation.

ii. The Vendor will serve as a thought leader around Medical Management initiatives to specifically address Plan Members' current and anticipated health care needs.

iii. The Vendor will compare related cost and outcomes across specific diagnosis categories and provide solutions to address any discrepancies identified among providers.

iv. The Vendor will provide solutions to address significant and unfavorable medical diagnoses and care gap closure trends specific to Plan Members.

v. Describe any limitations and/or issues with meeting requirements in b.i.-iv. above.

The Vendor shall provide details on the following, including actual impact achieved on reducing costs and improving outcomes / health status:

vi. Sample innovative Medical Management pilot programs currently in place as well as any planned or in development.

vii. Examples of innovative models of care programs/pilots planned, in development, retired, or currently in place, including solutions to challenges and outcomes as applicable.

viii. Examples of thought leadership provided to clients and if implemented, detail the process, timeline, intervention(s), strategies to solve challenges, and outcomes, as applicable.

ix. Examples of practice and/or provider level quality improvement interventions, including solutions to challenges and outcomes.

c. The Plan requires a Vendor that can identify Plan Members that require specialized care.

The Vendor shall confirm it will appropriately identify and engage Members in each of the following programs. Include in the description the algorithms used to identify Members for the program as well as any limitations to delivering the programs:

i. Transition of Care (TOC) Programs.

ii. High utilizer outreach and management programs.

iii. Complex case management programs.

iv. Describe any limitations and/or issues with meeting requirements in c.i.-iii. above.

d. The Plan requires a Vendor that will work with the Plan to develop and implement new targeted care management programs, as requested by the Plan. Some programs may require integration with other Plan vendors or Plan Partners. The Vendor may also propose new care management programs for Plan Members.

The Vendor shall confirm and describe each of the following:

i. Upon request, the Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members.

ii. The 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, the Vendor, and any other Plan vendors or Plan Partners involved in the program administration.

iii. Describe any limitations and/or issues with meeting requirements in d.i. - ii., above.

The Vendor shall describe each of the following:

iv. All targeted and special care management programs available to the Plan.

v. Process to research, define strategy, develop, and implement a targeted or special care management program.

The Vendor shall provide:

vi. Examples of any targeted programs developed and implemented, include any barriers experienced and outcomes as a result of the program.

e. The Plan requires a Vendor that will conduct risk stratification for identifying and targeting Plan Members who could benefit from disease management, case management, and health coaching services.

The Vendor shall confirm that it will stratify and perform targeted outreach based on the following:

i. Current health status.

ii. Functional status.

iii. Risk of disease/disease progression.

iv. Risk of hospitalization or recent hospitalization.

v. Hospital readmissions.

vi. Risk identified by Wellness Review completion, medical claims, and Rx drug claims.

vii. Enrollment in special programs (e.g., lower or waived co-pays for drugs related to a chronic condition, waived co-pay) that require engagement with a nurse or health coach.

viii. High utilization of services (e.g., non-emergent/emergent related to chronic illness, ambulance, hospitalization, pharmacy, hospital re-admissions). High utilization will be determined by the Vendor as approved by the Plan.

ix. Low or poor utilization of services (e.g., absence of a PCP visit or an annual preventive exam for a 45-year-old with a diagnosis of asthma).

x. High claim amount.

xi. History of high cost claims over a specified period of time.

xii. Situations where a Member did not receive appropriate care based on accepted standards of care (gaps in care).

xiii. Special populations identified for high intensity case management, such as Members with renal disease or mental health issues, or other conditions to be agreed upon between the Plan and the Vendor.

xiv. Other criteria requested by the Plan.

xv. Describe any limitations and/or issues with meeting requirements in e.i.-xiv. above.

The Vendor shall describe each of the following:

xvi. Programs of disease management, case management, and care coordination that are currently provided to clients. Description should include details on number of required sessions, core components, and any national models that are followed in these programs. Indicate which programs will be available to the Plan on January 1, 2022.

xvii. Process of outreach and intervention to Members identified as requiring disease management or case management that will incorporate the Member's lifestyle, education level, socioeconomic factors, health and wellness behaviors, attitudes/readiness to change, and values. This should include but is not limited to:

1) Triage, assessment, and intervention following clinical protocols.
2) Education about treatment options.
3) Appropriate referrals for medical management (e.g., case management and disease management or other available resources (weight loss programs, diabetes prevention programs, tobacco and vaping cessation programs, etc.).

xviii. Ability to propose innovative benefit design around long-term care including transition support from the hospital to the community (community would encompass home, nursing home, retirement home, hospice, skilled nursing facility, etc.).

xix. Ability to perform specialty case management and care coordination for high cost specialty conditions such as oncology, multiple sclerosis, or rheumatoid arthritis.

xx. Alternative methods for reaching “unable to reach” Members and Members that opt to be added to do not call lists.

xxi. Capability to securely store and update Member contact information.

The Vendor shall provide the approach, process, and tools used to:

xxii. Conduct the risk stratification.

xxiii. Collect Member contact information.

xxiv. Members for outreach.

xxv. Conduct outreach to Members.

xxvi. Address “unable to reach” Members.

xxvii. Communication for items (i) through (v) listed above, including modes of communication other than telephonic.

xxviii. Work with Members and providers to achieve closure of “gaps in care.”

xxix. Collaborate with providers and hospitals to provide support services and coordinate patient care.

xxx. Perform disease management, including the specific diseases or conditions targeted for intervention.

xxxi. Perform case management, including the specific diseases or conditions targeted for intervention.

xxxii. Provide end of life supports.

f. The Plan prefers a Vendor that will work with other Plan vendors and/or Plan Partners to provide the appropriate care and support for Plan Members.

The Vendor shall confirm and describe the following:

i. Vendor’s ability to perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.

ii. Describe any limitations and/or issues with meeting requirement in f.i. above.

The Vendor shall describe the following:

iii. Vendor’s process to identify and report on outcomes following referral to Plan vendors and Partners.

g. The Plan prefers a Vendor that provides strong health coaching services.

The Vendor shall confirm and describe the availability of each of the following. Include in the description the educational requirements and professional certifications of the staff providing the services along with the training provided to prepare them to work with Plan Members.

i. Disease Management Health Coaching Services, including specialized health coaches such as Certified Diabetes Educators (CDE), Registered Dietitians, Pharmacists, Exercise Physiologists, etc., in addition to Registered Nurses.

ii. Active Lifestyle Health Coaching Services, including nutritionists, behavioral therapists, exercise physiologists/personal trainers, etc.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements g.i. – ii., above.

h. The Plan requires a Vendor that incorporates the latest technology when managing Plan Members' health.

The Vendor shall confirm and describe the following:

i. Vendor incorporates the use of use of mHealth products to collect member-level data, such as glucometers, scales, blood pressure monitoring systems used by home-based monitoring, mobile applications, or wearables.

ii. The Vendor shall describe any limitations and/or issues with meeting requirement h.i., above.

i. The Plan requires a Vendor that can support the Plan in its estimation of ROI for Medical Management programs provided and can provide the ROI methodology of Medical Management programs for the current book of business.

The Vendor shall confirm and describe that it will provide the following:

i. Necessary data and participate fully in the calculation of ROI by the Plan and its actuary in consultation with the TPA.

ii. The ROI calculation methodology used by the Vendor for its current BOB for the overall Medical Management program, as well as for each component of service described above.

iii. Any tools that the Vendor has access to that will assist the Plan in assessing financial impact and/or return on investment of the Plan's current plan designs.

iv. Any strategies to assess financial impact and/or return on investment for proposed plan design changes.

v. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. – iv., above.

5.2.6 Pharmacy Management

5.2.6.1 Overview and Expectations

The Plan seeks a Vendor that will partner with the Plan to meet its strategic priorities. The Vendor must be willing to collaborate with the Plan and the Plan's PBM and other Plan vendors to support aggressive management of the pharmacy and medical benefits. The Vendor must also value strong specialty pharmacy Medical Management programs that seek to improve quality of care and reduce associated costs. The Vendor must partner with the Plan on new and innovative specialty pharmacy initiatives. If requested, the Vendor must be willing to transition some or all specialty pharmacy claims to the PBM.

Objectives

a. Ensure quality care and maximize savings through strong specialty pharmacy Medical Management programs with the goal of reducing costs and improving quality.

b. If requested, implement pharmacy plan design elements that provide value to the Plan and Plan Members.

c. Engage as a strategic partner on specialty pharmacy Medical Management initiatives.

d. Maintain a seamless integration with the Plan's PBM.

e. Utilize an aggressive pharmacy management approach with respect to pharmacy and medical benefits.

5.2.6.2 Services

a. The Plan requires a Vendor that maintains strong specialty pharmacy Medical Management programs that improve the quality of care and reduce associated costs.

The Vendor shall confirm the existence of and describe each of the following programs, including, but not limited to, evidence-based utilization, transformation in disease treatments, patient support and counseling, management reporting, and authorization rules:

i. Specialty pharmacy Medical Management clinical program.

ii. Oncology management program.

iii. Specialty Drug utilization management.

iv. Other programs and/or polices that reduce specialty pharmacy costs, for example, site of service.

v. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iv. above.

The Vendor shall describe each of the following:

vi. How home infused therapies are managed to reduce drug spend.

vii. Active or pilot oncology initiatives to reduce drug spend.

viii. Any innovative models of medical specialty pharmacy care pilots or programs planned or under way.

ix. Any examples of medical specialty pharmacy initiatives or joint ventures with other large clients.

b. The Plan requires a Vendor that will pass medical specialty pharmacy Rebates to the Plan.

The Vendor shall confirm and describe the following:

i. Vendor will pass 100% of specialty pharmacy Rebates to the Plan.

ii. Vendor will process and deposit the Rebate within twenty-four (24) hours if the Rebate is made out to the Plan or ten (10) State Business days if made out to the Vendor.

iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan requires a Vendor that is willing to transition specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.

The Vendor shall confirm and describe the following:

i. Vendor will develop and implement a specialty pharmacy transition plan that will transition some or all specialty pharmacy medications from being covered under the medical benefit to being covered under the pharmacy benefit with the Plan's PBM.

ii. Vendor will provide claims and analytical data to support the transition.

iii. Vendor will provide specific operational requirements including limitations, necessary to transition specialty pharmacy medication coverage (e.g., grandfathering Members, site of care cost).

iv. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – iii. above.

d. The Plan requires a Vendor that is willing to share claims data and other data with Plan vendors to support pharmacy benefit or other pharmacy programs that provide value, as requested by the Plan.

The Vendor shall confirm and describe the following:

i. 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.

ii. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on the 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.

iii. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – ii. above.

e. The Plan requires a Vendor that will support the Plan's PBM carve-out.

The Vendor shall confirm and describe each of the following:

i. Vendor will carve-out PBM services from this Contract.

ii. Vendor will accept PBM claims data to facilitate the medical management of Plan Members. Include a list of PBMs for which Vendor has integrated.

iii. Vendor will meet with the Plan and the Plan's PBM to trouble shoot any Member enrollment issues.

iv. Vendor will meet with the Plan and the Plan's PBM to discuss any Vendor initiatives that may impact the data sent to the PBM by the Vendor.

v. Vendor shall describe any limitations and/or issues with meeting requirements e.i. – iv. above.

f. The Plan requires a Vendor that will integrate Member claims and deductible and/or other out-of-pocket accumulation information with the Plan's PBM.

The Vendor shall confirm and describe each of the following:

i. Vendor will integrate Plan Member medical deductible and/or other out-of-pocket accumulations with Plan Member pharmacy claims deductible and/or other out-of-pocket accumulations from the Plan's PBM for Members in a high deductible health plan or other plan design that has a combined medical and pharmacy deductible and/or out of pocket.

ii. Vendor shall describe any limitations and/or issues with meeting this requirement f.i.

5.2.7 Enrollment and Group Set-Up

5.2.7.1 Overview and Expectations

The Plan seeks a Vendor with a platform that can support the Plan's enrollment rules, as defined by N.C.G.S. 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 Direct Bill Member Groups. The Plan requires a Vendor that can report on Groups at the individual Group level and aggregate at the Entity and Plan levels.

The Vendor must also have extensive experience with Medicare eligibility as the Plan has both Medicare primary and Medicare secondary members. The Vendor must act 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. As an Expanded Reporter, the Vendor must be willing to submit the Query Only File to get Part A, B, & C information on Plan Members, perform a quarterly audit with Plan Enrollment data in Vendor's system, and make updates as appropriate. The Vendor must have the ability to enroll Dependents when the Subscriber is Medicare primary and enrolled with a Medicare Advantage carrier but the Dependents are not Medicare primary and enrolled on Vendor's plan. Additionally, the Vendor must be able to accommodate Medicare primary and Medicare secondary Members who may be enrolled in the same or different Plan Designs.

Objectives

a. Support the Plan's eligibility and enrollment rules as defined by N.C.G.S. Chapter 135, Article 3B.

b. Support enrollment of over 500,000 members.

c. Support the Plan's Group Set-Up requirements.

d. Support all Federal and State enrollment requirements.

e. Support the Plan's open enrollment.

f. Ensure the Plan's Medicare eligible Members are enrolled in accordance with Plan rules and federal requirements.

g. Perform a quarterly enrollment audit with data obtained from the Expanded Reporting Option available through Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

h. Ensure accurate and timely production of ID cards.

i. Produce accurate letters and notices.

j. Support the election of a Primary Care Provider (PCP) for all enrolled Members.

k. Produce customized Member level ID cards that include, but are not limited to the Plan's logo, messaging, and the Plan's PBM information. See Exhibit 9 for a sample of the Plan's current ID Card.

l. Ensure a seamless transition of Member enrollment.

5.2.7.2 Services

a. The Plan requires a Vendor that can support Plan enrollment as defined by N.C.G.S. Chapter 135, Article 3B, Part 4.

Vendor shall confirm that it will administer these statutory provisions covering enrollment for all types of Members, including, but not limited to:

i. Active Employees and Dependents.

ii. Members who are Medicare primary due to End Stage Renal Disease (ESRD).

iii. Active Employees on leave of absence.

iv. Retirees and Dependents.

v. Extended short term and long-term disability Members and Dependents.

vi. Surviving Dependents.

vii. Reduction in Force Employees who stay enrolled with Employing Unit for first twelve (12) months and are responsible for the Employee share of the premium.

viii. Reduction in Force employees, after the initial twelve (12) months, who are responsible for the full premium and moved to the direct bill group.

ix. Firemen and rescue workers.

x. Former legislators and their Dependents.

xi. COBRA Participants who have COBRA administered by a third-party vendor.

xii. Non-Permanent Employees.

xiii. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xii. above.

b. The Plan requires a Vendor that will accept and load Member enrollment from EDI received from the Plan's EES vendor and that will load enrollment manually when requested by the Plan and the Plan's EES vendor. The Vendor will have view-only access into the Plan's EES vendor's system to validate enrollment information.

The Vendor shall confirm and describe each of the following:

i. Vendor will automatically load Member enrollment from the industry standard 834 HIPAA X12 5010 file received from the Plan's EES vendor.

ii. Vendor will have a pass-through rate of at least 95% on accurate transactions received electronically from the Plan's EES vendor.

iii. 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.

iv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Member enrollment.

v. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – iv. above.

The Vendor shall describe the following:

vi. Quality controls that are in place to ensure accuracy of eligibility file loads.

vii. The number of resources that will be dedicated to managing the Plan's enrollment.

viii. How historical enrollment information is maintained.

c. The Plan prefers a Vendor that can accept, load, and transmit multiple Member ID numbers.

The Vendor shall confirm and describe each of the following:

i. Vendor will accept and store multiple Member ID numbers from the Plan's EES vendor such as a unique member ID number created by the EES vendor, the Member SSN, and an employer ID number.

ii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors, as requested by the Plan.

iii. Vendor will use the unique Member ID number provided by the EES vendor on the Member ID Card, if requested by the Plan.

iv. Vendor will use employer ID number on the electronic invoices, if requested by the Plan.

v. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – iv. above.

d. The Plan requires a Vendor that can accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years. The Vendor will not be required to load enrollment with an effective date that is prior to the commencement of services for this Contract.

Example: June 2023, Vendor receives enrollment with a February 1, 2022 effective date. Vendor updates Member with appropriate 2022 and 2023 coverage.

The Vendor shall confirm and describe each of the following:

i. Vendor will accept and load Member enrollment with retroactive effective dates that may cross multiple Plan Years.

ii. Vendor will adjust enrollment effective or terminations dates retroactively that may cross Plan Years.

iii. Vendor will adjust enrollment attributes such as premium wellness credits with retroactive effective dates that may cross Plan Years.

iv. Vendor will adjust group premium invoices with retroactive enrollment adjustments that may cross Plan Years.

v. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iv. above.

e. The Plan requires a Vendor that can support the Plan's Group set-up structure which includes more than 400 individual Employing Units, the Retirement Systems Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. The Vendor must set up new Groups as requested by the Plan. The Vendor will also be required to report on each Employing Unit individually and aggregate certain Employing Units. A list of the Plan's current Group structure, which includes their Group and Entity identifiers, can be found in Exhibit 10, Group Structure.

The Vendor shall confirm and describe each of the following:

i. Vendor will support the Plan's Group set-up structure which includes more than 400 individual Employing Units, the Retirement System Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group. Support includes, but is not limited to:

1) Setting-up each Group with the appropriate naming convention which should be displayed on Member ID Cards, the secure Member portal, Group premium invoices, and reports. Examples of Group naming conventions:
   - Department of State Treasurer
   - Charlotte Mecklenburg Schools
   - Retirement Systems
2) Setting-up each Group with the appropriate Plan Designs.
3) Setting-up each Group with the appropriate premium rates.

ii. Vendor will vary Plan Design options at the Group level. Example: While all active subgroups may have access to the 80/20, 70/30 and HDHP, a subset may also have access to a regional offering.

iii. Vendor will set-up new Groups throughout the year, as requested by the Plan.

iv. Vendor will provide enrollment and claims reporting at the individual Employing Unit level and at the aggregate level. The information required to aggregate the Employing Units will be included in the EDI from the Plan's EES vendor and will be further defined during implementation.

v. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-iv. above.

f. The Plan prefers a Vendor that can complete new Group set-up and that can assist the Plan with coordinating Group set-up information with other Plan vendors and if necessary, assist with any new group training.

The Vendor shall confirm and describe each of the following:

i. Vendor will coordinate Group set-up with other Plan vendors, as directed by the Plan.

ii. Vendor will provide training to new Groups, as requested by the Plan.

iii. Vendor shall describe any limitations and/or issues with meeting requirements f.i. - ii., above.

g. The Plan requires a Vendor that supports both Medicare Primary and Non-Medicare Primary Members within the same Group and Plan Design.

The Vendor shall confirm and describe the following:

i. The Vendor will enroll both Medicare Primary and Non-Medicare primary Members into the same group and Plan design.

Example: Employing Unit – Department of State Treasurer
- 80/20 PPO Plan includes:
  - Non-Medicare Primary Members
  - Medicare Primary Members
- 70/30 PPO Plan includes:
  - Non-Medicare Primary Members
  - Medicare Primary Members

ii. Vendor shall describe any limitations and/or issues with meeting requirement g.i., above.

h. The Plan requires a Vendor with extensive experience with Medicare eligibility that is willing to 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. As an Expanded Reporter, the Vendor must be willing to submit the Query Only File to get Part A, B, & C information on Plan Members and perform a quarterly audit with Plan Enrollment data in Vendor's system and make updates as appropriate. See process in Exhibit 12, CMS Responsible Reporting Entity (RRE) Process.

The Vendor shall confirm and describe each of the following:

i. Vendor shall 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.

ii. Vendor will submit, at a minimum, a quarterly Query-Only File to CMS to get Part A, B, and C information on Plan Members and perform a quarterly Medicare Primacy audit with Plan Enrollment data in Vendor's system. The Vendor shall utilize the results of the audit in conjunction with the Plan's Medicare primacy rules, to determine which Plan Members' Medicare information requires updating.

iii. Vendor will update Vendor's system with the necessary updates from the Medicare Primacy audit and send Members' updated Medicare information to the Plan's EES vendor.

iv. Vendor shall describe any limitations and/or issues with meeting requirements h.i. - iii., above.

i. The Plan requires a Vendor that can accept Medicare information from the Plan's EES vendor as well as update and maintain Member Medicare information based on claim information. The Vendor should also be able to appropriately code Members who are over 65 but not Medicare Primary.

The Vendor shall confirm and describe each of the following:

i. Vendor will maintain Medicare Part A and Part B eligibility dates, effective dates, and termination dates.

ii. Vendor will maintain multiple Medicare primacy effective and termination dates.

iii. Vendor will maintain multiple Medicare entitlement reasons.

iv. Vendor will recognize and maintain Non-Medicare primary status for Members over 65 who are not eligible for Medicare.

v. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. - iv., above.

j. The Plan requires a Vendor that can enroll Split Contracts.

The Vendor shall confirm and describe each of the following:

i. Contract will support enrollments where the family members are split between the 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 the Vendor).

ii. 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.

iii. Vendor shall describe any limitations and/or issues with meeting requirements j.i. - ii., above.

k. The Plan requires a Vendor that 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.

The Vendor shall confirm and describe each of the following requirements:

i. Vendor will provide a single web-based PCP selection tool that can be integrated with the Plan's EES vendor's enrollment site.

ii. Vendor will develop workflows that support the maintenance of the PCPs which may require that the Vendor notify Members if their elected PCP is no longer in the network, or to notify the EES vendor if any PCP code information has changed. The Member communication should include instructions for electing a new PCP. The final workflows will be defined during Contract implementation.

iii. Vendor will send any updated PCP information back to the EES vendor. For example, if the Member does not update their PCP with a PCP that is in the Vendor's network, the Member's PCP selection should be updated to "none selected".

iv. Vendor's systems will store a PCP election for each enrolled Member.

v. Vendor's systems will store a PCP election date at the Member level.

vi. Vendor will notify providers that they have been selected as a Member's primary care provider.

vii. Vendor shall describe any limitations and/or issues with meeting requirements k.i. - vi., above.

The Vendor shall describe the following:

viii. The proposed process for updating the EES vendor when the identifying PCP codes have changed.

ix. The proposed process for updating the EES vendor when the PCP no longer participates in the network.

l. The Plan requires a Vendor that can support the production of custom Member-level ID cards.

The Vendor shall confirm and describe each of the following ID card requirements:

i. Vendor will produce individual ID cards for each enrolled Member.

ii. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 9 for sample of the Plan's current ID card.)

1) Plan's logo.
2) Plan's messaging.
3) Plan's network.
4) Out-of-NC network.
5) Plan's Rx BIN and PBM information.
6) Group Name (e.g. Wake County Schools, University of North Carolina, Department of Transportation).
7) Member's selected PCP.

iii. Members can request new ID cards online.

iv. Members can print a temporary ID card that includes the Plan's PBM information and custom network information.

v. Vendor will produce new ID cards when the Member's PCP changes.

vi. Vendor will mail all ID cards the latter of five (5) days from receiving enrollment data or five (5) days before the effective date.

vii. Vendor offers a virtual ID card for Members who prefer to use mobile technology.

viii. The Vendor shall describe any limitations and/or issues with meeting requirements I.i. - vii., above.

The Vendor shall describe each of the following ID card requirements:

ix. Events that trigger production of new Member ID cards.

x. Any other unique Member ID card innovations that may be of interest to the Plan.

m. The Plan requires a Vendor that understands the importance of a successful Open Enrollment and has the resources required to support the Plan's Open Enrollment. While it is the Plan's goal to offer only one Open Enrollment per year, multiple Open Enrollments may be required.

The Vendor shall confirm and describe each of the following:

i. Vendor will participate in end-to-end Vendor testing prior to Open Enrollment, including mock premium bills to the Employing Units.

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

iii. Vendor will support multiple Open Enrollments in one Plan year, if requested by the Plan.

iv. Vendor will vary the Open Enrollment periods by Group and/or Product, if requested by the Plan.

v. Vendor will receive Member enrollments from the Plan's EES vendor prior to Open Enrollment 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 Open Enrollment. 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.

vi. Vendor will receive and process Member elections from the Plan's EES vendor after Open Enrollment using a full file or via daily change files. 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.

vii. Vendors will produce and distribute ID cards for over 500,000 Members after Open Enrollment so that Members receive their ID cards prior to the new Plan Year.

viii. Vendor will have all Open Enrollment enrollments processed in time to produce group premium bills in early December for January coverage.

ix. The Vendor shall describe any limitations and/or issues with meeting requirements m.i. - viii., above.

The Vendor shall describe each of the following:

x. Process for receiving Open Enrollment elections, including number of elections that can be received and processed in a single day.

xi. Process and timing for working open enrollment elections that do not process electronically.

n. The Plan requires a Vendor that 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.

The Vendor shall confirm and describe each of the following:

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

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

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

iv. Vendor will customize any Member letters and/or notices that are available to Members online or by mail. Customization includes, but is not limited to, the ability to include the Plan's branding.

v. Vendor will create new, ongoing, or as needed letters to Plan Members, as requested by the Plan.

vi. Vendor will include non-discrimination notices on all significant publications and communications as required by Section 1557 of PPCA.

vii. Vendor will produce the 1094-C and 1095-C forms.

viii. Vendor will produce the 1095-B form.

ix. Vendor will provide call center support to respond to both HBR and Member inquiries about 1094-C and 1095-B forms.

x. Vendor will file IRS forms electronically.

xi. Vendor will continue filing corrections to the IRS throughout the year.

xii. The Vendor shall describe any limitations and/or issues with meeting requirements n.i. - xi., above.

o. The Plan requires a Vendor that will support the receipt of 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 11 for the Vendor Audit Process.

The Vendor shall confirm that it will perform the following services:

i. Monthly audit of the Plan's active membership with the EES vendor which includes monthly correction of any indicated mismatches to align the Vendor and EES vendor records.

ii. Monthly audit of the Retirement Group, the Direct Bill Group, the Sponsored Dependent Group, and the COBRA Group with the EES vendor which includes monthly correction of any indicated mismatches to align the Vendor and EES vendor records.

iii. Vendor will implement other audits with any other Plan vendor, as requested by the Plan.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements o.i. - iii., above.

5.2.8 Group Billing and Collection

5.2.8.1 Overview and Expectations

The Plan seeks a Vendor that can provide a full range of best in class Group billing and collection services. These services include, but are not limited to, Group premium billing, collection, and reconciliation for each of the Groups and reporting at the Plan, Group, and Entity level. The Vendor shall produce a Group Premium Invoice for each Employing Unit for both the Employer and Subscriber premiums for Active Employees and the Employer Share for the premium for 12-month RIF Members, Leave of Absence (LOA) Members, and Members enrolled in the HDHP offered to non-permanent full time Employees. While the Vendor will not be responsible for premium collection for the Retirement Group, the Vendor will be required to produce a monthly Group Premium Invoice for the Retirement Group that will be used for reconciliation purposes. The Vendor shall accept electronic fund transfers (EFTs), checks, and funds transferred through the State banking system. The Vendor must also provide services that assure the highest levels of quality, accuracy, efficiency and timeliness. The Vendor shall 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. As such, the Plan may have unique limitations or special requirements around deposits and collections.

- State banking: https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf
- Cash management: https://www.osc.nc.gov/state-employees/statewide-policies/Section-300

Objectives

a. Ensure accurate and timely premium billing, premium collection, premium deposit, reconciliation, and reporting.

b. Promote efficiency, accuracy, and a superior customer experience for the Plan and its Employing Units by selecting a Vendor with state-of-the-art business tools, processes, and services.

c. Ensure Employing Units have appropriate resources and tools to reconcile and process the monthly invoices.

d. Ensure all applicable policies and regulations of the Office of State Controller and the Department of State Treasurer, including state banking requirements, are supported.

e. Ensure a seamless transition of invoicing and collection services.

5.2.8.2 Services

a. The Plan prefers a Vendor with a premium billing system that is fully integrated with the Vendor's enrollment and claims administration systems.

The Vendor shall describe each of the following:

i. The group premium and billing platform, including development (i.e., purchased or developed internally), recent enhancements, planned enhancements, and operating requirements.

ii. The integration between the premium billing system, enrollment system, claim system, and, if offered, the employer portal.

iii. The workflow that outlines the process between enrollment coverage changes and Group premium billing changes (i.e., single Subscriber adds a Dependent. Is the coverage change automatic in the group premium billing system or is a process step required?).

b. The Plan requires a Vendor that can support the Plan's premium rate structure which differs by Plan Design, Medicare and Non-Medicare primary status, tier, premium wellness credits earned, years of service, and eligibility type. The Plan's current Group Billing Rate Structure can be found in Exhibit 13,.

The Vendor shall confirm and describe each of the following:

i. Vendor will support the Plan's Group billing premium rate structure as shown in Exhibit 13, Group Billing Rate Structure.

ii. Vendor will apply the appropriate premium rate to the Member's enrollment based on the enrollment attributes provide by the EES vendor. Attributes may include:

1) Tier Code (the Plan currently has a four (4) tier structure).
2) Plan Design Elected by each family member (In a Split-Contract scenario, family members can be loaded in different Plan Designs).
3) Medicare Primary, Non-Primary Status for each family member.
4) Premium Wellness Credits earned.
5) 12-Month RIF indicator.
6) Leave of Absence (LOA) indicator.
7) Part time status.
8) Cost Factor (Defines Retiree contribution level).
9) Employment status code.

iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan requires a Vendor that can meet the Plan's unique Group premium billing requirements which includes the ability to ensure all financial transactions are compliant with state banking guidelines, including the policies and regulations of the Office of State Controller (OSC) and the Department of State Treasurer which can be found at the following links:

- State banking: https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf
- Cash management: https://www.osc.nc.gov/state-employees/statewide-policies/Section-300

The Vendor shall confirm and describe each of the following:

i. Vendor will comply with all policies and regulations of the OSC and the Department of State Treasurer, as outlined in the Finance and Banking Section of this RFP (Section 5.2.3) and as may be amended from time to time, when managing the Group Billing and Collections for the Plan.

ii. Vendor will provide a consolidated electronic Group Premium Invoice to each Employing Unit, via a web-based electronic billing tool with both summary and detailed data. The Group Premium Invoice shall include coverage period, group/account number, product and coverage tier, employer and Employee amounts, Member and employer identifiers and Subscriber name (aka List Bill). The Group Billing Rate Structure is outlined in Exhibit 13.

iii. Vendor will provide all the reports and tools necessary for the Employing Units or Entity to reconcile their invoices on a monthly basis.

iv. Vendor will aggregate the Group Premium Invoices for Employing Units that are paid and reconciled by a centralized unit while maintaining the ability to recognize the Employing Unit the Member is tied to (i.e. State agencies that are all handled centrally by OSC).

v. Vendor will calculate, and display interest owed on late premium payments for certain Employing Units in electronic billing tool. Currently the Plan charges interest for premiums due for Charter Schools and Local Governments per N.C.G.S. § 135-48.55.

vi. Vendor will vary the invoicing schedule by Employing Unit and month to align with individual Employing Units payroll timelines.

vii. Vendor will adjust the monthly Group Premiums Invoices with retroactive adjustments received since the last Group Premium Invoice was produced.

viii. Vendor will set the premium due date at the 1st of each month.

ix. Vendor will accept premium payments by check.

x. Vendor will accept premium by ACH.

xi. Vendor will accept premium payments transferred through the State Banking System.

xii. Vendor will deposit payments received within twenty-four (24) hours of receipt to comply with the State's banking and cash management requirements.

xiii. Vendor will accept and apply electronic Data Files containing multiple Group premium payments from the State or another vendor and upload into the premium billing system within twenty-four (24) hours of receipt (i.e., One vendor or Entity submits premium payments on one file for multiple state agencies).

xiv. Vendor will track and report premium receipts.

xv. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – xiv. above.

d. The Plan prefers a Vendor that will hold claims for individual Groups that do not pay their full premiums by the due date.

The Vendor shall confirm and describe each of the following:

i. Vendor will hold claims for individual Groups that do not pay in full, or do not pay up to a certain percentage (threshold) of the amount due, by the due date.

ii. Vendor can vary the premium threshold by Group. For example, the Retirement System must pay 100% or the premiums due to advance the hold, but the Department of State Treasurer's threshold may only be 99% to advance the hold date.

iii. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – ii. above.

The Vendor shall provide the following:

iv. A description of the premium billing and collection process, including a sample monthly billing timeline. The timeline should include the "cut-off" time for receiving eligibility changes that would be reflected on the Group Premium Invoice.

v. A description of the premium receipt posting and reconciliation process.

vi. A definition of delinquent premium.

vii. A description of the claims-hold process for Members with an Employing Unit that does not remit payment by the due date.

viii. A description of the Employing Unit notification process when the premium is delinquent.

ix. A sample of the reports available to the Plan to track premium receipts.

x. A sample premium bill, at the Employing Unit level. (If premium bill format varies by delivery method, provide sample of each type.)

xi. A description of the team that will support Group premium billing and collection.

e. The Plan requires a Vendor that will support the Plan's premium billing rules for Members who enroll through their Employing Until but whose Employee premiums are billed by the Plan's billing vendor which makes these Members Direct Bill members because only the Employer Share of their premium is billed to the Employing Unit. Refer to N.C.G.S. §§ 135-48.40, 134-48.41, and 135 48.40(e) for more information on these Plan Members. The Vendor must also be able to accommodate any Employees who are 100% contributory and are therefore required to pay the full premium. No portion of their premium shall be billed to the Employing Unit, but they must appear on the invoice.

The Vendor shall confirm and describe each of the following:

i. Vendor will bill the Employing Unit for only the employer portion of the premium for Members who are invoiced for the Employee share of the premium by the Plan's billing vendor. Members who are invoiced for the Employee premium will be flagged in the enrollment Data Files from the EES vendor.

ii. If requested by the Plan, Vendor will display the 100% contributory Employees in the monthly Group Premium Invoice as covered, but not to invoice the Employing Units for their premiums. These Members will be flagged in the enrollment Data Files from the EES vendor.

iii. Vendor shall describe any limitations and/or issues with meeting requirements e.i. – ii. above.

f. The Plan requires a Vendor that will, upon request, support the Plan, the Employing Units, and/or the Office of State Controller with invoice reconciliation. While it is a requirement that the Vendor provide the necessary tools for entities to complete their own reconciliation, there are instances where additional research and information is required to resolve outstanding discrepancies.

The Vendor shall confirm and describe each of the following:

i. Vendor will produce a monthly Group Premium Invoice and corresponding reports for the Retirement System Group. The Retirement System Group includes both direct-bill Members where only the employer share of the premium is invoiced and full-bill Members where both the employer and Subscriber share of the premium are invoiced.

ii. Vendor will assist the Plan and the Plan's billing vendor with Retirement System reconciliation on an as needed basis.

iii. Vendor will assist the Plan and the Plan's billing vendor with Employing Unit reconciliation on an as needed basis.

iv. Vendor shall describe any limitations and/or issues with meeting requirements f.i. – iii. above.

g. The Plan prefers a Vendor who will ensure that all Group Premium Invoices are accurate and that proper financial controls are in place.

The Vendor shall confirm and describe the following:

i. The existence of an internal quality control program and audits that will ensure accuracy of the billing and collection process.

ii. The types and frequency of standard reconciliation process, including, but not limited to, reconciliation of billed in comparison with paid amounts and reconciliation of bill generation and presentment.

iii. The performance standards for Group billing and collection accuracy. Provide results for each of the last two (2) years.

iv. Vendor shall describe any limitations and/or issues with meeting requirements g.i. – iii. above.

5.2.9 Data and Technology

5.2.9.1 Overview and Expectations

Aligned with the Plan's vision and mission to be an innovative, data driven organization, the Plan seeks a Vendor that utilizes the latest advances in health information technology to support the Plan's volume, complexity, and unique requirements, and that maintains best-practices in all areas of technology, including infrastructure, data management, data security, reporting, and analytics. The Plan seeks to partner with a Vendor with best-in-class infrastructure and systems capable of meeting the Plan's current and future requirements. This includes the ability to meet the Plan's initial and ongoing testing needs which requires dedicated testing environments and resources. The Plan also seeks a Vendor that will dedicate resources with the appropriate subject matter expertise in these critical functions.

Consistent with the Plan's mission of operating a data-driven organization, the Plan seeks a Vendor that has the tools, technologies, strategies, and thought leadership that will allow for cutting-edge, advanced level reporting, data analytics, and modeling that provides valuable insights for better decision making in support of the operational and strategic priorities of the Plan.

Objectives

a. Partner with a Vendor that has the technology, infrastructure, and subject matter expertise to support the Plan.

b. Ensure Vendor has the system flexibility and resources to meet the Plan's custom Data File and Plan vendor integration requirements.

c. Partner with a Vendor that places a high value on data security and constantly and consistently strives to improve data security and data management.

d. Engage a Vendor that will support customized Data Files to and from multiple Plan vendors, the Plan, and/or Plan Partners and will work with the Plan to establish Data File schedules that meet the Plan's requirements.

e. Partner with a Vendor that has the expertise, resources, and technology to meet the ad hoc and ongoing data reporting and analysis needs.

5.2.9.2 Thought Leadership

a. The Plan requires a Vendor that can provide strategy and thought leadership regarding health care data processing, data management, and data reporting and associated disciplines.

The Vendor shall provide copies of the strategy, planning, and process and procedure documents for each of the following:

i. Project management.
ii. IT infrastructure.
iii. Backup and recovery.
iv. Development/Testing/ Production environments.
v. Implementation testing.
vi. Regression testing.
vii. Break/ fix testing.
viii. Data management.
ix. Data governance.
x. Data quality.
xi. Data security.
xii. Data integration.
xiii. Data transmission.

xiv. Data reporting.
xv. Data analytics.
xvi. Data standards.
xvii. Reference data.

The Vendor shall provide the following:

xviii. A list of training and certifications required for Vendor's project management staff.

5.2.9.3 Technology Services

a. The Plan requires a Vendor that will provide state-of-the-art Data Centers that will be secure 24/7/365 with an uptime of 99.9%. This includes having the tools, technology, and protocols to ensure the confidentiality, integrity, and availability of the Plan's data, to prevent unauthorized access, and to prevent data corruption.

The Vendor shall confirm and describe the following:

i. Existence of U.S. based Data Centers and whether they are operated internally or outsourced/sub-contracted.

ii. Plan data will not be "co-mingled" with data from the rest of Vendor's book of business.

iii. Existence of a U.S. based primary and disaster recovery Data Centers.

iv. Existence of automated fail-over processes, technology, organization, and infrastructure.

v. Existence of 24/7/365 security monitoring and reporting for the Data Centers, application systems and sub-contracted technology.

vi. Existence of processes to ensure only appropriate personnel have access to Data Centers, application codes and systems, and the Plan's data.

vii. Mission critical equipment and systems are in a restricted area. Include in the description the level and roles of employees who have access to these restricted areas and the Plan's data.

viii. Existence of security systems such as, but not limited to, key cards, badges, and PINs to ensure access to the Data Centers is restricted to appropriate personnel.

ix. Existence of layered security controls to protect the Plan's data, servers, applications, and network.

x. Existence of security provisions in the systems and Data Centers to protect the Plan's data.

xi. Adherence to National Institute of Standards and Technology (NIST) data security standards appropriate for moderate information system(s).

xii. How data is being disposed/archived on schedule using NIST standards.

xiii. Existence of system and network redundancy and failover provisions (LAN and WAN, Telcom, Power) that will ensure 99.9 percent uptime.

xiv. Vendor has data security policies and procedures that are reviewed and updated quarterly.

xv. Vendor will share all data security policies and procedures annually or as requested by the Plan and revise them as needed within a 6-month timeline.

xvi. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xv. above.

The Vendor shall provide:

xvii. Copies of the Vendor's data security policies and procedures.

xviii. The name and credentials of the Vendor's Chief Data Security Officer or equivalent position.

xix. The schedule for backed-up data and the rotation of backed-up media (e.g., Daily back up kept for sixty (60) days, plus monthly backups for twenty-four (24) months and yearly backup for the last five (5) years); and how often the backups are successfully restored and tested to validate data and media has not been corrupted.

xx. The security strategy for data at rest, data in use, and data in motion.

xxi. The secure process that is used to ensure the receipt of timely, accurate, traceable data for the data storage.

xxii. The protocols for management of a PII/PHI security breech.

xxiii. Technology services organization chart with roles and responsibilities.

The Vendor shall describe each of the following:

xxiv. How data shared with the Plan, Plan vendors, and Plan Partners is securely maintained and managed during and after transmission of Data Files.

xxv. How security risks are identified, escalated, and documented. Include any mitigating tactics.

xxvi. Overall Data Center architecture. Include documentation to support the design.

xxvii. Systems and applications that will be used to support EDI transaction management and other B2B services.

xxviii. Number of outages that occurred in the past 24 months.

xxix. Total amount of time clients experienced a planned and unplanned outage for the same 24-month period.

xxx. Whether or not security has ever been breached and if so, the nature of the security breach, and the actions taken and/or procedures introduced post security breach.

b. The Plan prefers a Vendor that will work with the Plan to ensure scheduled down time does not impact Plan deliverables.

The Vendor shall confirm the following:

i. Clients are notified at least (60) sixty days prior to any planned system downtime.

ii. Client preferences about down time are taken into consideration.

iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii. above.

c. The Plan prefers a Vendor with a Data Warehouse that can meet all the Plan's data needs.

The Vendor shall confirm:

i. The existence of a Data Warehouse.

ii. Vendor shall describe any limitations and/or issues with meeting requirement c.i. above.

The Vendor shall describe each of the following:

iii. Product and version.

iv. Architecture and data model.

v. All tools used and what tools are available to access the data in the Data Warehouse.

vi. Any recent or planned enhancements to the Data Warehouse.

vii. Policies and processes in place to manage any changes to the Data Warehouse environment that will be used for the Plan.

d. The Plan requires a Vendor that will provide a production environment that can dynamically allocate additional resources when demand exceeds the current production configuration.

The Vendor shall confirm and describe the following:

i. How performance of servers and/or processors are monitored.

ii. How EDI demand is dynamically supported.

iii. Configuration of the production environment, including but not limited to:

1) The platform and database used.
2) Number of servers.
3) Processors.
4) Memory.

iv. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – iii. above.

The Vendor shall provide each of the following:

v. A detailed list and description of any outsourced/sub-contracted technology, infrastructure, and services or capabilities.

vi. A list of the products used to support EDI transaction management. Include an overview of each product's architecture which should include each of the following:

1) Current version.
2) Next scheduled update/release and version.
3) Product(s) are supported by third party vendor until 'month/year'.

e. The Plan requires a Vendor to have a Business Continuity/Disaster Recovery plan.

The Vendor shall confirm and describe the following:

i. The Vendor will update and test the Business Continuity/Disaster Recovery plan annually.

ii. The Vendor will report on whether or not the Business Continuity/Disaster Recovery plans were invoked over the past seven (7) years and, to provide explanation of when and why they were invoked, their effectiveness and the repercussions, including financial or legal penalties, loss of business, etc.

iii. The Vendor will provide guidelines that have been established to review and update the Business Continuity/Disaster Recovery plan and targeted recovery time, including the date when the last Business Continuity/Disaster Recovery was updated.

iv. The Vendor will perform nightly backup of the Plan's data.

v. The Vendor shall describe any limitations and/or issues meeting requirements e.i. – iv., above.

The Vendor shall provide each of the following:

vi. Standard Operation Procedures (SOP) for all EDI activity.

vii. Process and turnaround time for completing new data requests.

viii. Process for escalating data error issues as well as the chain of command for reporting and managing escalations to the Plan.

ix. Description of the tools and processes for monitoring and measuring service quality.

5.2.9.4 Testing Services

a. The Plan requires a Vendor with sufficient test regions to support the Plan.

The Vendor shall confirm and describe the following:

i. Vendor will provide dedicated End-to-End testing environment(s) that can be refreshed with production data to support the Plan during the initial implementation and any ongoing implementations such as the annual open enrollment testing or any new Plan vendor implementations which may require both Vendor unit testing and End-to-End Testing with Plan vendors.

ii. When requested by the Plan, Vendor will provide multiple testing environments using virtual servers or partitioned systems to successfully complete concurrent projects initiated by the Plan.

iii. Vendor will provide a test environment and test data that is an exact replica of the production environment for regression testing. Include in the description how test data is populated.

iv. The Vendor shall describe any limitations and/or issues meeting requirement a.i.-iii. above.

The Vendor shall describe the following:

v. The Plan's testing support organization chart with roles and responsibilities and how they are aligned to the Plan's dedicated Data Manager and Implementation Manager.

vi. The configuration of the testing environment, including the platform and database used, number of services, processors, memory, etc.

vii. Methodology and approach to testing quality assurance of products and processes.

viii. Methodology and approach to performance testing.

ix. How regression testing will be performed, what data will be used, and what automation tools and support services will be provided.

x. What testing automation software is provided, what training will be offered to the Plan for its use, and how it will be used for implementations and for Open Enrollment.

5.2.9.5 Data Warehouse Support Services

a. The Plan requires a Vendor that ensures the data provided to the Plan for use in the Plan's Data Warehouse is accurate, reliable, and timely, and matches the cycles of reporting provided to the Plan so that data reporting is reliable by time period to provide consistent results across reports and data files.

The Vendor shall confirm and describe the following:

i. Data will be delivered at least once a month, by the 15th of the month following the processing period.

ii. Data records will be delivered as incremental additions or adjustments, or full files as requested by the Plan.

iii. Data will be delivered with a mechanism to identify unique records across months.

iv. Data delivered will be accompanied by reference tables, updated on a regular basis.

v. Data delivered will be cross referenceable by unique keys across all datasets provided by the Vendor to the Plan.

vi. The Vendor shall describe any limitations and/or issues to meeting the requirements listed in Section a.i. – v.

b. The Plan requires a Vendor that will assist the Plan in understanding any custom data provided for the Plan's Data Warehouse outside of industry standards.

The Vendor shall confirm and describe the following:

i. Vendor will participate in knowledge transfer work sessions as requested by the Plan.

ii. Vendor will participate in report validation sessions, as requested by the Plan.

iii. The Vendor shall describe any limitations and/or issues to meeting the requirements listed in Section b.i. – ii., above.

The Vendor shall describe the following:

iv. Other activities, reports, etc., that the Vendor will provide to ensure the Plan and the Vendor can reconcile the metrics being managed and reported by the Vendor and can reproduce matching results from the data provided to the Plan, for the Data Warehouse.

5.2.9.6 Data Governance

a. The Plan requires a Vendor with a strong focus on data governance.

The Vendor shall confirm and describe the following:

i. Vendor's existing data governance program and detailed description of the overall availability, usability, integrity, and security of data used. Include in the description an organization chart with roles and responsibilities for the data support organization that will support the Plan.

ii. Existence of data governance policies and procedures. Include in the description how often these policies and procedures are reviewed.

iii. Existence of quality control around all processes and procedures related to data. Include in the description the process, policy, methodology, use of any industry standards and tools and best practices for data file extracts and reports including ad hoc reports.

iv. Governance program for both inbound and outbound file transmissions.

v. Vendor shall describe any limitations and/or issues meeting requirements a.i. – iv.

The Vendor shall describe each of the following:

vi. How the success of governance is measured.

vii. How the governance process is invoked in the event of an issue or question.

viii. Process to resolve any data quality issues, questions, or inconsistencies.

ix. Tools, technology, and service used to validate inbound and outbound edits and business rules, specify proprietary versus outsourced/sub-contracted vendors.

x. Transformation and business rules available to meet the Plan's specialized business needs and provide the best data consumption both for inbound and outbound processing.

1) Eligibility configurations.
2) Claims configurations.
3) Configurations.

xi. Process for correcting historical errors in Vendor's data, Data Warehouse, or data management processes.

xii. Process for resolving quality issues identified by the Plan (i.e. response/resolution time, proactive prevention of recurrence).

5.2.9.7 Data Quality

a. The Plan requires a Vendor with a strong focus and commitment to data quality.

The Vendor shall confirm and describe the following:

i. Data quality repairs are made at transaction record level in the appropriate source system. Include in the description the typical turnaround time for making any corrections.

ii. Data is accurate and consistent across Vendor's platform(s).

iii. Vendor will meet weekly to discuss data quality and address ongoing data issues. The meeting shall be attended by the Vendor's Data Manager that will be 100% dedicated to the Plan.

iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i.-iii., above.

The Vendor shall describe the following:

v. Standards used to ensure data is accurate and consistent over the life span of the data.

vi. Tools, technology, and service used to validate inbound and outbound edits and business rules, specify proprietary versus outsourced/sub-contracted vendors.

vii. Vendor will re-use business rules for processing files being sent to the Plan or Plan vendors for consistent data quality.

5.2.9.8 Data Management

a. The Plan requires the Vendor to have the tools, technology, and protocols to provide for continual operations and maintenance of the metadata used in conjunction with the master and transactional data.

The Vendor shall confirm and describe the following:

i. The Vendor makes continuous and consistent updates to the metadata (information that provides information about other data, e.g., fully descriptive data dictionaries, reference data, field formats, field characteristics, field usage, etc.) which will be shared with the Plan on an ongoing basis.

ii. The Vendor makes continuous and consistent updates to the reference data (value sets for identifiers and codes) used to perform data analysis which will be shared with the Plan on an ongoing basis.

iii. Vendor will share the methodology and data logic used to produce the standard reports that will be provided to the Plan and how that logic corresponds to the Data Files that the Vendor will provide to the Plan on an ongoing basis.

iv. Transformation and business rules available to meet the Plan's specialized business needs and provide the best data consumption both for inbound and outbound processing.

v. Vendor will maintain at least ten (10) years of Plan data, all of which can be reported on upon request by the Plan.

vi. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.-v., above.

5.2.9.9 Data Interchange

a. The Plan requires a Vendor with the capability to process and accurately load daily custom and ASC x12 EDI transmission sets from Plan vendors and/or Plan Partners to support the ongoing operations of the Plan.

The Vendor shall confirm and describe the following:

i. 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.

ii. Vendor will accept and process multiple files within the same day.

iii. Vendor will accept and process multiple concurrent file transmissions.

iv. Vendor will accept and exchange unique Member ID's generated from Plan vendors through EDI files.

v. Vendor will accept daily Data Files, seven (7) days a week.

vi. Vendor will have the capability to accept and load no less than 250,000 transactions in a single file transmission within a four (4) hour window.

vii. Vendor will process "change" records as either dropped or added records.

viii. Vendor will load and process "drop" and "add" files for same Members within the same day.

ix. Vendor will use current, most advanced data quality tools or system configuration to ensure the accuracy of inbound and outbound transactions.

x. Vendor will manually handle and track exceptions, for instance, discrepancies, or enrollments that error out or do not otherwise process and require manual intervention. Include in the description the workflow for handling enrollments that do not automatically process and how each one is tracked to completion.

xi. Vendor will exchange the enrollment and eligibility data using SFTP and HTTPS secure protocols with PGP encryption.

xii. Vendor will generate and send Vendor's unique Member ID through acknowledgment EDI files.

xiii. Vendor will re-use business rules for processing inbound files from the Plan or Plan vendors for consistent data quality.

xiv. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits.

xv. Vendor will itemize information considered "trade secret" or proprietary.

xvi. Vendor will extract and/or load daily EDI files containing 50,000 transactions within a 4-hour window.

xvii. Vendor will, at a minimum, have the capability to extract and/or load data files containing the Plan's full membership within a 24-hour window.

b. The Plan requires a Vendor that has the capability to accurately produce recurring outbound Data Files for Plan vendors and upon request, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 15, Vendor Data Feeds for 2019.

The Vendor shall confirm and describe the following in regard to operational data:

i. Vendor will provide ASC X12 transaction sets that include, but are not limited to:

1) 275 Patient Information. This transaction set is used to communicate individual patient information requests and patient information (either solicited or unsolicited) between separate health care entities in a variety of settings to be consistent with confidentiality and use requirements. Patient information consists of demographic, clinical, and other supporting data.

2) 276 Health Care Claim Status report. This transaction set is used by a provider, recipient of health care products or services, or their authorized agent to request the status of a health care claim or encounter from a health care payer. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.

3) 277 Health Care Information Status Notification. This transaction set is used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter, health care services review, or transactions related to the provisions of health care. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.

4) 278 Health Care Services Review Information. This transaction set is used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of request for review, certification, notification or reporting the outcome of a health care services review. Users of this transaction set are payors, plan sponsors, providers, utilization management and other entities involved in health care services review.

5) 834 Benefit Enrollment and Maintenance. This transaction set is used to establish communication between the sponsor of the insurance product and the payer. Such transaction(s) may or may not take place through a third-party administrator (TPA). For the purpose of this standard, the sponsor is the party or

entity that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association, or insurance agency. The payer refers to an entity that pays claims, administers the insurance product or benefit, or both. A payer can be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Champus, etc.), or an entity that may be contracted by one of these former groups. For the purpose of the 834-transaction set, a third-party administrator (TPA) can be contracted by a sponsor to handle data gathering from those covered by the sponsor if the sponsor does not elect to perform this function itself.

6) 835 Health Care Claim Payment/Advice. This transaction set is used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

7) 837 Health Care Claim. This transaction set is used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third-party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third-party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

c. The Vendor shall describe any limitations and/or issues meeting requirements a. – b., above.

d. **The Plan requires a Vendor that will release data to the Plan as described in N.C.G.S. § 135-48.32(b). Any limitations on the Plan's use of data shall be no more restrictive than as described in N.C.G.S. § 135-48.32.**

The Vendor shall confirm each of the following:

i. Vendor will release data to the Plan as described in N.C.G.S. § 135-48.32(b).

ii. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in N.C.G.S. § 135-48.32.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements in Section d.i.-ii., above.

The Vendor shall describe each of the following.

iv. Any limitations that may be placed on the Plan, Plan vendors, and Partners or Employing Units, as far as access to systems or data.

v. Information considered "trade secret" or proprietary, itemized by categories.

5.2.9.10 EDI Monitoring Services

a. The Plan prefers a Vendor that has the capability to review the status of EDI files in real-time and provide automated notifications and alerts.

The Vendor shall confirm and describe each of the following:

i. Vendor's capability to view EDI file status through a portal.

ii. Existence of a portal or other user interface that will display for external users (Plan staff or the Plan vendors) the real-time status of file(s) and data exceptions.

iii. Vendor will provide the Plan or Plan vendors access to review specific EDI transactions and actual raw data.

iv. Vendor will provide an automated capability to monitor business processing. Services including, but not limited to:

1) Files processing.
2) Files delivered.
3) Files received.
4) Files processed.
5) Files percent completed.
6) Discrepancies found.
7) EDI throughput percentage.

v. Vendor will send notifications or alerts to one or more recipients of either the Plan, Plan vendors, and Partners, as directed by the Plan.

vi. Vendor will support an optimized schedule for sending and receiving files to and from the Plan or Plan vendors, as requested by the Plan and agreed upon during implementation planning.

vii. Vendor will provide a copy of all files sent to Plan vendors to the Plan via SFTP.

viii. The Vendor shall describe any limitations and/or issues meeting requirements in sections a.i. – vii., above.

5.2.9.11 Data Audit and Reconciliation Services

a. To ensure the accuracy of the enrollment data in the Vendor's system, the Plan requires a Vendor that can accept and process Full Files, or Audit Files, from the Plan's EES vendor for the purposes of both auditing and reconciling enrollment and financial data.

The Vendor shall confirm and describe each of the following:

i. Vendor will perform enrollment and eligibility audits and reconciliations, on a schedule requested by the Plan.

ii. Vendor will use automated processes to ensure the appropriate fields are audited.

iii. Vendor will use automated processes to ensure the appropriate amounts are reconciled.

iv. The Vendor shall describe any limitations and/or issues meeting requirements a.i. – iii., above.

The Vendor shall complete Table 4 below to identify which data elements are and are not currently part of an automated audit process and shall describe the following:

v. Vendor's current process for automatically updating any discrepancies to match the Enrollment and Eligibility System (EES).

vi. Vendor's process for automating updates based on audit findings to complete reconciliation.

vii. Vendor's process for prioritizing and implementing enhancements that may be required to meet the Plan's, or other vendor's, reconciliation needs.

Table 4			
Data Element	**Y/N**	**Data Element**	**Y/N**
Member Demographics			
Full Name		Relationship	
Multiple Addresses		Multiple Member IDs	
Multiple Phone Numbers		Multiple Email Addresses	
SSN		Gender	
Date of Birth (DOB)		Date of Death	
Elections			
Original Effective Date		Termination Date	
Current Plan Effective Date		Current Plan Termination Date	
Benefits Level		Family Coverage Level	
Multiple Spans of Coverage		Current Span of Coverage	
Terminated Coverage		Future Coverage	
Coordination of Benefits			
Medicare Part A eligibility date		Medicare Part B eligibility date	
Medicare Part A enrollment date		Medicare Part A termination date	
Medicare Part B enrollment date		Medicare Part B termination date	
Medicare Primary Date(s)		Medicare Secondary Date(s)	
Plan Primary Date(s)		Plan Secondary Date(s)	
Medicare Beneficiary Identifier		Medicare Entitlement Reason(s)	
Plan Specific Offerings			
PCP Name		PCP Location	
PCP Effective Date		PCP Termination Date	
Premium Credits		Employee job status	

b. The Plan requires a Vendor that has advanced data integration capabilities to support Plan programs.

The Vendor shall confirm and describe the following:

i. Vendor will integrate with Plan vendors and/or Plan Partners to support Plan programs, if requested by the Plan. For example, if the Plan wants to share data about what incentives a Member may have earned via Vendor's platform.

ii. The Vendor shall describe any limitations and/or issues meeting requirement b.i., above.

5.2.10 Customer Experience

5.2.10.1 Overview and Expectation

A top priority for the Plan is ensuring a superior customer experience with all customer-facing resources and tools. The Plan seeks a Vendor who has similar priorities and who will strive to excel in this area. Every process and procedure and customer touch point should be designed to provide the best customer experience possible. Customers include Plan Members, Health Benefit Representatives (HBRs), and the Plan. Communications must be written clearly and simply for all customers to easily understand them.

There must be a variety of options, including robust web tools and customer call centers, for customers to interact with the Vendor. The Vendor must show a dedication to constant customer experience improvements and be an innovator in online Member engagement. Online engagement includes 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.

Objectives

- Provide a superior customer experience for Plan Members and HBRs.
- Provide state of the art web tools for Plan Members and HBRs.
- Support single sign-on from the EES vendor for Members to view claims and out-of-pocket accumulations.
- Contract with a Vendor that is willing to partner with the Plan on initiatives and enhancements that will improve Member and HBR satisfaction through enhanced processes, services, and online tools.
- Contract with a Vendor that is willing to customize its communication materials and online tools to meet the Plan's needs.
- Contract with a Vendor that has a track record of going above and beyond the call of duty to exceed customer expectations.

5.2.10.2 Services

a. The Plan requires a Vendor with a Member call center to have hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to all Member inquiries. The call center should be dedicated to the Plan with a Plan-specific phone number and greeting.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide a dedicated Member 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. Include in the description the anticipated number of call center resources that will be dedicated to the Plan.

ii. Vendor will add additional resources to the call center at no additional cost to the Plan as required to meet increased demand during peak call periods, such as during Open Enrollment.

iii. Vendor will have a dedicated toll-free number for Plan Members.

iv. Vendor will answer the phones with a greeting that identifies the call center as a representative for the State Health Plan.

v. Availability of a 24/7 interactive voice response (IVR) system with basic eligibility, benefit, and claims status information for Members.

vi. Vendor will customize the IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.

vii. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.

viii. Vendor will receive emails from Plan Members and respond to their inquiries.

ix. Upon request, Vendor will provide expanded hours of operation during the Open Enrollment period at no additional cost to the Plan. Include in the description the proposed hours. The Plan's enrollment and eligibility call center is generally open on Saturdays during Open Enrollment.

x. Vendor will provide non-English speaking services for callers who may need assistance in other languages. Include in the description what languages are available.

xi. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them. Include in the description other services the Vendor may offer for this population.

xii. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – xi. above.

The Vendor shall describe each of the following:

xiii. Any other non-web-based services provided to Members by the Vendor's Customer Call Center.

xiv. The Plan and Member customer service model for Vendor's current largest group.

xv. The method for handling complaints, for developing and implementing action plans to resolve complaints, and for reporting complaints and follow-up actions to the Plan.

xvi. The training that will be provided to Vendor's Call Center resources, to educate them on Plan enrollment rules, plan designs, incentives, and Plan vendor integration requirements.

xvii. Vendor's experience managing both Medicare Primary and Non-Medicare primary populations within one Group. Include detailed information about how Call Center representatives assigned to the Plan will be trained on Medicare rules and the Plan's specific Medicare primary product enrollment rules.

xviii. The key performance indicator (KPI) targets and results for the Vendor's Member Call Centers for each of the last two (2) calendar years.

b. The Plan prefers a Vendor with integrated call tracking and recording systems that enable the Vendor or the Plan to easily track, pull, audit, and report on Member and HBR calls.

The Vendor shall confirm and describe each of the following:

i. 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.

ii. Vendor will record and track **all** HBR calls including call reason and call resolution.

iii. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.

iv. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.

v. Vendor will provide copies of call notes to Members upon request.

vi. Vendor will provide reports, based on call reason type, to the Plan upon request.

vii. The existence of a call audit program to measure the accuracy of the information provided to Members and HBRs who call the Vendor.

viii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – vii., above.

c. The Plan requires a Vendor with an Escalation Team and single point of contact to work with the Plan to resolve any escalated issues.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide an Escalation Team to respond to and resolve inquiries from the Plan.

ii. Vendor will have a single point of contact and a back-up contact for Plan leaders to contact to resolve any escalated Member issues that may arise.

iii. Vendor will designate team members to be given access to the Plan's PBM's systems to make emergency pharmacy updates, when requested by the Plan.

iv. Vendor will process benefit and enrollment exceptions within twenty-four (24) hours, or as requested by the Plan.

v. Describe any limitations and/or issues with meeting requirements c.i.-iv. above.

d. The Plan requires a Vendor with an HBR call center to have hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to all HBRs for premium billing, eBilling, and enrollment inquiries. The call center should be dedicated to the Plan with a Plan-specific phone number and greeting.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide a dedicated HBR call center for enrollment, premium billing, and eBilling questions with a dedicated toll-free number with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to HBR inquiries. Include the description of the anticipated number of resources that will be assigned to Employing Unit call center.

ii. Vendor will accept and respond to Employing Unit emails.

iii. Vendor will answer the phones with a greeting that identifies the Vendor's representative as a member of the State Health Plan.

iv. Vendor will provide reporting to the Plan around HBR users' most recent login history to the billing platform.

v. Describe any limitations and/or issues with meeting requirements d.i.-iv. above.

The Vendor shall describe the following:

vi. The service model most frequently used by the Vendor to support groups with a similar number of HR resources as the Plan (there are currently over 1,000 HBRs supporting more than 400 groups).

e. The Plan requires a Vendor that offers a robust, secure Member portal for Plan Members which can be customized to meet the Plan's needs. Members should have access to view and print their claims and benefit information, order ID cards and print temporary ID cards, search for providers, and shop for services. The portal should also include wellness tools and other health care support tools. If the Plan chooses to offer applicable plan designs, Members should also be able to view their Health Reimbursement Account (HRA) and/or Health Savings Account (HSA) information and engage in other activities that increase their health literacy.

The Vendor shall confirm and describe each of the following services:

i. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.

ii. 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.

iii. Vendor will customize the portal with the Plan's branding.

iv. In addition to displaying the Plan's branding, the 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.

v. A Subscriber has access to his/her own data as well as his/her own Dependent's data via the Member portal as allowed by law.

vi. A Dependent only has online access to his/her own data via the Member portal.

vii. 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.

viii. Member portal will capture Plan Members' preferences for communication and appointment reminders including, but not limited to, frequency, topics, mode (text, email, mail).

ix. Member portal will provide a personal portal calendar with the ability to set appointments with case and disease management counselors, active life coaches and other program consultants including the ability to enable text message reminders.

x. Member portal will push appointments to personal calendars, allow a Member's health team to have access to Member's personal portal calendar, and will add appointments with set reminders.

xi. Member 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.

xii. Member portal will provide and moderate online forums and live chat groups. Include in the description how the forums will be managed and whether the Plan or Employing Units will have access to run and or manage their own topics.

xiii. 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.

xiv. Member portal will allow Members to:

1) View claims and claim payment status.
2) View and print EOBs.
3) View deductible and out-of-pocket (OOP) accumulations.
4) 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 ID Cards.
8) Print temporary ID cards.
9) Order new HRA or HSA debit cards, if applicable.

10) 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.
11) Complete a health assessment that could be customized by the Plan.

xv. Member portal will accept and display Member-specific information from other systems and Vendor's health team, including:

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.

xvi. Vendor will provide the following services whether the Member is logged into the secure site or accessing these tools on the unsecured site:

1) Search for providers by specialty.
2) Search for procedure/service cost.

xvii. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-xvi. above.

The Vendor shall provide each of the following:

xviii. Description of all the services, including any clinical information, available to Members via the secure Member portal.

xix. Description of the mobile technology available to Plan Members and the types of services offered though this technology including, but not limited to, virtual ID card that will display the Plan's custom ID, mobile care programs, customized alerts.

xx. Copy of the 2019 scheduled down time for the Member and employer portals.

xxi. Results of system availability for Members and employers, excluding scheduled down time for each of the last two (2) years.

f. The Plan prefers a Vendor with the flexibility to support the Plan's initiatives by providing customized web solutions.

The Vendor shall confirm and describe each of the following:

i. Vendor will customize the materials available to Plan Members via the secure Member portal.

ii. Vendor shall describe any limitations and/or issues with meeting requirement f.i. above.

The Vendor shall describe the following:

iii. Any other web services included by the Vendor that will provide value to the Plan and Plan Members.

g. The Plan requires a Vendor with online billing functionality that shall be used to provide monthly Employing Unit premium invoices, including summary and detail invoice reports, to each Employing Unit and/or Entity.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide an online, web based, billing tool with role-based security at the Employing Unit, Entity and Plan level. The Plan should have “super-user” access at the Plan level to view data at the Employing Unit level. The Employing Units should only have access to see data related to their Employing Unit. Within the Employing Unit, users should be able to have both update and view-only access. Additionally, an aggregate user role will be necessary for specific multi-group management.

ii. HBRs will have access and ability to export to a spreadsheet and print electronic billing documents from the online billing tool.

iii. The online billing tool will maintain historical invoices for at least 10 years, with the most recent 3 years available online for users.

iv. The online billing tools will offer resources to support monthly billing reconciliation by the Employing Units.

v. Employing Units will be able to pay the invoice online, via ACH.

vi. Employing Units will also be able to pay by check and that payment will display in the online billing tool.

vii. Vendor will include multiple Member IDs including, but not limited to, a SSN and/or an employer assigned ID on the invoice presented by the online billing tool.

viii. Vendor will provide tools to the Employing Unit that allows them to run mock bills prior to the production of the monthly invoice.

ix. Vendor shall describe any limitations and/or issues with meeting requirements g.i. – viii. above.

h. The Plan prefers a Vendor that has a secure employer web portal accessible to the Plan to view Plan Member claims and enrollment data. Approved Plan staff should be able to view individual Member and claims data and run reports at the aggregate Plan level and Employing Unit level.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment information.

ii. Vendor will provide an online portal that Plan Staff can use to view individual Member claims. The claims view access in the portal should be similar to the view access a Member has via the secure member portal.

iii. Vendor will provide an online portal that provides ad hoc reporting capabilities that will allow the Plan to run reports at the aggregate Plan level, Entity level, and the Employing Unit level.

iv. Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iii. above.

The Vendor shall describe the following:

v. Any other functionality available via the online portal.

i. The Plan prefers a Vendor that will participate in and support the Plan’s customer experience initiatives including, but not limited to, surveying Members and HBRs.

The Vendor shall confirm and describe each of the following:

i. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiatives, upcoming Plan mailers and/or events, and develop and implement process improvements between Plan vendors and Partners.

ii. 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 the 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. The Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.

iii. Vendor will conduct other surveys, as requested by the Plan.

iv. Vendor will conduct HBR satisfaction surveys. The Plan will be responsible for communicating the survey to HBRs and may provide a link to the survey on the Plan's web site. The Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.

v. Vendor will attend Plan-hosted Open Enrollment events to educate members on Plan options. The Plan representatives are generally on the road across the state during most of September and October promoting Open Enrollment. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.

vi. Vendor will provide both web-based and regional on-site HBR billing training to HBRs. Currently, the Plan conducts quarterly regional events for HBRs to educate them on premium billing and enrollment. Representatives from the TPA and EES vendor are required. Other events are scheduled as needed.

vii. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.

viii. Vendor will attend Wellness Fairs and other promotional events around the state, as requested by the Plan.

ix. Upon request, Vendor will provide resources to conduct biometric screening at wellness events, as requested by the Plan. If requested, Vendor shall have the ability to send the biometric results to the Members' primary care providers.

x. Vendors will provide language interpreters, including sign language, at events as requested by the Plan.

xi. The Vendor should describe any limitation to meeting requirements i.i. - x., above.

The Vendor shall describe the following:

xii. Any other resources or services included by the Vendor to support Member and HBR outreach and educational events.

j. The Plan requires a Vendor that will support the Plan's custom benefit books and will work with the Plan to customize Member and HBR communication materials. The Vendor must also develop and implement new communication materials to support any programs implemented for the Plan.

The Vendor shall confirm and describe each of the following:

i. 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.

ii. Vendor will co-brand letters or other materials the Vendor will send to Members and HBRs.

iii. Vendor will customize the content of any letters or other materials the Vendor will send and/or display to Members and HBRs.

iv. Vendor will develop and disseminate appropriate Member communication for each Medical Management program.

v. Vendor will develop and implement new communication materials for Members, HBRs, and/or Providers to support any programs implemented for the Plan.

vi. Vendor will suppress specific Member communications, upon request.

vii. Vendor will develop and disseminate appropriate Provider communications, as requested by the Plan.

viii. The Vendor shall describe any limitation and/or issues meeting requirements j.i. – vii., above.

The Vendor shall provide each of the following:

ix. Samples of communication developed for targeted populations for specific medical management interventions.

x. Samples of member-directed communications that can be shared with the Members' primary care provider (PCP).

xi. Samples of innovative communication methods that are currently used or are in development for future use.

k. The Plan prefers a Vendor that has expertise in Member Communications.

The Vendor shall confirm and describe the following:

i. The availability of Marketing and Communication resources for the Plan.

ii. Vendor will mail direct communications pieces to Members.

iii. 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. In the description Vendor should include customization possibilities of both items. Refer to Exhibits 9 and 14 for sample ID Cards and EOB.

iv. The Vendor shall describe any limitation and/or issues meeting requirements k.i. – iii., above.

5.2.11 Product Management

5.2.11.1 Overview and Expectations

The Plan seeks a Vendor that offers innovation in both Product and Plan Designs. The 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. The 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.

The Plan currently offers three (3) Preferred Provider Organization (PPO) plans to Members, including approximately 25,000 Medicare primary Members who have not elected a Medicare Advantage Plan. Two of these plan designs, the 80/20 Plan and the 70/30 Plan, include copay incentives for electing a primary care provider (PCP). The third plan, a High Deductible Health Plan, is for non-permanent full time Employees. The health benefit plans currently offered can be found at the following links:

- 80/20 Plan: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_80-20_benefit_booklet.pdf
- 70/30 Plan: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_70-30_benefit_booklet.pdf
- HDHP: https://files.nc.gov/ncshp/documents/open-enrollment-documents/2019_hdhp_benefit_booklet.pdf

Objectives:

a. Engage a progressive Vendor with a proven track record for delivering plan design innovation, speed to market, and an aptitude for “bending the trend” of health care costs.

b. Promote Member engagement by selecting a Vendor with state-of-the-art web tools, communication strategies, and programs that support consumer driven health care.

c. Improve the Customer experience by selecting a Vendor with the breadth and depth of resources to provide fully integrated Products.

d. Ensure quality care and maximize savings.

5.2.11.2 Product Services

a. The Plan requires a Vendor that can not only support the Plan’s current PPO Plans but has the flexibility to support any requested changes. The Vendor shall also be able to ensure that all Products and Plan Designs are compliant with federal regulations including the Patient Protection and Affordable Care Act (PPACA).

The Vendor shall confirm and describe:

i. Vendor will administer the 2020 PPO offerings which include the 80/20 PPO Plan, the 70/30 PPO Plan and the HDHP Plan which are described in detail on the Plan’s web site: https://www.shpnc.org/2019-employee-benefits. These plan designs include, but are not limited to, the following requirements:

1) Ability to apply a copay and a deductible to the same service.

2) Ability to 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 16, Primary Care Provider Incentive Program for more information on PCP copay reductions.

3) Ability to integrate deductible and/or out-of-pocket (OOP) accumulators with the Plan’s PBM to support a combined Medical/Rx deductible and OOP maximums.

4) Ability to waive the ER copay when the Member is admitted for an inpatient stay and/or an observation stay.

5) Ability to apply 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) Acupuncture.
i) Outpatient Behavioral Health.
j) Per Inpatient Confinement.

ii. Vendor will ensure all Products and Plan Designs are compliant with all federal regulations, including the PPACA.

iii. Vendor will administer all benefits as required by Article 3B of Chapter 135 of the North Carolina General Statutes and as may be amended from time to time.

iv. Vendor will administer benefits in accordance with all Federal and State requirements.

v. 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.

vi. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.

vii. The Vendor shall describe any limitations or issues with meeting the requirements described in a.i.- vi. above.

b. The Plan prefers a Vendor that can configure up to four benefit (coinsurance) levels per PPO Plan as follows:

- **Tier 1 network benefit: Highest coinsurance level for preferred in-network providers.**
- **Tier 2 network benefit: Second highest coinsurance level for non-preferred in-network providers.**
- **Out-of-Area (OOA) provider benefit: Third highest coinsurance level for areas where there is no network provider available to the Member for the particular service.**
- **Non-network provider benefit: Lowest benefits for non-network providers.**

Example:

Tier 1 Provider: No deductible / 100% coinsurance

Tier 2 Provider: $500 deductible / 80% coinsurance

OOA Provider: $500 deductible / 70% coinsurance

Non-network Provider: $1000 deductible / 50% coinsurance

The Vendor shall confirm that it will, upon request, support the following:

i. A four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an OOA benefit, and a non-network benefit.

ii. A three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.

iii. A three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.

iv. The Vendor shall describe any limitations or issues with meeting the requirements described in b.i -iii. above.

c. The Plan requires a Vendor that will provide innovative Plan Designs and programs including Plan Designs integrated with incentives.

The Vendor shall confirm and describe that it will, upon request, support each of the following plan design features:

i. Set cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.

ii. Customize Vendor's current value-based and incentive Plan Design features and/or implement new, customized ones for the Plan.

iii. Integrate with other Plan vendors to deliver value-based and/or incentive benefits.

iv. Set benefit limits by any age.

v. Set benefit limits by place of service.

vi. Set benefit limits by frequency of service.

vii. Set benefit limits by facility type.

viii. Set benefit limits by per-diem maximums.

ix. Set benefit limits by confinement.

x. Set benefit limits by episode of care.

xi. Set benefit limits by DRG.

xii. Set provider copay by specialty type.

xiii. Apply different coinsurance and/or deductible for specialty pharmacy claims.

xiv. Apply a copay on a service with a coinsurance other than 100%.

xv. Include or exclude copays in the out-of-pocket calculation.

xvi. Track an individual and family OOP maximum.

xvii. Include deductible carry-forward.

xviii. Exclude deductible carry-forward.

xix. Set non-network coinsurance at any percentage.

xx. Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.

xxi. The Vendor shall describe any limitations and/or issues with meeting requirements c.i. – xx. above.

The Vendor shall describe each of the following:

xxii. Current value-based plan design elements available in Vendor's current product suite with projected or actual cost/savings on a PMPY basis. Include in the description willingness to put performance guarantees around these elements.

xxiii. How incentives have been successfully woven into current products and/or plan designs with projected or actual cost/savings on PMPY basis. Include in the description the willingness to put performance guarantees around these elements.

xxiv. Any reference-based pricing initiatives in North Carolina and nationally that could or would be in place during the term of the Contract.

d. The Plan prefers a Vendor that offers a full-service health reimbursement account (HRA).

The Vendor shall confirm and describe that, upon request, it will implement an HRA for Plan Members with the following features:

i. HRA annual balances based on the number of family members enrolled. Example:

1) Subscriber only = $600 starting balance.
2) Subscriber + one (1) dependent = $1200 starting balance.
3) Subscriber + two (2) or more dependents = $1800 starting balance.

ii. Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.3 Include in the description a copy of the integration workflow between the medical claims processing systems and the HRA processing system.

iii. Proration that reduces the starting HRA amount for Members who enroll after the beginning of the benefit year.

iv. 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.

v. Ability to accept and appropriately apply HRA rollover funds from the prior TPA into Members' HRAs.

vi. Automatic claims reimbursement functionality from the HRA.

vii. Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.

viii. Annual HRA rollover functionality.

ix. Ability to customize the HRA Member portal, as requested by the Plan.

x. Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.

xi. HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.

xii. Ability to support "split-families" where one or more of the family members are not eligible for the HRA because he or she is Medicare Primary. Example: Medicare Primary Subscriber is enrolled in the 70/30 Plan and the spouse and Dependent Child are enrolled in the HRA PPO.

xiii. HRA Debit Card.

xiv. 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.

xv. Ability to provide an HRA on a copay based plan like the 80/20 PPO.

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

xvii. The Vendor shall describe any limitations and/or issues with meeting requirements d.i. - xvi. above.

e. The Plan prefers a Vendor that offers Health Savings Accounts (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.

The Vendor shall confirm and describe that it will, upon request:

i. Provide HSAs for Members enrolled in an HDHP.

ii. Provide HSA banking services to support funding by the Plan.

iii. Support custom funding reconciliation services, as requested by the Plan.

iv. Support integration with an HSA administrator other than the one offered by the Vendor.

v. Customize the HSA Member portal, as requested by the Plan.

vi. Customize any HSA Member materials, including letters, as requested by the Plan.

vii. Provide HSA debit cards that can be customized with the Plan's logo.

viii. Provide HSA checking accounts.

ix. Provide welcome kits to Members when they initially enroll in an HSA.

x. Describe any limitations and/or issues with meeting requirements e.i.-ix. above.

The Vendor shall provide each of the following:

xi. Description of all the services provided under HSA banking.

xii. List of banks available to Members for HSA accounts.

xiii. Process flow for initial Member HSA bank account set-up.

xiv. Process flow for updating banks with ongoing Member enrollment and demographic changes.

xv. Process flow for Plan deposits into Members' HSA bank accounts.

xvi. Sample reports available to the Plan to manage banking services.

xvii. Timeline for implementing HSA banking services.

xviii. Resources available to the Members to help set up HSA bank accounts if the Plan does not fund the HSA account.

f. The Plan prefers a Vendor who integrates Telehealth into the standard plan designs.

The Vendor shall describe the following:

i. Telehealth benefit options available to the Plan.

g. The Plan prefers a Vendor that can offer unique products for Medicare Primary Members.

The Vendor shall confirm and describe the following:

i. Vendor will provide a self-funded Group Medicare Supplement Plan as requested by the Plan.

ii. The Vendor shall describe any limitations and/or issues with meeting requirement g.i. above.

h. The Plan requires a Vendor that can partner with the Plan on benefit development that includes an annual benefit development life cycle that begins about eighteen (18) to twenty-four (24) months prior to the effective date but may not be finalized until close to the effective date.

The Vendor shall confirm and describe:

i. The Vendor will partner with the Plan as early as twenty-four (24) months prior to the effective date to develop new benefits.

ii. The Vendor will preview Vendor's new benefit features, plan design features, and/or products at least nine (9) months prior to rollout.

iii. The 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 NC General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iii. above.

5.2.12 Claims Processing and Appeals

5.2.12.1 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. The Vendor shall also provide tools that detect and prevent the payment of duplicate, excluded, and/or fraudulent claims as well as identify and properly bundle claims that should be included with other services. The Plan requires a Vendor with strong performance measures and operational teams that consistently strive to achieve superior results. The Vendor must be able to administer medical and pharmacy claims appeals as required by Chapters 58 and 135 of the North Carolina General Statutes and federal law. The Vendor should be able to implement processes for all financial transactions that are compliant with State banking requirements and provide timely documentation and reporting to support the Plan's financial reporting. As such, the Plan may have unique limitations or special requirements around funding claims and adjustments.

[*Note: See Section 5.2.3 "Finance and Banking" for more details].*

Objectives

a. Ensure claims are processed in accordance with federal and state regulations as well as the Plan's specific benefit rules. Refer to benefit summaries and benefit booklets available at the following link: https://www.shpnc.org/2020-benefit-information.

b. Partner with a Vendor that can configure and, if necessary, enhance its claims system to support innovative plan designs and benefits.

c. Minimize "pay and pursue" claims recovery by selecting a Vendor that strives to prevent erroneous claims payment by focusing on robust pre-edits that seek to prevent duplicate, excluded, fraudulent, and improperly bundled claims payment.

d. Ensure the Plan's Medicare eligible claims are processed in accordance with Plan rules and federal requirements.

e. Promote efficiency by selecting a Vendor with state-of-the-art business tools, processes, and Services.

f. Ensure all applicable policies and regulations of the Office of State Controller and Department of State Treasurer are supported.

5.2.12.2 Services

a. The Plan requires a Vendor that can provide the following claims services.

The Vendor shall confirm and describe each of the following:

i. Vendor will administer claims in accordance with the terms outlined in the 70/30 PPO Plan, 80/20 PPO Plan, and HDHP PPO Plan Benefit Booklets found at the following link: https://www.shpnc.org/2020-benefit-information.

ii. Vendor will configure and, if necessary, enhance its claims system to support innovative plan designs and benefits.

iii. As required by N.C.G.S. § 90-414.4, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. Vendor must deny any claims received from providers that are not in compliance on the date of service.

iv. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.

v. Vendor will process claims according to restrictions in age, diagnosis, procedure code, revenue code, modifier, provider classification, provider network restriction, or place of service.

vi. Vendor will maintain and make accessible to the Plan at least ten (10) years of claims history.

vii. Vendor will generate appropriate letters and notifications, and will customize them as requested by the Plan.

viii. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add additional edits at the Plan's request.

ix. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – viii. above.

b. The Plan prefers a Vendor that can perform the following claims services.

The Vendor shall confirm and describe each of the following:

i. Upon request, Vendor will pay all claims, including non-network claims based on assignment of benefits.

ii. Vendor will provide a weekly summary of any claims totaling ≥ $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.

iii. Vendor will attempt to negotiate a lower rate for any out-of-network claims ≥ $5,000, even in scenarios where the Plan allows for the payment of billed charges for emergent, medically necessary care.

iv. Describe any limitations and/or issues with meeting requirements b.i. – iii. above.

The Vendor shall describe each of the following:

v. The claims processing platform, including development (i.e., purchased or developed internally), recent enhancements, planned enhancements, and operating requirements. Include any planned platform change and timeline for implementation.

vi. The claims workflow from receipt to final processing.

vii. The methodology and tools used to support pre-edits or pre-release claims reviews that avoid "pay and chase" and the savings associated with these edits or processes.

c. The Plan requires a Vendor that can support the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM.

The Vendor shall confirm and describe each of the following:

i. Vendor will support the Plan's appeals process required by Chapters 58 and 135 of the North Carolina General Statutes. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.

ii. Vendor will support the Plan's pharmacy appeals with customized reporting.

iii. Vendor will produce custom appeals letters.

iv. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's office, as appropriate, throughout the appeals process. When necessary, Vendor's subject matter experts will be required to testify during hearings.

v. Describe any limitations and/or issues with meeting requirements c.i. – iv. above.

The Vendor shall describe each of the following:

vi. Appeals process for Vendor's current book of business.

vii. Changes that will be required to meet the Plan's statutory requirements.

The Vendor shall provide the following:

viii. A sample of a level one and level two claims appeal letter for the Vendor's current book of business.

d. The Plan requires a Vendor that can provide the following Medicare claims services.

The Vendor shall confirm and describe each of the following:

i. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.

ii. Vendor will process claims when Medicare is primary. Include in the description the process the Vendor will use to ensure that Medicare primary Members' claims are not inappropriately paid as State Health Plan primary.

iii. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part 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 17, Claims Processing Phantom Plan - Medicare Part B for more information on Phantom Processing.

iv. Vendor will accurately display the processing of these claims on an EOB. Provide a sample of an EOB with claims that have been coordinated with Medicare.

v. Vendor will support the Plan's PBM by sharing information about Members with Phantom B processing.

vi. Vendor shall describe any limitations and/or issues with meeting requirements d.i. – v. above.

The Vendor shall provide each of the following:

vii. The top five (5) clients, by size (total Members), currently utilizing Medicare direct services and the number of Medicare primary members in each client's plan.

viii. Auto-adjudication rate of Medicare crossover claims.

ix. Current process for confirming Medicare primary status.

e. The Plan requires a Vendor that can perform coordination of benefits (COB) services.

The Vendor shall confirm each of the following:

i. Vendor will support the Plan's COB rules as outlined in the Plan's Benefit Booklets found at the following link: https://www.shpnc.org/2020-benefit-information.

ii. Vendor will coordinate benefits without credit reserve.

iii. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-ii. above.

f. The Plan requires a Vendor that will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, disclosures, reporting, etc.).

The Vendor shall confirm each of the following:

i. Vendor will support all applicable state laws including, but not limited to, those listed in N.C.G.S. § 135-48.51.

ii. Vendor will support all applicable federal regulations, including, but not limited to, 42 CFR Part 2.

iii. Vendor will support all future state and federal requirements.

iv. Vendor shall describe any limitations and/or issues meeting requirements f.i.-iii. above.

The Vendor shall describe the following:

v. The process for monitoring regulations that may impact claims administration.

vi. Any subsequent implementation approach for new regulations.

g. The Plan requires a Vendor that will ensure the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of the Vendor's action, inaction, or system failure.

The Vendor shall confirm the following:

i. The Plan will not be responsible for prompt-pay interest as a result of the Vendor's action, inaction, or system failure.

ii. Vendor shall describe any limitations and/or issues with meeting requirement g.i. above.

h. The Plan seeks a Vendor that will provide EOBs to Members that meet Plan and Federal requirements and are presented in an easy to read and understandable format.

Vendor shall confirm each of the following:

i. Vendor will produce EOBs that meet all Federal requirements.

ii. Vendor will mail EOBs to Members.

iii. Vendor will prevent Subscribers from having access to dependent EOBs when the Subscriber does not have custodial rights.

iv. Vendor will customize EOBs with the Plan's logo and custom network and other information as illustrated in attached Sample EOB, Exhibit 14.

v. Vendor shall describe any limitations and/or issues with meeting requirements h.i. – iv., above.

i. The Plan prefers a Vendor that can perform the following EOB services.

Vendor shall confirm each of the following:

i. Vendor will mail EOBs to directly to Dependents eighteen years of age or older without a copy to the Subscriber.

ii. Vendor will mail a Dependent's EOB to a different address, if a different address exists in the Dependent's demographic record.

iii. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.

iv. Vendor will provide an EOB via the secure Member portal.

v. If applicable, Vendor will provide a single, combined Medical and Health Reimbursement Account (HRA) EOB. If available, provide sample.

vi. Vendor will include communications developed by the Plan as “inserts” in the EOB envelop.

vii. Vendor will display claim descriptions and details on EOBs using the level of detail, labels, and descriptions requested by the Plan.

viii. Vendor shall describe any limitations and/or issues with meeting requirements i.i. – vii., above.

j. The Plan requires a Vendor that can support the Plan’s eighteen (18) month timely filing rules set forth in N.C.G.S. § 135-48.52(6).

The Vendor shall confirm each of the following:

i. Vendor will support an eighteen (18) month claims run-out.

ii. Vendor will recognize a new claims submission and reject it after the eighteen (18) month timely filing period.

iii. Vendor shall describe any limitations and/or issues meeting requirements j.i. - ii., above.

The Vendor shall describe the following:

iv. Time period allowed to providers, per the Vendor’s provider contracts, to submit initial claims and claims corrections.

k. The Plan seeks a Vendor with claims systems that can support primary care provider (PCP) “gate-keeper” rules, if requested.

The Vendor shall confirm and describe the following:

i. Options available to apply PCP gate-keeper logic to claims.

ii. Vendor shall describe any limitations and/or issues with meeting requirement k.i., above.

5.2.13 Audit

5.2.13.1 Overview and Expectations

The Plan seeks a Vendor that places great value on the accuracy of its deliverables. This Vendor must demonstrate a dedication to quality in all aspects of its operation, be willing to share internal and external accuracy and audit results, and collaborate with the Plan on quality initiatives. Furthermore, the 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 the Vendor to be time sensitive to all audit requests and be prepared to support multiple audits simultaneously.

Audit Types

- Standard Audits are performed on an ongoing quarterly basis by the Plan’s auditors. These standard audits are used to measure claims accuracy, generally and associated with the Performance Guarantees (Section 6.3), and in preparing the State’s Comprehensive Annual Financial Report (CAFR). Note: Certain audits are conducted by a Certified Public Accountant firm and relied upon by the North Carolina Office of the State Auditor.
- Focused Audits and Comprehensive Electronic Audits are also performed on an as-needed basis at the Plan’s discretion throughout the Plan Year.
- State Audits. The North Carolina Office of the State Auditor may initiate an audit at any time pursuant to statutory authority (N.C.G.S. Chapter 147, Article 5A).

Objectives:

a. Ensure appropriate controls are in place to promote, monitor, and report on accuracy throughout the Vendor's organization.

b. Ensure the Plan's auditors have appropriate and timely access to required data and personnel.

c. Ensure the North Carolina Office of the State Auditor has appropriate and timely access to required data and personnel.

d. Ensure the Plan has access to data, workflows, personnel, and reports needed to monitor and analyze the Vendor's results and, when appropriate, initiate process improvements.

5.2.13.2 Services

a. The Plan requires a Vendor that 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 and a targeted sample selected from a comprehensive analysis of all claims by the Plan's audit vendor. The random claims sample of these Standard Audits will be used to validate Performance Guarantees. Both the random claims sample and the targeted sample will be used to identify overpayments owed to the Plan. A separate audit by Plan auditors and/or the North Carolina Office of the State Auditor will be used to support the Comprehensive Annual Financial Report (CAFR). 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, the fact that the Vendor may have identified and/or recovered an overpayment or underpayment prior to the audit is irrelevant in determining whether an error occurred.

The Vendor shall confirm and describe each of the following:

iv. Vendor will support ongoing quarterly claims accuracy audits, or Standard Audits, performed by the Plan's auditors. An audit plan will be provided prior to the initial quarterly audit that will define the ongoing Standard Audit timelines.

v. Vendor will provide claims files to the Plan's auditors on a monthly basis.

vi. Vendor will provide the Plan's auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits.

vii. Vendor will provide remote view only access to the claims adjudication system used by claims processors to review any and all claims in Vendor's claims and eligibility processing system(s).

viii. Vendor will provide the Plan's auditors access to detailed documentation associated with the Electronic Document Processing (EDP) system and all subsystems relevant to services provided under this Contract, at the Vendor's facilities.

ix. Vendor will share provider contracts and system pricing with the Plan's auditors for review and audit.

x. Vendor will provide on-site office space at the Vendor's facilities that are actually processing Plan claims including system access for the Plan's auditors, the Plan, or the North Carolina Office of the State Auditor.

xi. 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.

xii. Vendor will accept the Plan's auditor's claims audit methodology and audit results to measure claims accuracy for Performance Guarantees on a quarterly basis.

xiii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within thirty (30) days of the final report or another timeframe as specified by the Plan.

xiv. For any audit findings that reveal systemic or easily repeatable issues, the Vendor will provide full impact reports and review and recover out-of-sample claims. These out of sample claim recoveries will not impact performance guarantee measures.

xv. Vendor shall describe any limitations and/or issues meeting requirements a.iv. – xiv., above.

b. The Plan requires a Vendor that in addition to supporting ongoing quarterly claims accuracy audits will 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. For purposes of Focus Audits and Comprehensive Electronic Audits regarding claims, 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, the fact that the Vendor may have identified and/or recovered an overpayment or underpayment prior to the audit is irrelevant in determining whether an error occurred.

The Vendor shall confirm and describe each of the following:

iv. Vendor will support multiple audits simultaneously. Although the Plan will work with the Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.

v. Vendor will support Focus Audits such as, but not limited to, COB Audits, duplicate claim audits, pricing audits, eligibility audits, and Comprehensive Electronic Audits with a minimum of sixty (60) days-notice, on an as needed basis. An audit plan will be provided prior to the beginning of the audit.

vi. Vendor will provide any additional claims data or supporting documentation within two (2) weeks of the Plan's auditors' request to facilitate the audit.

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 thirty (30) days of the final report or another timeframe as specified by the Plan.

The Vendor shall confirm the following:

ix. Upon finalization of any audit, including, but not limited to, a Standard Audit, Focus Audit, or Comprehensive Electronic Audit, and within 30 days of receipt of a demand from the Plan, the Vendor shall reimburse the Plan the full amount of any overpayments or improper payments discovered by the Plan's auditors, whether from an in-sample or out-of-sample claim, that had not been detected and recovered by the Vendor prior to the Plan's auditors' disclosure of the audit findings to the Vendor. Reimbursements under this section shall not be offset against administrative expenses and must be repaid separately. Any recoveries undertaken by the Vendor related to these amounts shall be used solely to mitigate the Vendor's losses under this section, if any, and shall not be used to offset any amounts due the Plan.

x. In addition to reimbursement, if the Plan's auditors determine that there are systematic issues affecting the adjudication of the Plan's claims, the Vendor shall coordinate with the Plan to develop and immediately implement a corrective action plan subject to the Plan's approval.

xi. Vendor shall describe any limitations and/or issues meeting requirements b.iv. – x., above**.**

c. The Plan requires a Vendor that will support any other audits relative to services provided, fees, performance of operational areas, operational support areas, and enterprise support areas as directed by the Plan, the Plan's auditors, or by the North Carolina Office of the State Auditor.

The Vendor shall confirm and describe each of the following:

i. Vendor will support any other audits conducted by the Plan's auditors.

ii. Vendor will support any other audit requested by the North Carolina Office of the State Auditor.

iii. Vendor will support any other audit requested by the Plan.

iv. Vendor will provide on-site office space at the Vendor's facilities for which Plan claims or other operational Plan services are provided, including system access for the Plan's auditors, the Plan, or the North Carolina Office of the State Auditor.

v. Vendor shall describe any limitations and/or issues with meeting requirements c.i.-iv., above.

The Vendor shall describe each of the following:

vi. The preferred methodology for supporting any of the audits described in this section.

vii. The process for any Plan auditors to access systems and/or to send and receive Data Files.

viii. Any limitations to providing data to the Plan's auditors.

ix. Any access restrictions to onsite claims reviews.

d. The Plan seeks a Vendor that places a high value on the accuracy of all its deliverables, demonstrates a dedication to quality in all aspects of its operation, and is willing to share internal and external accuracy and audit results.

The Vendor shall confirm and describe each of the following:

i. Vendor has internal audit programs and will share internal audit results, as requested by the Plan. Include a list of all the audit programs associated with the services to be performed in support of this Contract.

ii. If requested, Vendor will customize the Vendor's standard audit reports to meet the Plan's specific audit needs.

iii. Vendor will provide benchmark and book of business results in addition to Plan specific results when reporting accuracy.

iv. Vendor will create an audit and/or quality control program if necessary to meet the requirements under this Contract.

v. Vendor shall describe any limitations and/or issues with meeting requirements d.i.-iv., above.

The Vendor shall describe each of the following:

vi. How records for Medicare eligible members are audited to ensure accurate claims payment (Medicare COB). Include the frequency of these audits.

vii. How doctors' orders and certificate of medical necessity documents are audited to ensure Durable Medical Equipment (DME) claims are processed accurately. Include the frequency of these audits.

viii. How fee schedules and other pricing tools are audited for accuracy. Include the frequency of these audits.

e. The Plan requires a Vendor that upon request, will provide workflows, data, and other materials for process review and when necessary, meet with the Plan within thirty (30) days of the request.

The Vendor shall confirm and describe each of the following:

i. Vendor will provide requested workflows, data, and other materials needed to review the Vendor's process within thirty (30) days of request.

ii. Vendor will demonstrate the Vendor's process to the Plan within thirty (30) days of request.

iii. Vendor will work with the Plan to develop process improvement plans.

iv. Vendor shall describe any limitations and/or issues with meeting requirements e.i.-iii., above.

f. The Plan requires a Vendor that will collaborate on process improvement initiatives.

The Vendor shall confirm and describe each of the following:

i. Vendor will allow the Plan to perform onsite reviews and validations of the Vendor's internal processes.

ii. Vendor will collaborate with the Plan on process improvement initiatives.

iii. Vendor shall describe any limitations and/or issues with meeting requirements f.i.-ii., above.

5.2.14 Recovery and Investigations

5.2.14.1 Overview and Expectations

The Plan seeks a Vendor with strong overpayment identification and recovery programs. The Vendor should routinely identify pre-payment and overpayment trends, perform root cause analysis, and institute process and technology improvements to address gaps. The Plan, at its discretion, may use its own vendors to seek recoveries; therefore, the Vendor must support the Plan's recovery vendors by providing claims data, adjusting claims, and posting payments. The 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.

Objectives

a. Ensure the Vendor has a progressive and aggressive overpayment identification and recovery program.

b. Ensure the Vendor has a comprehensive pre-payment program.

c. Ensure the Vendor uses state of the art technology and programs to detect and reduce fraud, waste, and abuse.

d. Ensure the Vendor is able to support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. Chapter 105A, Article 1) by identifying debtors who owe money to the Plan and qualify for refunds with the North Carolina Department of Revenue.

e. Ensure the Vendor is able to support the Plan's Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29) by identifying debtors who owe money to the Plan and are receiving retirement and/or disability benefits administered by the Department of State Treasurer's Retirement Systems Division.

f. Ensure the Vendor is willing to partner with the Plan on process and technology improvements to reduce overpayments and fraud.

g. Ensure the Vendor will provide the necessary reports to monitor recoveries, cost savings dollars, special investigations, and fraud cases.

h. Ensure the Plan, at its discretion, is able to utilize outside vendors for specific recoveries and special investigation services and that those vendors will be supported by the Vendor.

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

5.2.14.2 Services

a. The Plan requires a Vendor that will provide strong pre-payment audit programs and that is willing to provide monthly reports to the Plan with summary and detail information outlining the programs' results.

The Vendor shall confirm and describe the following:

i. Vendor will provide comprehensive pre-payment programs. Include in the description the pre-payment or "avoidance" savings for the Vendor's book of business associated with the programs in place for each of the last two (2) calendar years.

ii. Vendor will provide Plan specific pre-payment savings dollars reports on a monthly basis that include both summary and detail information outlining the programs' results.

iii. Vendor will customize the reports, if requested by the Plan.

iv. The Plan, at its discretion, may use its own vendors to establish pre-payment audits. The Vendor shall provide all necessary data and onsite access to the Plan's pre-payment audit vendors. Include in the description, the preferred methodology for supporting the Plan's pre-payment audit vendors, including the process for the Plan's vendors to access the appropriate data in the Vendor's systems to complete the audits and coordinate claims payment/denial of the claims.

v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.-iv., above.

b. The Plan requires a Vendor that can provide strong overpayment identification and recovery programs and meet the accounts receivable requirements of the North Carolina Office of State Controller. The Vendor must be willing to follow all statutes and state policies governing debts and accounts receivable. The Vendor will also be required to support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. 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). This requirement also applies to any claims or reimbursements made by a Subcontractor, such as, but not limited to, a Subcontractor that processes HRA reimbursements. Finally, the Vendor must support Plan vendors that seek recoveries on the Plan's behalf.

The Vendor shall confirm and describe:

i. Vendor will provide overpayment identification and recovery programs. Include in the description, overpayment recovery results for the Vendor's book of business, including the overpayment reason (paid after termination date, Commercial COB, Medicare COB, duplicate claim, third party liability recovery, etc.) for each of the last two (2) calendar years.

ii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.

iii. Vendor will customize the reports, if requested by the Plan.

iv. Vendor will implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.

v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. Chapter 105A, Article 1).

vi. Vendor will submit a bi-weekly debtor file to the North Carolina Department of Revenue.

vii. Vendor will provide the Plan the actual debt owed for each debtor within two (2) days of receiving the Debt Setoff recovery list from the Plan.

viii. Vendor will adjust any Debt Setoff recovery monies within 30 days of receiving approval from the Plan.

ix. Vendor will support the Plan's participation in the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29). Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.

x. Vendor will support the Plan's participation in Wage Garnishment (N.C.G.S. § 135-48.37A). Refer to Exhibit 18, Overall Recovery Flow, Provider Recovery Process & Member Recovery Process.

xi. Vendor will support the Plan's right to pursue debts against Providers through Credit Card Intercepts (N.C.G.S. § 1-359).

xii. Vendor will support the Plan's recovery vendors by providing data, adjusting claims, and posting payments. The Vendor shall provide all necessary data and onsite access to the Plan's recovery vendors. Include in the description, the preferred methodology for supporting the Plan's recovery vendors and the process for Plan recovery vendors to access systems and/or to send and receive Data Files.

xiii. Vendor will implement debt collections processes with a collection agency approved by the North Carolina Attorney General's Office. The list of approved collections agencies may change within the life of the Contract, as required by the North Carolina Attorney General's Office.

xiv. 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 the Vendor to ensure the claims are appropriately adjusted and recoveries are deposited in the Plan's depository accounts.

xv. Vendor will deposit into the Plan's depository account any recoveries received on behalf of the Plan, including, but not limited to, those from State Collections Agencies, Plan vendors, or Members within twenty-four hours of receipt as required in 5.2.3.2.a.i. and include the recoveries in the appropriate reports.

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 that shall not exceed twelve (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 anyone to be in default who misses one (1) payment. If anyone sends in a partial payment, he or she must be caught up in one (1) month or he or she will be considered to be in default.

xix. Vendor shall not enter into a settlement on the Plan's behalf without first obtaining the Plan's approval.

xx. Vendor will track and report actual cost savings dollars against targets and benchmarks.

xxi. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.

xxii. 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).

xxiii. Vendor shall describe any limitations and/or issues with meeting requirements b.i.-xxii., above.

The Vendor shall describe each of the following:

xxiv. Total recovery dollars requested and received as a result of Vendor error, for the Vendor's book of business for each of the last two (2) calendar years.

xxv. Transactions that automatically trigger a recovery review. (Example: retroactive termination, retroactive update of other insurance information, etc.)

xxvi. Processes and edits in place to identify improper provider billing. This includes, but is not limited to, up-coding, excessive charges, unbundling of services, multiple surgical procedures performed during one operation, and duplicate billing submissions including billing across programs (e.g., pharmacy and physician office or pharmacy and DME) and multiple provider TINs.

xxvii. Quality review of claims to ensure compliance with medical management determinations, medical claims policies, appropriate provider reimbursement arrangement, plan-specific benefits, and other measures.

xxviii. Any Subcontractor utilized for recoveries.

xxix. The Vendor's ability to aggregate, track, and collect interest and costs of collection for debts owed to the Plan, if the Plan decides to add these in the future.

c. The Plan requires a Vendor that demonstrates a dedication to fraud and abuse detection, reduction, and recovery as well as a willingness to assist in the prosecution of those who commit fraud.

The Vendor shall confirm and describe:

i. Vendor will have an investigation or similar unit to investigate possible fraud and abuse.

ii. Vendor will share details about specific investigations that impact the Plan, including the names of the providers involved.

iii. Vendor will provide Plan specific investigation reports on a monthly basis.

iv. Vendor will customize the reports, if requested by the Plan.

v. Vendor will provide copies of demand letters, settlement agreements, or other documents related to investigations.

vi. Vendor will cooperate with the Plan in litigation against those who are suspected of committing fraud.

vii. Vendor will use anti-fraud technology and/or software to prevent and detect fraud and abuse.

viii. Vendor shall not enter into a settlement on the Plan's behalf without first obtaining Plan approval.

ix. The Plan, at its discretion, may use its own vendors to investigate possible fraud and abuse and seek the appropriate recoveries. The Vendor shall provide all necessary data and onsite access to the Plan's investigation vendors. Include in the description, the preferred methodology for supporting the Plan's investigation vendors and the process for Plan vendors to access systems and/or to send and receive Data Files.

x. Vendor will support the Plan's investigation vendors by providing data, adjusting claims, and posting payments.

xi. Vendor will not establish a payment plan for a provider or active or inactive Member that exceeds twelve (12) months without the Plan's prior approval.

xii. Vendor shall describe any limitations and/or issues with meeting requirements c.i. - xi., above.

The Vendor shall describe each of the following:

xiii. How Vendor's fraud and abuse recovery targets are measured and what industry benchmarks are used to measure success.

xiv. Investigation methodology.

xv. Investigation targets and results from each of the last two (2) years.

xvi. Type and frequency of training provided to fraud and abuse detection and recovery staff.

xvii. Specifics about the resources available to the Plan to assist in the prosecution of those suspected of committing fraud and abuse.

xviii. Process for referral of those suspected of fraud and abuse. Include in the description the criteria for and process by which providers are removed from the Vendor's network.

d. The Plan prefers a Vendor that will partner with the Plan on an ongoing basis on all aspects of recovery and investigation efforts.

The Vendor shall confirm and describe:

i. Vendor will share root cause analysis of recoveries required because of Vendor error.

ii. Vendor will provide requested workflows, data, and other materials needed to review the Vendor's process within thirty (30) days of request.

iii. Vendor will partner on process improvements to address root causes uncovered as a result of recovery discovery.

iv. Vendor shall describe any limitations and/or issues with meeting requirements d.i. - iii., above.

The Vendor shall describe each of the following:

v. Process for prioritizing and addressing process and system gaps uncovered through routine analysis of processing and system errors.

vi. Types of claims edits and bundling technology and/or software used to prevent overpayments.

5.2.15 Initial and Ongoing Implementation

5.2.15.1 Overview and Expectations

Initial Implementation

The Plan seeks to partner with a Vendor having the systems and resources to support on-time implementation of all programs and services included in this Contract. The Vendor must provide dedicated resources and expertise to support simultaneous implementation of multiple work streams. Those work streams include, but are not limited to:

- Group Set-Up, enrollment, and premium billing
- Banking and finance
- Vendor integration and EDI
- Provider Network, (North Carolina State Health Plan Network)
- Program development (to determine which of the Vendor's programs may be implemented)
- 2022 benefit offerings
- Customer experience – e.g., customer service, member communications, employing unit training, etc.

During the initial implementation, the Vendor will work with the Plan to document which programs will be implemented when all services commence on January 1, 2022, how the programs will be rolled out to Plan Members, and what customizations may be required by the Plan. The Vendor shall also work with all Plan vendors to implement customized EDI files to and from the Vendor. Any other customized Data Files required to support programs to be in place on January 1, 2022 will also be designed and implemented.

The Vendor will also have to implement and integrate the Plan's custom network, the North Carolina State Health Plan Network, prior to January 1, 2022. This will include the transfer of provider data, the implementation of reimbursement methodology as outlined in Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, the integration required to load and maintain the Vendor's provider search tool, and the establishment of ongoing maintenance of all provider data interfaces.

To meet the Plan's expectations of providing a superior Customer Experience, the Vendor must have the resources available to assist with review and customization of all Member facing materials, including, but not limited to, communications provided to Members via the secure Member portal, any letters provided to Members, EOBs, and the Plan's Benefit Booklets. The Vendor must also work with other Plan vendors to set up the appropriate call transfer protocols and build any new workflow schematics that may be required. The Plan will work with the Vendor to ensure the Vendor's staff is appropriately trained and understands all Plan policies and requirements.

To meet the Plan's requirements for Group Set-Up and Enrollment, and to support the Open Enrollment period for the 2022 Benefit Year, the Vendor must be able to accept EDI files prior to January 1, 2022 and produce the first Group Premium Invoices in December 2021 for January 2022 coverage. The Vendor shall work with Plan staff and other Plan vendors to determine the Group set-up requirements and develop and implement a roll-out strategy for all Groups which includes, but is not limited to, providing regional and web training for the more than four hundred and fifty (450) Groups. The Vendor will also support the Plan during Open Enrollment events throughout the fall of 2021.

Ongoing Implementations

Throughout the life of the Contract, the Plan will implement new benefits, services, and Plan vendors that will require the 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. In all instances, the Plan will work with the Vendor to develop an Implementation Plan that is mutually agreeable to the Vendor, the Plan, and to the other Plan vendors involved. Depending on the scope of the project, 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 the Vendor as soon as feasibly possible about all proposed changes.

Annual Benefit Change Schedule

The Plan's *preferred schedule for annual benefit changes is to confirm the next year's benefits by February of the preceding year. To meet this schedule, the Vendor must be available to work with the Plan in the preceding months to design benefit change recommendations, and the Board of Trustees must vote and confirm benefits during the February Board meeting. Example of preferred 2022 Benefit Timeline Development Schedule:

- September 2020 – December 2020: Complete development of 2022 benefit recommendations
- January – February 2021: Present 2022 benefit recommendation to the Board
- February – September 2021: Plan, Vendor, and Plan vendors implement 2022 benefits
  - End to End testing of new benefits, including EDI and claims payout
  - Rate configuration
  - Process overview
  - Audit of new configuration
- October 2021: Open Enrollment commences for all Plan Members

While this is the preferred method, as noted earlier, the implementation timeline may be much shorter.

5.2.15.2 Services Initial Implementation

a. The Plan requires a Vendor with the resources, expertise, and technology to support the Plan's implementation schedule. In addition to completing group set-up, benefit configuration, data transfer, Plan, HBR, and Member training prior to the January 1, 2022 commencement of services, the Vendor must be able to successfully establish EDIs with the Plan and Plan vendors, bill the Employing Units, and issue ID cards.

The Vendor shall confirm and describe each of the following:

i. Vendor will have a fully assembled implementation team ready to begin work within two 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, and Group Premium Billing.
   2) Banking and Finance.
   3) Plan vendor Integration and EDI which includes, but is not limited to:
      a) EES vendor Integration.
      b) PBM vendor Integration.
      c) Billing vendor Integration.
      d) Billing Client Integration.
      e) Plan Data Warehouse Integration.
      f) Plan Custom Network (Data Files to the Plan).
   4) Custom Provider Network.
   5) Program Development.
   6) 2022 Benefit Offerings.
   7) Customer Experience which includes, at a minimum:
      a) Member Communications.
      b) Employing Unit Training.
      c) Customer Service.

The Vendor shall confirm and describe each of the following, including the types of resources to be assigned and the names and profiles of the work stream project leads.

ii. Vendor will provide a dedicated implementation manager whose sole account is the Plan, who in coordination with the dedicated account manager and account management team, will effectively manage the implementation of this program. The dedicated implementation manager must continue to support the Plan a minimum of 90 days after the implementation date of January 1, 2022, 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.

iii. Vendor will develop Functional Requirements Documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation for each work stream derived from the Plan's business requirements. These documents must be mutually agreed upon by the 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.

iv. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live. To support testing, the 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 the 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.

v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.–iv., above.

The Vendor shall provide each of the following:

vi. Description of the implementation and project management approach along with a high-level project timeline that includes durations and tasks by resource required, for the Vendor, the Plan, and Plan vendors.

vii. Description of the training approach for Vendor's staff.

viii. Description of the cooperation and resources that may be required from the Plan's current claims processing vendor to meet the implementation timeline.

ix. Description of the process for other Plan vendors to access systems and/or to send and receive Data Files.

x. List any access restrictions or Data File requirements for the Plan or Plan vendors.

xi. Describe any actions the Plan will need to take to assist with the performance of the proposed services, such as letters of authorization to other Plan vendors, information regarding organizational structure and reporting relationships, and similar matters.

xii. A description of how Vendor's operational, program, and project teams will be built or expanded to support the Plan.

b. The Plan requires a Vendor with the resources to meet the initial implementation schedule which will include some services that must be in place prior January 1, 2022.

The Vendor shall confirm and describe each of the following:

i. Vendor will support the 2022 Open Enrollment which will be in October of 2021, but may be rescheduled to a different time in the Plan's sole discretion. The 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.

ii. Vendor will produce and deliver Group Premium Bills in December of 2021 for January 2022 premiums.

iii. Vendor will complete all work to support a PBM "Carve-Out" which includes the data integration to support deductible and out-of-pocket accumulators between the medical and pharmacy benefits by January 1, 2022.

iv. Vendor will have the depository bank accounts setup and tested at least forty-five (45) days prior to January 1, 2022.

v. Vendor will deposit and properly report premium receipts for the first month of coverage into the Plan's bank account prior to the effective date of coverage.

vi. Vendor will collect premium receipts on behalf of the Plan and deposit into the Plan's bank account within 24 hours to comply with cash management policies in December 2021.

vii. Vendor will have all elements of the Plan's custom network, the North Carolina State Health Plan Network, implemented prior to January 1, 2022. This includes, but is not limited to, the transfer of provider data from the prior TPA, the implementation of reimbursement methodology as outlined in Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, the integration required to load and maintain the Vendor's provider search tool, and the establishment of ongoing maintenance of all provider data interfaces.

viii. There will be 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.

ix. Vendor shall describe any limitations and/or issues with meeting requirements b.i. –viii., above.

c. The Plan requires a Vendor with the resources and expertise to work with the Plan to implement benefits for the 2022 Plan Year.

The Vendor shall confirm and describe the following:

i. Vendor can load the current 2020 benefits without exception. Benefits are outlined in the benefit booklets at the following link: https://www.shpnc.org/2020-benefit-information.

ii. Vendor will work with the Plan to develop and implement any required benefit changes for the 2022 benefit year.

iii. Vendor will work with the Plan to develop an implementation plan to ensure all Members who enroll by December 1, 2021 with a 2022 effective date will have ID cards, and if appropriate, prior to January 1, 2022.

iv. 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, 2022.

v. Vendor shall describe any limitations and/or issues with meeting requirements c.i. –iv., above.

d. The Plan requires a Vendor that will provide business and technical resources to review all programs and services provided through this Contract, and work with the Plan to document which programs and services will be in place at Go-Live.

The Vendor shall confirm each of the following:

i. Vendor will provide business and, if necessary, technical resources to review all programs and services available through this Contract and complete any customization required by the Plan prior January 1, 2022. If requested by the Plan, Vendor will support a readiness review and/or implementation audit at least sixty (60) days prior to January 1, 2022. Vendor shall participate in all readiness review and/or implementation audit activities conducted by the Plan or Plan vendors to ensure the Vendor's operational readiness.

ii. Vendor shall describe any limitations and/or issues with meeting requirement d.i., above.

5.2.15.3 Services: Post Initial Implementation

a. The Plan requires a Vendor that will partner with the Plan to deliver new initiatives, Plan Design changes, and Plan vendor changes, as requested by the Plan. This will require the Vendor to have the business and project management resources available to support these items on an ongoing basis. When possible, the delivery date will be determined by the project life cycle, but in many instances the delivery date will be pre-determined.

The Vendor shall confirm each of the following:

i. Vendor will develop Functional Requirement Documents, Implementation Plans, Test Plans, Deployment Plans, and Close Out Documentation for each work stream derived from the Plan's business requirements. These documents must be mutually agreed upon by the Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator regarding day-to-day activities is authorized to sign these documents for the Plan.

ii. Vendor will support both Unit Testing and End-to-End Testing for new initiatives, Plan Design changes, and vendor changes, prior to deployment. To support testing, the Vendor must not only have the technical and business resources, but also the appropriate test environments. As mentioned above, the Test Plan will be mutually agreed upon by the Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator regarding day-to-day activities is authorized to sign these documents for the Plan.

iii. Vendor will support and participate in End-to-End Testing that may be required to support enhancements developed by other Plan vendors.

iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iii., above.

5.2.16 Reporting

5.2.16.1 Overview and Expectations

The Plan seeks a partner that can support its custom reporting requirements which includes 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, the Vendor must have the resources and expertise to assist the Plan as needed.

5.2.16.2 Reporting Services

a. The Plan requires a Vendor with the ability to provide canned reports and ad hoc self-service reporting capabilities to the Plan, Plan vendors, and Partners in various formats.

The Vendor shall confirm:

i. Vendor will provide required reports to the Plan in each of the following formats:

1) Excel.
2) PDF.
3) Text.
4) XML.
5) HTML.
6) CSV (raw format).

ii. Vendor shall describe any limitations and/or issues meeting requirement a.i., above.

b. The Plan prefers a Vendor with deep expertise in data analytics and modeling that can partner with the Plan to meet its strategic priorities.

The Vendor shall confirm and describe that the Vendor will provide the following:

i. Innovative thought leadership using advanced modeling techniques on trouble spots, population health management opportunities, fraud, waste and abuse, geographic, or other trends.

ii. Accurate and insightful analyses as requested by the Plan that will help identify areas of opportunity for improved services or reduced costs.

iii. Cost driver analyses, including the identification of cost drivers such as demographic changes, plan design changes and market occurrences (i.e., changing clinical protocols), as requested by the Plan.

iv. Trending analyses on such measures as cost, utilization, clinical outcomes, and enrollment migration, as requested by the Plan.

v. Predictive analyses on such measures as Member migration (plan migrations, physical migrations, utilization migrations, etc.).

vi. Cost impact analyses of an aging population.

vii. Clinical, cost, and productivity impact analysis of chronic conditions.

viii. Wellness Indicators analysis, including, but not limited to:

1) Smoking/Tobacco Use.
2) Drug Abuse/Misuse/Diversion (illicit and prescribed drugs).
3) Overweight/Obesity/Sedentary or Inactive lifestyle.
4) Stress, Depression, Anxiety.

ix. Benchmarking and comparative analyses. Specify the sources utilized for benchmarking/comparison of data (i.e., First Databank, Medispan, Agency for Healthcare Research and Quality (AHRQ), and National Quality Foundation (NQF)).

x. Comparative analyses (historical, current state, and predictive) of the Plan's total Member population (or stratification thereof) compared to comparable cohorts.

xi. Identification and characterization (clinical and financial) for Episodes of Care.

xii. Advanced modeling capabilities and tools including longitudinal analysis (forward and historical) predictive analyses, data-driven decision trees, data segmentation, data mining, text mining, visual statistics, neural networks, etc.

xiii. State-of-the-art, interactive tools for consumption and visualization of reporting and analytic results. Include sample reports/demos of visualization results.

xiv. Queries, business logic, and other information to provide in depth understanding of the results and the ability to recreate the results based on the data within the Plan's Data Warehouse.

xv. Data monitoring dashboards that allow multiple groups within the Plan to access, view, and analyze key performance data across vendors / Partners / carrier integration.

xvi. Vendor shall describe any limitations and/or issues meeting requirements b.i - xv., above.

The Vendor shall describe the following:

i. Experience with risk scoring methodology, link analysis, and graph pattern analysis.

ii. Modeling technologies and tools used, including available open source technology.

iii. Machine learning capabilities.

iv. Any external, third party and/or subscription-based data sources available for driving better insights and analytic results.

v. How the use of Vendor's advanced modeling capabilities helped drive a client solution.

vi. The options for providing and accessing analytic modeling results (e.g., email, portal, tool access, etc.).

The Vendor shall provide:

vii. Client examples where the aforementioned capabilities and tools have been utilized.

viii. An overview of the Vendor's methodology for grouping services and care into bundled episodes. Provide peer-reviewed validation of the methodology to grouping care into episodes.

ix. Sample screenshots/demos/reports/generic login access to these tools or capabilities.

x. Sample reports that reflect experience with population adjustments such as risk scores, episodes of care, treatment groupers, etc.

xi. Protocols outlining the process that the Vendor will follow with the Plan if there is a discrepancy in data or analytics between the Vendor and the Plan.

xii. An overview of commitment to transparency, the approach, and how Vendor will work with the Plan to resolve any discrepancies.

c. The Plan requires a Vendor that provides superior customer reporting.

The Vendor shall confirm and describe each of the following:

i. Vendor will customize any report, as requested by the Plan.

ii. Vendor will combine claims and financial data in reporting.

iii. Vendor will email all standard reports, to the email addresses provided by the Plan. If PHI is included, the reports shall be sent securely.

iv. Vendor will provide all standard reports on the reporting schedule outlined in Attachment K.

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 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, tenure.
3) Geography.
    a) Zip Code.

b) County.
c) Hospital Service Area (has).
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) Primary Care Physician (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).

vii. Vendor will provide innovative reporting functionality including interactivity, remote access, embedded graphics, data mapping, decision tree logic, and data drill downs as well as dashboard reporting.

viii. The Vendor shall describe any limitations and/or issues with meeting requirements c.i. – vii. above.

The Vendor shall describe and provide samples of each of the following:

ix. Standard reports that will be available to the Plan.

x. Ad hoc reporting capabilities.

xi. Availability of dashboards and enhanced reporting tools.

5.2.16.3 Standard Reports

a. The Plan requires a Vendor that offers standard reports to satisfy the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. The method for providing the report will be determined during implementation. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements. (See Attachment K: Reports, for due dates.)

i. Weekly membership reports that include, but are not limited to, the following information:

1) Group Number.
2) All internal and external member Identification numbers.
3) Subscriber number.
4) Coverage effective date.

5) Coverage expiration date.
6) Current benefit effective date.
7) Current benefit expiration date.
8) Member First Name.
9) Member Last Name.
10) Member SSN.
11) Member date of birth.
12) Member tier.
13) Member benefit identifier code(s).
14) Member date of birth.
15) Medicare primary flag.
16) Medicare Coverage.
    a) Medicare A.
    b) Medicare B.
17) Medicare effective date.
18) Medicare expiration date.

ii. Monthly Member reporting package based on enrollment the last day of the previous month that includes each of the following:

1) Enrollment by Plan Design, Entity, Group, Tier and Medicare Status.
2) In-state Member counts by county broken down by Plan Design and then totaled.
3) Out-of-state Member counts by state or country broken down by Plan Design then totaled.
4) Enrollment by Group number broken down by Subscriber and Dependent then totaled.
5) Graphs (Pie Charts) that include.
    a) All Members by Plan Design.
        - In-state Members by Plan Design.
        - Out-of-state Member by Plan Design.
    b) All Members by Coverage Tier.
    c) Top 10 Counties.

iii. Monthly PCP Election report that includes, but is not limited to:

1) Total number of Members that have elected a PCP broken down by Plan Design.
2) Statistics about the Members who see the PCP on their card and those that see other PCPs.
3) Types of PCP elected (i.e. General practice, pediatrician, family medicine, etc.).
4) List of elected providers and number of Members who have elected them as their PCP.

iv. Describe any limitations and/or issues with meeting requirements a.i.-iii. above.

5.2.16.4 Banking and Finance Reports

a. The Plan requires a Vendor that can provide banking and finance reports that satisfy the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Monthly accounts receivable aging report that includes, but is not limited to:

1) The amount of premiums due, but not received.
2) The amount of any unapplied premiums.
3) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days and over 120 days.
4) Supporting documentation from which these amounts are derived.

ii. Quarterly report of any uncollectible accounts (including premiums or recoveries)

1) Recommended for debt write-off which includes, but is not limited to:

a) Account name.
b) Subscriber number, if applicable.
c) Description/justification of the reason for write-off.
d) The provider code, if applicable.
e) Dollar amount and date originally paid, if applicable.
f) Payee status.
g) Identifying number (e.g. invoice, claim, case).
h) Total amount proposed for write-off.

2) Recommended for exhausted debt (debt the Vendor should stop tracking and pursuing when agreed upon recovery process has been completed) which includes, but is not limited to:

a) Account name.
b) Subscriber number, if applicable.
c) Description/justification of the reason for exhausted debt.
d) The provider code, if applicable.
e) Dollar amount and date originally paid, if applicable.
f) Payee status.
g) Identifying number (e.g. invoice, claim, case).
h) Total amount proposed for exhausted debt.

iii. Monthly prepaid premiums report which includes, but is not limited to:

1) Employing Unit group number.
2) Employing Unit group name.
3) Date payment received as well as payment due date.
4) Amount paid and amount due.
5) Monthly totals for all groups/Members.
6) Upon request, ability to produce Member level detail.

iv. Daily deposited premiums and other receipts reporting package, reported separately by Product type, e.g., PPO, HSA, HRA, etc., including:

1) Summary report, which includes, but is not limited to:

a) Date of deposit.
b) Total amount received by check.
c) Total amount received by ACH.
d) Distinct identification of which amounts relate to premiums and which amounts relate to other types of deposits.
e) Descriptive labeling of other deposits.
f) Grand total of the daily deposits.

2) Any documentation from the banking institution of the deposited amounts posted daily, e.g., bank deposit slips, electronic deposit report, lockbox report, etc.

3) Daily deposit supporting documentation report, which includes, but is not limited to:

a) Employing Unit group number.
b) Employing Unit group name.
c) Type of deposit, i.e. checks, ACH, and/or wire.
d) Amount of deposit for each group and a grand total per deposit type.
e) Upon request, ability to produce Member level detail.

f) Any other reports or information to support other types of deposits, e.g. recoveries, claims refund, etc.

v. Daily NSF report listing all for the previous month which includes:

1) Group number, if applicable.
2) Subscriber number, if applicable.
3) Date returned.
4) Dollar amount.

vi. Monthly misapplied deposits and/or collections report (e.g. applied premium deposit to wrong group or wrong client) which includes date originally deposited and how they were corrected.

vii. Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:

1) Number of checks processed weekly.
2) Number of EFTs processed weekly.
3) Payments amount(s) by type e.g. claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.
4) Weekly total by type.
5) Month to date total by type.
6) 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.

viii. Monthly deposit reconciliation which includes, but is not limited to:

1) Date of each daily deposit.
2) Total amount of deposit for each day.
3) Breakdown of amount by type of deposit, i.e. checks, wires, ACH (drafts).
4) Monthly total of each type.

ix. Monthly reconciliation of claims and other disbursements which includes, but is not limited to:

1) Daily transactions listed individually with a daily total as well as a summary total.
2) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds and other disbursements.

x. As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:

1) Final due date to escheat the warrants/checks.
2) Name of state and dormancy period for each state.
3) Number of warrants for each state and dollar amount.
4) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all product types. Explanation of any special circumstances or issues.

xi. 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.

xii. Monthly Statement of Account (SOA) which includes all charges including claims, administrative fees, and all premiums paid. It is a full picture of all income/expenses for the month.

xiii. Vendor shall describe any limitations and/or issues meeting requirements a.i. - xii., above.

5.2.16.5 Financial Performance Reports

a. The Plan requires a Vendor that will provide financial performance reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Performance Guarantees (PG), as outlined in Section 6.3.4, reports as follows:

1) Monthly PG status report.
2) Quarterly PG report cards.
3) Annual PG report cards that include summary data and year end PG results.

ii. Monthly Performance Matrix reports as outlined in Exhibit 19, Matrix Reports, and listed below:

1) Reports 1 and 2: Charge Summary Paid and Incurred Reports.
2) Reports 3 and 4: Charge Summary Trend Paid and Incurred.
3) Reports 5 and 6: Coinsurance & Deductible, Full Population-Paid and Incurred.
4) Reports 7and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.
5) Reports 9 and 10: Copay-Incurred and Paid.
6) Report 11: Copay-Incurred (Claims Run out).
7) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
8) Reports 14 and15: Financial Summary-Paid and Incurred.
9) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.
10) Report 18: Premium Billing.
11) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

iii. Monthly Triangulations reports with the following stratifications:

1) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.
2) Plan design and/or product, including a summary based on total membership.

iv. Monthly prompt payment interest claims report that include, but are not limited to:

1) Prompt pay for adjusted claims.
2) Prompt pay for new claims.
3) Claim count.
4) Total interest paid.

v. Weekly group premiums arrears reports that indicates the "paid through date" or "hold" date for any Group that is delinquent.

vi. Weekly or on-demand premium payment report that provides payment detail for each Group.

vii. Vendor shall describe any limitations and/or issues meeting requirements a.i. - vi., above.

5.2.16.6 Claims Reports

a. The Plan requires a Vendor that can provide claims reports that meet the Plan's needs.
The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Monthly Processed claims reports that include, but are not limited to:

1) Claims type.
2) Total claims billed.
3) Total claims paid.

ii. Monthly Deductible and Out-of-Pocket reports, by plan design, by month.

iii. Monthly COB reports that identify savings associated with both Medicare and Commercial COB.

iv. Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:

1) Denial reason.
2) Number of claims for each denial reason.
3) Total charges for each denial reason.

v. 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):

1) Member ID.
2) Plan ID.
3) Member age.
4) Diagnosis.
5) Service start date.
6) Encounter service type.
7) Place of service.
8) Provider specialty description.
9) Paid amount.

vi. Monthly medical and pharmacy appeals reports that include, but are not limited to:

1) Number of first level appeals received.
2) Number of first level appeals approved.
3) Number of first level appeals denied.
4) Number of second level appeals received.
5) Number of second level appeals approved.
6) Number of second level appeals denied.
7) Statistics on types of appeals received, approved and denied at both first and second level.

vii. A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:

1) Member ID.
2) Member First Name.
3) Member Last Name.
4) Type of Appeal Review Decision.
5) Type of Appeal Category.
6) Date Appeal Initiated.
7) Final Written Date.
8) Appeal Decision Description.
9) Medication Name, Strength and Dosage.

viii. A monthly pharmacy appeals **resolved detail** report that includes, but is not limited to, the following:

1) Member ID.
2) Member First Name.
3) Member Last Name.
4) Type of Appeal Review Decision.

5) Type of Appeal Category.
6) Final Written Date.
7) Appeal Decision Description.
8) Medication Name, Strength and Dosage.
9) Method Appeal Received.
10) Appeal Origin.
11) Drug Class.

ix. Vendor shall describe any limitations and/or issues with meeting requirements a.i. - viii. above.

5.2.16.7 Network Management Reports

a. The Plan requires a Vendor that can provide network management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.

ii. Vendor shall describe any limitations and/or issues with meeting requirements a.i., above.

5.2.16.8 Medical / Utilization / Outcomes Reports

a. The Plan requires a Vendor that can provide medical management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following Medical Management reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. 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.

ii. Quarterly Case Management Clinical Outcomes.

iii. Quarterly Preventive Care Service Utilization.

iv. Vendor shall describe any limitations and/or issues with meeting requirements a.i. – iii., above.

b. The Plan requires a Vendor that can provide Utilization Management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following Utilization Management reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. 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.

ii. Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.

iii. Vendor shall describe any limitations and/or issues with meeting requirements b.i. – ii., above.

c. The Plan requires a Vendor that can provide Opportunities and Outcomes reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following Opportunities and Outcomes reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements.

i. Quarterly Clinical Quality Improvement: Opportunities and recommendations to improve clinical quality.

ii. Annual Medical Policy Revisions: Result of reviews, changes, and/or proposed changes to medical policies coverage for new technologies and/or services.

iii. Vendor shall describe any limitations and/or issues with meeting requirements c.i. – ii., above.

5.2.16.9 Pharmacy Management Reports

a. The Plan requires a Vendor that can provide pharmacy management reports that meet the Plan's needs.

The Vendor shall confirm that it will provide each of the following reports:

i. A quarterly utilization report detailing specialty pharmacy Rebates**.**

ii. A quarterly medical specialty pharmacy utilization report by specialty drug broken into the following subcategories:

1) Active Employees.
2) Non-Medicare Members in the Direct Bill and Retirement Groups.
3) Medicare Members in the Direct Bill and Retirement Groups.

iii. The Vendor shall describe any limitations and/or issues with meeting requirements a.i.- ii., above.

5.2.16.10 Customer Experience Reports

The Plan requires a Vendor that can provide a Weekly Operations Dashboard by the end of the day each Thursday and include records received and/or processed Sunday through Saturday of the previous week.

The Vendor shall confirm that it will provide:

i. The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:

1) Total Member calls received.
2) Weekly ASA rate for Member calls.
3) Weekly first contact resolution rate.
4) Weekly second contact resolution rate.
5) Weekly inquiry on time completion rate.
6) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.
7) TAT for completing manual enrollment updates.
8) TAT for the production of monthly premium invoices.
9) Number and percentage of clean claims processed ≤ 30 days.
10) Number and percentage of claims processed > 30 days.
11) Number and percentage of claims processed > 60 days.
12) Number and percentage of claims processed > 90 days.

ii. A Monthly Web Trends Report that provides stats on Plan Members transaction history on Vendor's web pages and web tools.

iii. Vendor shall describe any limitations and/or issues with meeting requirements a.i.- ii., above.

5.2.16.11 Recovery and Special Investigation Reports

a. The Plan requires a Vendor that can provide recovery and special investigations reports that meet the Plan's needs.

The Vendor shall confirm that it will provide:

i. Book of business data.

ii. Monthly recovery reporting package that includes, but it not limited to the following:

1) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).
2) Total requested or saved, by recovery type and recovery subcontractor.
3) 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.)
4) Total by subcontractor, including Plan recovery Vendors.
5) Quarter and year to date results.
6) Trends.
7) If available, benchmark data.

iii. Monthly Plan specific investigation reports that include, but are not limited to, the following data:

1) Name of provider.
2) Number of members impacted.
3) Date case opened.
4) Basis for review.
5) Summary of case.
6) Status of the case.
7) Total projected Plan claims dollars associated with the case.
8) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.

iv. A quarterly medical audit repayment report that includes, but is not limited to, the following data:

1) Date of Service.
2) Member Name.
3) Subscriber Number.
4) Claim Number.
5) Original Paid Amount.
6) Appropriate Paid Amount.
7) Overpayment Amount.
8) Amount Repaid to the Plan.
9) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.
10) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

v. Vendor shall describe any limitations and/or issues with meeting requirements a.i.- iv., above.

5.2.17 Meeting Requirements

a. The Plan requires a Vendor that has the resources and availability to establish standard ongoing meetings with the Plan as well as to be available to meet with the Plan, as requested. Some meetings will be on site and others will be held telephonically. The standard meeting schedule will be developed during implementation and may be modified from time to time, as requested by the Plan.

The Vendor shall confirm and describe each of the following:

i. Vendor will establish routine, ongoing meetings with the Plan and provide the appropriate subject matter experts and decision makers to facilitate the meetings. These meetings may be held at the Plan's offices or held telephonically.

ii. Vendor will meet with the Plan on an as needed basis to discuss issues, initiatives, or other items, as requested by the Plan.

iii. Vendor will attend public meetings of the Plan's Board of Trustees.

iv. Vendor shall describe any limitations or issues with meeting requirements a.i. - iii. above.

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.

The 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. A Microsoft Excel version of Attachment A may be obtained by sending a request to: Sharon.smith@nctreasurer.com with a copy to shpcontracting@nctreasurer.com.

6.0 CONTRACT ADMINISTRATION

By submitting a proposal, the 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 the Vendor shall be submitted in writing to the State's Contract Administrator for resolution. A claim by the State shall be submitted in writing to the 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 thirty (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) The 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 6.3.3. 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). 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 thirty (30) days of the request. Credit memo or invoice adjustment is prohibited.

c) Failure of the Vendor to accept reductions in fees according to the schedules in Section 6.3.3 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 the 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) The Vendor shall provide a written explanation to the Plan no later than thirty (30) calendar days prior to the due date of any deliverable if a delay is anticipated. This notice shall not relieve the 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 the 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 the 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) EDI delivery and receipt schedules will be developed during the implementation. Any Performance Guarantee related to the delivery or receipt of an EDI file will be based on the schedule developed during implementation and documented in the Implementation Plan. The ongoing EDI schedule will become a separate table that will be incorporated into this Contract.

d) Group Premium Invoicing schedule will be reviewed monthly. The schedule may change each month to align with Group payroll dates. Timely production of invoices includes availability and presentment to Groups online.

e) First Contact Resolution (FCR) is the number of interactions with Plan Members and HBRs resolved during the initial contact divided by the total number of interactions handled in the period. If Vendor must follow up with the inquirer, First Contact Resolution was not achieved. This is a cumulative, quarterly measure. For example, if there are 700 Member interactions (500 calls, 100 emails, 100 instant messages) and 300 HBR interactions (150 calls, 150 emails) there are a total of 1000 interactions to be counted towards FCR. If only 850 of the above interactions are resolved on initial contact, the FCR score would be 85%.

f) Second Contact Resolution is the same formula as above using only what was not resolved on first contact. This is a cumulative, quarterly measure. Continuing with the example above, from the remaining 150 interactions, if only 100 are resolved with the follow up contact the SCR score would be 67%. Specific details on interactions not resolved on second contact must be shared with the Plan for tracking through completion.

g) Inquiry On Time Completion is the number of inquiries responded to timely divided by the number of inquiries responded to. Completion dates must be communicated to the inquirer when responding to an inquiry that cannot be resolved on first contact. When no completion date is communicated, a one State business day target should be assumed for Members and two State business day target should be assumed for all others.

h) Attachment K. 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 throughput is measured as the number of successful automatic transactions divided by the number of the total number of transactions eligible for automation. For daily EES files eligible transactions will be all that passed upfront system edits. These edits will be reviewed and documented during implementation and any future changes will be introduced with an ADM.

b) Manual entry accuracy is reviewed at the family level and calculated at the Member level. There should be one point assigned at the Member level. If any field on the record is inaccurately entered, the score for that Member is zero. For example, the statistically valid sample size is 10% and 100 items were keyed manually. Ten policies are pulled for audit. Two (2) contain policies for families of four (4) and eight (8) are for individual policies. Total points available for this audit are sixteen (16) points. Upon audit, it is determined that an address was misspelled on one (1) policy and two (2) COB records were inaccurately updated on one family. Thirteen (13) out of sixteen (16) enrollments were completed accurately; therefore, the accuracy score is 81%. If additional inaccurate updates are identified (by the Group, Member, Plan, vendors, etc.), the additional error and transaction should be included in that month's accuracy score. The statistically valid sample size will be determined by the Plan and the audit will be conducted by the Vendor. The accuracy results will be reported monthly.

c) Invoice accuracy measures the accuracy of each Group's invoice. The information presented on each Group's monthly invoice should reflect all payments, premium adjustments, interest due, and enrollment changes accurately. If any inaccuracy is identified on an invoice, the entire invoice is considered incorrect. All invoices should be audited each month. For example, if 450 groups are invoiced and there is a system issue that causes 15 invoices to show an incorrect amount for Subscribers, then only 435 invoices were accurate. This would equate to a 97% accuracy score. If additional inaccurate updates are identified (by the Group, Member, Plan, vendors, etc.), the additional error and invoice should be included in that month's accuracy score.

d) Inquiry Accuracy measures the accuracy of the resolution provided to the inquirer. If any part of the information provided to the inquirer about Plan rules, benefits, or claims is inaccurate, the interaction is inaccurate. During implementation, the Plan shall document the audit process and outline expectations for the Vendor to provide requested interactions. The Vendor's telephonic accuracy audit results will be utilized to measure this Performance Guarantee. If additional inaccurate interactions are identified (by the Group, Member, Plan, vendors, etc.), the additional error and interaction should be included in that month's accuracy score.

e) 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.

f) 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.

g) Processing Accuracy (Claims): The number of claims processed with no procedural errors divided by the total number of claims processed.

h) The Deposit Error Rate will 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 premium receipt information as well as any other types of deposits are accurate in relation to the detail report. (See Section 5.2.3.)
   ii. Plan deposits are made to the wrong account and/or receipts belonging to other entities are incorrectly deposited to the Plan's account.

i) The Disbursements error rate will 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 5.2.3.)
   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.

j) 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. Plan Vendor Phone Numbers.

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

k) Benefit changes accuracy requires that the benefits administered by the Vendor are configured correctly with any new benefits and/or cost-shares requested by the Plan.

6.3.5 Summary of Performances Guarantees and Instructions for Completing Schedule II. Third Party Administration Performance Guarantees

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. The Performance Guarantees around implementation of services have been set by the Plan in Schedule I. However, for quarterly Performance Guarantees, Vendor shall populate Schedule II. with the amounts Vendor agrees to place at risk. Limitations on those amounts are described in the paragraph below.

The minimum amount that Vendor can place at risk for Performance Guarantees measured on a quarterly basis is fifteen percent (15%) of quarterly administrative fees paid by the Plan; however, Vendor may choose to risk more than fifteen (15%). The percentage (%) of fees Vendor is placing at risk is to be allocated among the various Performance Guarantees.

Each Performance Guarantee must have an allocation of at least one quarter percent (0.25%) of the total at risk fees unless otherwise indicated. The Plan has established greater minimums for certain Performance Guarantees; those minimum risk requirements are identified in the far right column of the chart. Vendor is instructed to allocate the amount at risk among the Performance Guarantees keeping in mind that a minimum of one quarter percent (0.25%) must be placed at risk for any one Performance Guarantee unless a different minimum is indicated. If Vendor is willing to risk more than fifteen percent (15%) of fees required, then the total for the various allocations will add up to the amount being placed at risk.

Continues on next page.

6.3.6 Schedules of Performance Guarantees

Schedule 1. Implementation Performance Guarantees *All performance targets and results are Plan, not book of business, specific.*		
Measure	**Implementation**	**Fee Reduction/ Monetary Risk**
Insurance	Proof of insurance required in Attachment C: 14. "Insurance" to be provided to the Plan within fifteen (15) calendar days of execution of Contract.	Vendor shall pay $10,000 for each day the proof of insurance is late.
Performance Bond	Proof of purchase of bond to be provided to the Plan within thirty (30) State Business Days of execution of Contract.	Vendor shall pay $10,000 for each day the proof of purchase of bond is late.
Timeliness	Initial enrollment Data File from Plan's EES vendor is processed in Vendor's system by 5:00 p.m. EST by the second State Business day after receipt. The target delivery date of the Enrollment Data File will be determined during implementation and documented in the Implementation Plan.	Vendor shall pay $10,000 for each day the file is not processed in Vendor's system beyond the target date.
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 for each day beyond the target date.
Timeliness	Depository bank accounts are set-up, tested, and operational at least forty-five (45) days prior to January 1, 2022.	Vendor shall pay $5,000 for each day beyond the target date.
Timeliness	If applicable, disbursing bank accounts are setup, tested, and operational at least thirty (30) days prior to January 1, 2022.	Vendor shall pay $5,000 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.
Timeliness	The Plan's custom network, the North Carolina State Health Plan Network, is tested and loaded in Vendor's system(s) by October 1, 2021 to facilitate Members' ability to search for providers via the Vendor's provider search tool.	Vendor shall pay 1-15 days late: $10,000 per day; 15+ days late: $20,000 per day.
Timeliness	All provider rates and reimbursement methodologies are loaded and tested in Vendor's system(s) by January 1, 2022 and Vendor is able to begin processing all Plan claims using these rates and methodologies on January 3, 2022.	Vendor shall pay 1-15 days late: $10,000 per day; 15+ days late: $20,000 per day.
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 per day; 15+ days late: $20,000 per day.

Schedule II. Third Party Administration Services Performance Guarantees				
Measure	**EDI & Enrollment Maintenance**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	All enrollment data files received from Plan's EES vendor processed ≤ 24 hours of receipt	98%		**0.25%**
Timeliness	Complete any manual enrollment update for Plan Members ≤ five (5) State Business Days of notification	99%		**0.5%**
Timeliness	Plan's outbound files sent daily, as scheduled	98%		**0.25%**
Accuracy	EDI Throughput	95%		**0.25%**
Accuracy	Manual entry accuracy rate	98%		**0.5%**
Measure	**Group Premium Billing**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	Produce Group Premium Invoices within one (1) State Business Day of approved billing schedule	98%		**0.25%**
Accuracy	Invoice accuracy	99%		**0.25%**
Measure	**Customer Experience**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	First Contact Resolution ≥ 85%	100%		**0.25%**
Timeliness	Second Contact resolution ≥ 95%	100%		**0.25%**
Timeliness	Inquiry On-Time completion ≥ 98%	100%		**0.5%**
Accuracy	Inquiry Accuracy	98%		**1.0%**
Accuracy	Claims Financial Accuracy Rate	99%		**0.5%**
Accuracy	Claims Payment Accuracy Rate	99%		**0.5%**
Accuracy	Process Accuracy Rate	99%		**0.5%**
Measure	**Pharmacy Benefit**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	Specialty pharmacy rebates made out to the Vendor are to be delivered to the Plan no later than ten (10) State Business Days after Vendor received payment from drug manufacturer.	100%		**0.25%**

Performance Guarantees ***All performance targets and results are Plan, not book of business, specific***				
Measure	**Financial Performance Reporting**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	Deliver Fiscal Year End Matrix reports by the July 15th each year	100%		**0.25%**
Timeliness	Deliver Fiscal Year End Triangulation reports by July 15th each year	100%		**0.25%**
Measure	**Banking and Finance**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	Group premium and other receipts deposited within twenty-four (24) hours of receipt	98%		**0.25%**
Timeliness	Daily reporting package of deposits (See Section 5.2.3) provided to the Plan on schedule	98%		**0.25%**
Timeliness	Weekly disbursement released only upon Plan approval	100%		**1%**
Accuracy	Daily deposit error rate	≤ 2%		**0.5%**
Accuracy	Weekly disbursements error rate	≤ 2%		**0.5%**
Total At Risk (To Be Completed by Vendor)				
Measure	**Open Enrollment**	**Target**	**Risk**	**Minimum Risk Required**
Timeliness	ID Cards are issued not more than two State Business Days from the mutually agreed upon dates of Open Enrollment project plan	100%	**N/A**	Vendor shall pay $5,000 for each day beyond the target date.
Accuracy	ID card accuracy is 100% accurate	100%	**N/A**	Vendor shall pay $2,500.00.
Accuracy	Accurate configuration of new plan benefits	100%	**N/A**	Vendor shall pay $5,000 for each day beyond the target date.
TOTAL				

ATTACHMENT A: PRICING

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 the 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.

If all Minimum Requirements are met, the Plan will provide the Vendor's designated recipient the cost proposal worksheets. The Plan will also notify its Actuarial/Analytical and Health Benefits Consulting vendor, Segal of NDA receipt. Segal will issue, to the Vendor's designated recipient, a link to a secure workspace, established separately for each qualified Vendor, within Segal's Secure File Transfer system. The designated recipient may access the secure site and download the data files that will be used for the repricing exercise and other requirements within the cost proposal. Segal will not release any data files to any Vendor without a signed NDA.

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

Gina Sander, FMLI
GSander@SegalCo.com
678-306-3158

1.1 Network Access

The Plan is looking 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 competitive pricing. Vendors are encouraged to include an additional option for a narrow, high-quality provider network. This section will address access to the proposed network of health care 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. Vendor must submit separate reporting for each network proposed. Access must be reported by county.

The 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:

Continues on next page.

Provider Type	Urban and Out-of-State	Suburban	Rural
Facilities			
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*
Professional Services			
Primary Care			
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*
Specialists			
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:

The 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 January 1, 2020, and may also include providers that have executed a legally-binding letter of intent or letter of agreement with the Vendor.
- The 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.

The Vendor must submit the summary grids, included in **Attachment A-2**, for each 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 the Vendor.

1.2 Network Pricing

The Plan is looking 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 Repricing File

A repricing file, containing participant claims experience for calendar year 2019, 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 the 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.

Six fields must be populated:

- NetStatus1 (representing the Vendor's broad network) and NetStatus2 (representing the Vendor's narrow network, if applicable) – Y / L / N
  - Y – Currently under contract
  - L – Letter of intent
  - N – Not under contract or Out-Of-Network provider
- ContAmt1 and ContAmt2 – contract amount (Allowed Amount) for each network
- ContType1 and ContType2 (contract type, representing each network) – (A, B, C, F, D, 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 each provider network being offered by the Vendor, including narrow network alternatives.

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 each network proposed:

- **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 the Vendor's proposal to be rejected. Attachments A4 and A5 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 the Vendor's proposal to be rejected.

1.3 Administrative Fees

The Vendor must provide the monthly administrative fee per subscriber for each of the five (5) years in the contract period. Fees must be provided on separate tabs for both the traditional approach and the custom network. 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 per member per month (PMPM) pricing for some additional, optional services, in case the Plan wants the TPA to perform those services.

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

Tables A-7.1 through A-7.3 must include all costs except actual claim payments for covered Members. Unspecified administrative fees will not be paid by the Plan.

1.4 Network Pricing Guarantees

The 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 the 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.

1.5 Self-Insured Projection

This section allows the Vendor to estimate the expected claim and administrative cost for the proposed provider network(s). Based on the claims experience provided in the repricing file, the Vendor is asked to estimate the expected future costs under its medical management and pricing arrangements with providers. It is expected that the Vendor will map the repricing data to the proposed network. This is to be the 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 inputs required of the Vendors:

- **Utilization Adjustment:** If the Vendor feels that its medical management will alter current utilization, the 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 the 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 the Vendor believes to be its per-service cost in the proposed network.

This section provides an opportunity for the Vendor to demonstrate the strength of its network. A separate **Attachment A-9** must be populated for each proposed network.

1.6 Data Certification

There is a required certification (**Attachment A-10**) of all information submitted, including data, guarantees, pricing worksheets, etc. The Vendor's actuary should sign the certification, but signature by either the Vendor's CFO or CEO will also be accepted. Appropriate language can be provided by the 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
- Attachment A-3: Repricing Layout
- Attachment A-4: Repricing Summary – Service Category
- Attachment A-5: Repricing Summary – By Provider
- Attachment A-6: Contract Improvements
- Attachment A-7: Administrative Services Fees
- Attachment A-8: Network Pricing Guarantees
- Attachment A-9: Self Insured Financial Projection
- Attachment A-10: Actuarial Certification

ATTACHMENT A: PRICING

Attachments A-1. through A-10. comprise Attachment A: Pricing, the Cost Proposal.

ATTACHMENT B: INSTRUCTIONS TO VENDORS

1. **READ, REVIEW AND COMPLY:** It shall be the 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.

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 the 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 the 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 page 1 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 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. The 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 the Vendor is directed or managed.

13. **INELIGIBLE VENDORS:** As provided in G.S. 147-86.59 and 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 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 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 the 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 the 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 G.S. 132-1.2. Any material labeled as confidential constitutes a representation by the Vendor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under 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, the 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 thirty (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 ten (10) calendar days from the date of receipt of the request, respond in writing to the 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 thirty (30) calendar days after receipt of the letter, or as soon as possible thereafter. Within ten (10) calendar days from the date of the protest meeting, the Executive Administrator will respond to the 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. **MISCELLANEOUS:** 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.

17. **COMMUNICATIONS BY VENDORS:** In submitting its proposal, the 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 the 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.

18. **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. 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.

19. **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 for goods and Services of potential interests to them 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.

20. **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 the Vendor's letterhead and signed by an official of the 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.

21. **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 issued through IPS.

22. **COST FOR PROPOSAL PREPARATION:** Any costs incurred by Vendor in preparing or submitting offers are the Vendor's sole responsibility; the State of North Carolina will not reimburse any Vendor for any costs incurred prior to award.

23. **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

1. **PERFORMANCE AND DEFAULT:** 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 the Vendor and specifying the effective date thereof. In that event, any or all finished or unfinished deliverable items under the Contract prepared by the Vendor shall, at the option of the State, become its property, and the 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 the 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.

   In the event of default by the Vendor, the State may procure the goods and Services necessary to complete performance hereunder from other sources and hold the Vendor responsible for any excess cost occasioned thereby. In addition, in the event of default by the Vendor under the Contract, or upon the Vendor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against the Vendor, the State may immediately cease doing business with the Vendor, immediately terminate the Contract for cause, and may take action to debar the Vendor from doing future business with the State.

a) 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 the Vendor requiring a separate maintenance or support agreement unless otherwise specifically agreed in writing. User access to the Services shall be routinely provided by the 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, the Vendor agrees to provide the Services at least in the manner that it provides accessibility to the services to comparable users.

b) 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 the 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 the 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.

c) 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 the Vendor. Any training specified herein will be provided by the Vendor to specified State users for the fees or costs as set forth herein or in an SLA.

d) 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.

e) 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.

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 the 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 the 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 the Vendor or its affiliates meet one of the conditions of 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 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 the Vendor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the proposal document the 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 the 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 the Vendor under the Contract. Payment by some agencies may be made by procurement card, if the 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 the Vendor. If payment is made by procurement card, then payment may be processed immediately by the Vendor.

7. **NON-DISCRIMINATION:** The 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, the 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, the 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 the 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. The 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 the Vendor, their use or operation, infringes on a patent, copyright, trademark or violates a trade secret in the United States. The 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 the Vendor shall be notified within a reasonable time in writing by the State of any such claim; and,
      ii. That the 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.

   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 the Vendor. In that event, any or all finished or unfinished deliverable items prepared by the 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 the Vendor's obligations nor the 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 the Vendor, the State may:

a) Forward the Vendor's payment check directly to any person or entity designated by the Vendor, and

b) Include any person or entity designated by Vendor as a joint payee on the Vendor's payment check.

In no event shall such approval and action obligate the State to anyone other than the Vendor and the 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 the Vendor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of the Contract.

14. INSURANCE:

COVERAGE - During the term of the Contract, the 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, the Vendor shall provide and maintain the following coverage and limits:

a) **Worker's Compensation** - The 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, the 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.

b) **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.

c) **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.

REQUIREMENTS - Providing and maintaining adequate insurance coverage is a material obligation of the 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. The 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 the Vendor shall not be interpreted as limiting the Vendor's liability and obligations under the Contract.

15. GENERAL INDEMNITY: The 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 the Vendor in the performance of the Contract and that are attributable to the negligence or intentionally tortious acts of the Vendor provided that the Vendor is notified in writing within 30 days that the State has knowledge of such claims. The 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. The representation and warranty in the preceding sentence shall survive the termination or expiration of the Contract.

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. The 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 the 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 the 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 the 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: Any State information, data, instruments, documents, studies or reports given to or prepared or assembled by or provided to the 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: The Vendor agrees that it shall be responsible for the proper custody and care of any data owned and furnished to the Vendor by the State (State Data), or other State property in the hands of the 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 the 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. The Vendor shall notify the State of any security breaches within 24 hours as required by G.S. 143B.1379. See 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, the 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 the Vendor, employees of the Vendor, subcontractors of the 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 the 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 the 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, not affecting the technical requirements & specifications may be developed or modified in writing and signed by the Vendor's Contract Administrator for day to day activities or other individual authorized to bind the 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**: The Vendor shall provide contract performance security based upon ten percent (10%) of the estimated contract total based on the 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 thirty (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

The 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 this Contract. The State will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Please complete items a, b, and c below.

a) Will any work under this Contract be performed outside the United States? ☐ YES ☐ NO

If the Vendor answered "YES" above, Vendor must complete items 1 and 2 below:

1. List the location(s) outside the United States where work under this Contract will be performed by the Vendor, any sub-Contractors, employees, or other persons performing work under the Contract:

2. Describe the corporate structure and location of corporate employees and activities of the Vendor, its affiliates or any other sub-Contractors that will perform work outside the U.S.:

b) The Vendor agrees to provide notice, in writing to the State, of the relocation of the Vendor, employees of the Vendor, sub-Contractors of the Vendor, or other persons performing services under the Contract outside of the United States ☐ YES ☐ NO

NOTE: All Vendor or sub-Contractor 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.

c) Identify all U.S. locations at which performance will occur:

ATTACHMENT E: CERTIFICATION OF FINANCIAL CONDITION

Name of Vendor: _____

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

☐ The 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: _____

☐ The Vendor has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.

☐ The Vendor is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.

☐ The Vendor is not the subject of any current litigation or findings of noncompliance under federal or state law.

☐ The 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 the Vendor.

Note: This is a continuing certification and Vendor shall notify the Contract Administrator within 15 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 in the space below:

_____

Signature Date

_____

Printed Name Title

[This Certification must be signed by an individual authorized to speak for the 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) of the 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, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled. This includes utilizing subcontractors to perform the required functions in this RFP. Any questions concerning NC HUB certification, contact the **North Carolina Office of Historically Underutilized Businesses** at (919) 807-2330. The Vendor shall respond to question #1 and #2 below.

a) Is Vendor a Historically Underutilized Business? ☐ **Yes** ☐ **No**

b) Is Vendor Certified with North Carolina as a Historically Underutilized Business? ☐ **Yes** ☐ **No**

If so, state HUB classification: _____

ATTACHMENT G: BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("BAA") is entered into between the North Carolina State Health Plan for Teachers and State Employees ("the Plan"), a division and covered healthcare component of the Department of State Treasurer ("DST"), and [INSERT NAME OF ENTITY] (hereinafter the "Contractor"), referred to as "Party" or collectively as "Parties." This BAA is effective when signed by the parties, and shall remain in effect for so long as the relationship between the Parties necessitates the use or disclosure of Protected Health Information (PHI).

BACKGROUND

The Department of State Treasurer includes as a division the North Carolina State Health Plan for Teachers and State Employees. The Plan is a health benefit plan which, standing alone, would be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DST - which includes several divisions that do not qualify as covered entities and whose functions are not regulated by HIPAA - 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 within the meaning of the HIPAA Privacy and Security Rules.

The purpose of this BAA between Contractor and the Plan is to protect the Plan Member information in accordance with the HIPAA Privacy and Security Rules. The parties enter into this BAA with the intent to comply with HIPAA provisions that allow for 1) a covered healthcare component of a hybrid entity (the Plan) to disclose PHI to a business associate and 2) a business associate (Contractor) to create, maintain, transmit, or receive PHI on behalf of the Plan once 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 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 a contract through which Contractor will provide certain services and/or products to the Plan. Pursuant to such arrangement, Contractor may be considered a "business associate" of the Plan as defined by HIPAA in that Contractor may have access to Protected Health Information in fulfilling its responsibilities.

The Parties agree as follows:

I. GENERAL TERMS AND CONDITIONS

A. **Definitions:** Except as otherwise defined herein, any and all capitalized terms in this Section 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 their business associates under 45 C.F.R. §160.402(c).

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 this BAA and 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 terminate this BAA and the Contract; or

2. May immediately terminate this BAA and 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 Protected Health Information that is created, maintained, transmitted or received by the Plan, and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by the Plan or its operating units to Contractor, or PHI which, on behalf of the Plan, is created, maintained, transmitted or received by Contractor or a Subcontractor, shall be subject to this BAA. This obligation to protect the 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 Protected Health Information 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 Data Use Agreement, 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 Data Use Agreement (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 the HIPAA and North Carolina state law requirements as applicable.

E. Contractor shall implement security policies and procedures and provide the Plan's HIPAA Privacy and Security Officer 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 will have an appropriate BAA, that conforms to applicable law and is consistent with this Agreement, in place with the agent or subcontractor before any PHI is disclosed or made available to the agent or subcontractor.

G. Contractor shall disclose to the Plan a list of any and all agents or subcontractors who have access to or use of PHI on behalf Contractor for the benefit 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

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 shared by Contractor 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. 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 Business Associates policies, procedures, and practices related to the use and disclosure of the Plan's PHI.

III. BREACH NOTIFICATION REQUIREMENTS

A. Upon discovery by Contractor of a suspected or actual breach of unsecured PHI, Contractor must notify the Plan's HIPAA Privacy and Security Officer ("PSO"), in writing, within ten State 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. See "Attachment A" for PSO contact information.

B. 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 sixty days following the

date the breach of unsecured PHI is discovered by Contractor, or such later date as is authorized under 45 C.F.R. §164.412, to:

1. 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

2. the media, to the extent required under 45 C.F.R. §164.406.

C. 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 take such action as is required by the Breach Notification Rule.

D. 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.

E. Contractor notices must be reviewed by the Plan's PSO before being sent to State Health Plan Members.

F. Any notices required to be delivered by Contractor shall be at the expense of Contractor; provided that Contractor has: 1) made the determination, in its sole discretion, that notices are required pursuant to this section; and 2) maintained control of the drafting, content, form, and method of distribution of the notices pursuant to this section.

G. 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 copy of the risk assessment or report.

H. 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. Contractor shall submit a formal report to the PSO (at the address listed in the signature block below) as soon as possible, but no later than within ten State Business Days from the time the Breach or Security Incident is discovered or initially reported or learns of such non-permitted use or disclosure. 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 and the date of the discovery of the Breach;

2. A description of the types of unsecured PHI that were 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 who received the non-permitted use or disclosure;

5. A brief description of what Contractor did or is doing to investigate the Breach;

6. A brief description of what Contractor did or will do to mitigate any and all 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 or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address; and

10. In addition to a written report, provide such other information as the Plan may reasonably request.

I. Contractor shall provide to the Plan or an Individual, in the reasonable time and manner requested by the PSO, 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.

J. Contractor shall provide the Plan with an annual report of all suspected or actual breaches of unsecured PHI by Contractor or by any agent or subcontractor of Contractor.

IV. ACCOUNTING FOR DISCLOSURES AND SALE OF PHI

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 EHR and PHI set forth in 42 U.S.C. § 17935(d).

C. 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).

D. 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 ARRA, 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 # 270-20191001TPAS Third Party Liability Recovery Services.

B. Except as otherwise limited in this BAA, Contractor may use PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor.

C. 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 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 person. The person must notify Contractor of any instances it is aware of that the confidentiality of the information has been breached.

D. 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).

E. 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).

F. 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 PSO, or to the Secretary, in a time and manner requested or designated by the Secretary, for purposes of the Secretary determining the Plan's compliance with HIPAA.

G. 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.

H. Contractor shall make reasonable efforts to 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).

I. 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 ("LDS") to the extent practicable or, if needed, to the minimum necessary to accomplish an intended purpose.

J. The Minimum Necessary Standard does not apply to such uses, disclosures, and requests set forth in 45 C.F.R. § 164.502(b)(2).

K. 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 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. RETENTION AND DESTRUCTION OF RECORDS

A. **Retention Period**: Unless otherwise specified in this BAA, Contractor shall retain any and 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).

B. **Return or Destruction of Records**: Upon termination, cancellation, expiration, or other conclusion of the BAA, Contractor shall:

1. Return to the Plan or destroy any and all PHI, in whatever form or medium (including any electronic medium under Contractor's custody or control), that Contractor created or received from the Plan, or created or received while carrying out a function on behalf of the Plan. Such return or destruction shall occur in a reasonable time period, but no later than thirty days after the termination, cancellation, expiration, or other conclusion of the Contract and/or BAA.

   a) Guidelines for Destruction: Contractor and its agents or subcontractors shall destroy PHI in accordance with the recommendations 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: After all PHI has been destroyed, an authorized representative of Contractor with knowledge of the data destruction shall complete and return to the Plan an attestation of destruction supplied by the Plan no later than thirty days after the end of the BAA and/or Contract. Upon completion, Contractor shall return the attestation by email to the Manager of Contracts and Compliance, or designee, and mail the original to the Plan.

2. If return or destruction of such information is not feasible, then Contractor shall extend the protections of this BAA to the information retained, and limit its further use or disclosure of such information to those purposes that make return or destruction of that information infeasible. Contractor shall sign an attestation as to why the information cannot be returned or destroyed, and that the protections of this BAA will be extended to the retained information.

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 requirement 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.

[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

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 and Security Officer

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

ATTACHMENT H: HIPAA QUESTIONNAIRE

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 supply a redacted version of that documentation 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 of 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 HIPAA privacy policies and procedures in place for employees to follow? Yes ☐ No ☐

7. Attach a copy of all 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 HIPAA security policies and procedures in place for employees to follow? Yes ☐ No ☐

11. Attach a copy of all 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 complaint 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

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

1. Upon the Plan's determination that the Vendor has met the Minimum Requirements, the Vendor will be provided access to Plan Data.
2. This Data is being provided for the sole purpose of assisting the Vendor in preparing a responsive and responsible proposal to the TPA Services RFP (RFP # **270-20191001TPAS**) and is for the purpose of Plan Operations.
3. The 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. The Vendor shall not distribute or share the Data with any person or entity not assisting the Vendor in preparing a response to the TPA Services RFP. The 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 the Vendor is held.
5. If the Vendor does not bid on the TPA Services RFP, the Vendor shall, upon making that decision, immediately destroy the Data from Vendor's files or records. The Vendor shall not retain or maintain any copies of the Data.
6. If the Vendor submits a proposal in response to the TPA Services RFP, the Vendor shall immediately destroy the Data from the Vendor's files or records upon notification that an award has been made or the TPA Services RFP has been cancelled.
7. The 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 the Vendor with knowledge of the Data destruction shall complete and return one original of the Plan's Certificate of Data Sanitization within 30 days of the event giving rise to the Vendor's obligation to destroy the Data. The Vendor can obtain a copy of the certificate by e-mailing Sharon Smith at Sharon.Smith@nctreasurer.com with a copy to SHPContracting@nctreasurer.com.
9. Provide the Name and email address of the individual designated to receive Data and Attachment A: PRICING.

   Name:_____

   Email:_____

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

BY: _____
(Person authorized to bind the Vendor)

ATTACHMENT J: MINIMUM REQUIREMENTS SUBMISSION INFORMATION RFP#270-20191001TPAS THIRD PARTY ADMINISTRATIVE SERVICES

Vendor Name:

Street Address:

City, State, Zip Code:

Telephone Number:

AUTHORIZED REPRESENTATIVES TO BIND VENDOR:

List individuals with authority to bind the Vendor in connection with this Contract and future contractual documents.

Name:	Title:	Email:
Name:	Title:	Email:
Name:	Title:	Email:

AUTHORIZED REPRESENTATIVE TO RESPOND TO QUESTIONS:

List individual with the authority to answer questions and provide clarifications concerning the Vendor's proposal.

Name:	Title:	Email:

Signature:

By signing below: You hereby certify that you have the authority to sign on behalf of the 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.

Print name:	Title:
Vendor's authorized signature:	Date:

ATTACHMENT K: REPORTS

Number	Name	Frequency
	Claims Reports	
CLM001	Processed Claims Report	Monthly-20th
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-20th
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-20th
CLM007	Monthly Pharmacy Appeals Detail Report	Monthly-20th
CLM008	Monthly Pharmacy Appeals Resolution Report	Monthly-20th
	Customer Experience Reports	
CUS001	Operations Dashboard	Weekly-Thursday-End of Day
CUS002	Web Trends Report	Monthly-20th
	Finance Reports	
FIN001	Accounts Receivable Aging Report	Monthly-13th
FIN002	Uncollectible Accounts Report	Quarterly-due forty five (45) days after the end of each quarter
FIN003	Prepaid Premiums Report	Monthly-15th
FIN004	Daily Deposit Report	Daily-Receive by 10:00 a.m. ET
FIN005	Not Sufficient Funds Report	Daily-5:00 p.m. ET
FIN006	Misapplied Deposits and/or Collections Report	Monthly-20th
FIN007	Net Disbursement Reporting Package	Weekly-due by 9:30 a.m. ET - 1st State Business day of week
FIN008	Deposit Reconciliation Report	Monthly-5th
FIN009	Reconciliation of Claims and Other Disbursements Report	Monthly-13th
FIN010	Escheats	Annually and as Otherwise Needed- no less than 20 calendar days prior to BCBSNC'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-20th
FIN012	Statement of Account (SOA) by State Fiscal Year Report	Monthly-20th
	Financial Performance Reports	
FP001	Performance Guarantee Report	Monthly-20th
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-20th - Except the fiscal year end report (June) which must be received by July 15th
FP005	Triangulation Report by Service	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
FP006	Prompt Pay Interest Report	Monthly-20th
FP007	Open Invoice Report	Weekly-Thursday-End of Day
Matrix Reports		
MAT001	Charge Summary Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT002	Charge Summary Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT003	Charge Summary Trend Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT004	Charge Summary Trend Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT005	Coinsurance &Deductible, Full Population-Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT006	Coinsurance &Deductible, Full Population-Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT007	Coinsurance & Deductible, Closed Population-Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT008	Coinsurance & Deductible, Closed Population-Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT009	Copay-Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT010	Copay-Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT011	Copay--Incurred (Claims Runout) Report	Monthly-20th - 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-20th - 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-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT014	Financial Summary-Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT015	Financial Summary-Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th

MAT016	Financial Reconciliation-Paid Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT017	Financial Reconciliation-Incurred Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT018	Premium Billing Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
MAT019	Member Utilization and Cost-Share by Type of Service Report	Monthly-20th - Except the fiscal year end report (June) which must be received by July 15th
	Membership Reports	
MEM001	Monthly Member Reporting Package	Monthly-15th
	Operations Reports	
OPS001	Weekly Membership report	Weekly-due by 10:00 a.m. ET - 1st State Business day of week
OPS002	PCP Election Report	Monthly-20th
	Network Management Reports	
NM001	GeoAccess Report	Quarterly-due forty five (45) days after the end of each quarter
	Pharmacy Reports	
PHM001	Specialty Pharmacy Rebates Report	Quarterly-due forty five (45) days after the end of each quarter
PHM002	Medical Specialty Pharmacy Utilization Report	Quarterly-due forty five (45) days after the end of each quarter
	Medical Management Reports	
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
	Recovery and Special Investigation Unit Reports	
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 claims audit report is issued

Exhibit 1

NORTH CAROLINA STATE HEALTH PLAN NETWORK

PARTICIPATION AGREEMENT

THIS NORTH CAROLINA STATE HEALTH PLAN NETWORK PARTICIPATION AGREEMENT (the "Agreement") is between Blue Cross and Blue Shield of North Carolina (herein referred to as "we" "us" and "our"), an independent licensee of the Blue Cross and Blue Shield Association, and the undersigned provider of health services as identified on Page 28 of this Agreement (herein referred to as "you" and "your") (the parties collectively referred to in this Agreement are the "parties").

WHEREAS, the North Carolina State Health Plan for Teachers and State Employees ("State Health Plan") operates for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents; and

WHEREAS, the State Health Plan seeks to facilitate the delivery of quality health care services through transparent pricing thereby driving affordability to Plan Members; and

WHEREAS, we contract directly with the State Health Plan to provide, arrange for, or administer the provision of Covered Services to State Health Plan Members; and

WHEREAS, we contract directly or indirectly with certain health care providers, intermediaries and provider organizations to provide, arrange for, or administer the delivery of such Covered Services to State Health Plan Members; and

WHEREAS, you provide certain specified Covered Services at the sites listed in the Site of Service Exhibit and wish to make those Covered Services available to State Health Plan Members; and

WHEREAS, you have agreed to participate in the North Carolina State Health Plan Network under the terms described in this Agreement; and

WHEREAS, this Agreement is separate and distinct from any agreement between the parties for services provided pursuant to benefit plans other than the State Health Plan, including but not limited to our commercial health plans, the other self-funded health plans that we administer, and the Medicare Advantage Plans that we sponsor, and shall not supersede or replace any such other agreements except to the extent expressly stated herein; and

WHEREAS, each party desires to enter into this Agreement to govern the terms of their relationship solely with respect to State Health Plan Members.

NOW THEREFORE, in consideration of the mutual covenants and agreements set forth herein, the parties agree as follows:

1. GENERAL DEFINITIONS.

The following are general definitions of technical insurance, managed care, or other terms which apply to this Agreement and will be construed consistent with definitions included in the applicable evidence of coverage. Terms not specifically defined in this Agreement may be defined as set forth in our Policies and Procedures, Benefit Plan materials, or other written materials, as applicable.

1.1. "Affiliate" means any of our direct or indirect subsidiaries or the direct or indirect subsidiaries of our ultimate corporate parent company.

1.2. "Application" means the application materials required for submission to Blue Cross and Blue Shield of North Carolina to be considered for credentialing and acceptance for participation in its Provider Network(s), as may be changed from time to time.

1.3. "Blue Cross and Blue Shield of North Carolina," "we," "us," and "our" means, as applicable, any one or more of the following: (i) Blue Cross and Blue Shield of North Carolina; or (ii) any corporate parent, subsidiary, or affiliate of Blue Cross and Blue Shield of North Carolina and/or a joint venturer or other entity contracted with Blue Cross and Blue Shield of North Carolina that has been added to this Agreement by Written Notice to you from Blue Cross and Blue Shield of North Carolina.

1.4. "Blues Plan" means any health insurance company that (a) has been licensed by the Blue Cross Blue Shield Association to use the Blue Cross and/or Blue Shield marks and (b) is not Blue Cross Blue Shield of North Carolina.

1.5. "Benefit Plan" means the particular set of health benefits and services approved by the State Health Plan Board of Trustees in accordance with N.C.G.S. 135-48.22(1) and provided as set forth in an applicable evidence of coverage, that is issued to a State Health Plan Member that describes the terms, conditions, limitations, exclusions, benefits, rights and obligations relating to the State Health Plan Member's health benefits and services, including services made available through our participation in the BlueCard/InterPlan program, BCBS Association National Quality Program, or other program coordinated with Blue Cross and Blue Shield of North Carolina. The evidence of coverage may be issued by the State Health Plan, us, an Affiliate, or other entities designated by us via notice to you, and may be administered by any of these parties. The only Benefit Plans subject to this Agreement are the self-funded plans offered by the State Health Plan.

1.6. "Coinsurance" means the percentage or other calculation of the amount otherwise due to you under this Agreement that is indicated in the Benefit Plan and is due and payable by the State Health Plan Member, if any.

1.7. "Copayment" means the fixed dollar amount indicated in the Benefit Plan that a State Health Plan Member may be required to pay toward the cost of a Covered Service.

1.8. "Covered Services" means the benefits and services, goods, equipment and supplies specified in the Benefit Plan to which State Health Plan Members are entitled in accordance with the terms and conditions thereof. Nothing in this Agreement shall obligate the State Health Plan to expand these Covered Services or provide coverage for other Health Care Services absent approval by the Board of Trustees pursuant to N.C.G.S. §§ 135-48.22 and 135-48.30.

1.9. "Deductible" means the amount indicated in the Benefit Plan that the State Health Plan Member may be required to pay for Covered Services before benefit payments begin for all or part of the remaining Covered Services.

1.10. "Electronic Communications" means electronic communication through email, provider website, facsimile, or within our Policies and Procedures of any notice, other than that requiring Written Notice hereunder.

1.11. "Emergency" or "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

1.12. "Emergency Services" means health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including prehospital care and ancillary services routinely available in the emergency department.

1.13. "Fee Schedule" means a list of the maximum per unit allowed amounts established for Covered Services that you provide to State Health Plan Members and which is subject to change based upon the terms of this Agreement.

1.14. "Grievance" means a written complaint submitted by a State Health Plan Member about any of the following:

- Our decisions, Policies and Procedures, or actions related to availability, delivery, or quality of health care services;
- Claims payment or handling, or payment for services;
- The contractual relationship between us and a State Health Plan Member; or
- The outcome of an appeal of a noncertification under N.C.G.S. § 58-50-61, or successor thereto.

1.15. "Grievance and Appeals Process" means the formal process described in the Benefit Plan and/or in the Provider Manual for the submission of Grievances or requesting review of denials of coverage or utilization review decisions. This process provides for expedited review, which may be requested over the phone, in cases where the State Health Plan Member's health would be detrimentally affected by a delay of care pending the standard review process.

1.16. "Health Care Services" means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

1.17. "Medically Necessary" or "Medical Necessity" means those Covered Services or supplies, described in N.C.G.S. § 58-3-200(b), that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under N.C.G.S. § 58-3-255, not for experimental, investigational, or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- Within generally accepted standards of medical care in the community;
- Not solely for the convenience of the State Health Plan Member, the State Health Plan Member's family, or a provider.

1.18. "Member" as used in this Agreement means a State Health Plan member who is eligible for coverage and/or benefits and is properly enrolled in a Benefit Plan pursuant to Article 3B of Chapter 135 of the North Carolina General Statutes.

1.19. "Network Participation Agreement" means an agreement between Blue Cross Blue Shield of North Carolina and a health care provider to provide health care items or services to Members.

1.20. "Non-Participating Provider" means those Practitioners and institutional health care providers that have not entered into a contract with us to participate in the North Carolina State Health Plan Network.

1.21. "North Carolina State Health Plan Network" consists of those Practitioners and institutional health care providers that have entered into agreements with us to provide health care services to State Health Plan Members enrolled in self-funded plans offered by the State Health Plan.

1.22. "Notice of Rescission" means a notice that we may issue prior to January 1, 2020 and that would effectuate a rescission of this Agreement.

1.23. "Overpayment" means any duplicate payment, or other payment made to you by Blue Cross and Blue Shield of North Carolina and/or a State Health Plan Member for Covered Services rendered to a State Health Plan Member in excess of the benefits payable according to the State Health Plan Member's Benefit Plan and/or this Agreement.

1.24. "Participating Provider" means a Practitioner or institutional health care provider who has entered a contract with us to participate in the North Carolina State Health Plan Network.

1.25. "Policies and Procedures" mean those rules, regulations, programs, policies and procedures adopted by us or our designee(s), as referenced in **Section 2.3.1** of this Agreement.

1.26. "PPO" means a preferred provider organization and may be referred to as such in the Provider Manual.

1.27. "Practitioner" means any practitioner of health care services who is duly licensed to administer such services by the state in which Covered Services are performed, subject to any licensure or regulatory limitation as to location, manner, or scope of practice.

1.28. "Practitioner Roster Exhibit" means the exhibit attached hereto that lists the individual Practitioners that may provide services to State Health Plan Members under this Agreement. In the event that you have an existing Network Participation Agreement with us at the time that you sign this Agreement, we will use your existing Practitioner Roster Exhibit as the Practitioner Roster Exhibit for this Agreement.

1.29. "Provider Manual" means the Blue Book Provider Manual, a reference guide containing our Policies and Procedures, billing guidelines, and reference materials, as provided by us and revised from time to time in accordance with the terms hereof.

1.30. "Provider Network(s)" consists of those Practitioners and institutional health care providers that have entered into agreements with us to provide health care services to individuals whose health insurance benefits are offered or administered by us in accordance with such individual's benefit plan.

1.31. "Site of Service Exhibit" means the exhibit attached hereto that lists the sites in which services may be provided to State Health Plan Members under this Agreement. In the event that you have an existing a Network Participation Agreement with Blue Cross and Blue Shield of North Carolina at the time that you sign this Agreement, we will use your existing Site of Service Exhibit as the Site of Service Exhibit for this Agreement.

1.32. "State Health Plan" is the North Carolina State Health Plan for Teachers and State Employees.

1.33. "Written Notice" means a notice that must be given in writing and delivered to the Notice Contact. Unless otherwise agreed by the parties, Written Notices must be given by (a) depositing for delivery with the United States Postal Services, first-class, postage prepaid mail; (b) depositing for delivery with the United States Postal Services, certified or registered mail, with return receipt requested; (c) depositing for delivery with a commercial courier service; or (d) hand delivery.

1.34. Additional Definitions. Additional terms may be defined in the Exhibits attached hereto.

2. YOUR SERVICES AND OBLIGATIONS

2.1. State Health Plan Member Services.

2.1.1. Services to be Provided. You agree to render Medically Necessary Covered Services to State Health Plan Members according to our Policies and Procedures and according to the terms of this Agreement. You further agree to render services in accordance with the requirements of any certificate of need issued to you and that we will not be obligated to pay you for services rendered which are not in conformance with applicable certificate of need requirements. The fact that a Practitioner may prescribe, order, or approve a service or supply does not, of itself, make it a Covered Service or Medically Necessary. Nothing herein will be construed to require you to provide Covered Services which you do not provide to the general public.

2.1.2. Services Rendered by Other Providers. You agree that when the need arises for a State Health Plan Member to receive other professional services, hospital, or other institutional services, or supplies, outside of the scope of services that you provide, you will assist with the referral, admission and/or transfer of the State Health Plan Member locally within the North Carolina State Health Plan Network, when reasonably possible and consistent with good medical care. In the event that you refer a State Health Plan Member outside of the North Carolina State Health Plan Network to a Non-Participating Provider for any reason, you agree to first inform the State Health Plan Member that the State Health Plan may not reimburse the full amount of a provider's charge, unless the provider's charge is less than the allowed amount that would otherwise be paid to the Non-Participating Provider; and, as a result, the State Health Plan Member may be subject to higher out-of-pocket payments by using a Non-Participating Provider. You acknowledge that repeated referrals to Non-Participating Providers without reasonable cause may subject you to sanctions, as outlined in the Provider Manual and **Section 5.2** of this agreement. You further agree that you will not limit, restrict, or prohibit a Practitioner by contract or otherwise from exercising their independent medical judgment and referring State Health Plan Members to any participating provider in the North Carolina State Health Plan Network that the Practitioner chooses and deems to be in the best interest of the Plan Member when balancing quality, affordability, and the medical needs of the State Health Plan Member. Nothing contained herein will be construed to require us to cover services provided by a given specialty or in a given setting when a lower level of care is deemed appropriate by us.

2.1.2.1. You agree to fully disclose to the State Health Plan Member and to us any and all financial interest you may have in any entity to which you refer, admit, or transfer the State Health Plan Member for Covered Services.

2.1.3. Excluded Services. You acknowledge that we may have exclusive agreements in place with certain providers (including through separate networks via one or more intermediary agreements) for specific types of Covered Services. Any such exclusive arrangements will be indicated in the Provider Manual given by us to you pursuant to **Section 3.2.5** of this Agreement or, if you are affected by such exclusive arrangements, otherwise by notification from us. You agree to assist with the transfer of State Health Plan Members to such exclusive providers when medically appropriate, and your obligation to provide Covered Services to State Health Plan Members, and your rights to receive in-network compensation for such Covered Services, will not extend to such services.

2.1.4. Responsibility for Services Rendered.

2.1.4.1. State Health Plan Member Relationship. The parties acknowledge and agree that this Agreement is not intended nor is construed to interfere with the patient relationship between you and a State Health Plan Member. The parties acknowledge and agree that you will have sole professional and ethical responsibility for services provided by you to State Health Plan Members under this Agreement. No provision contained in this Agreement nor any of our Policies and Procedures or benefit determinations will override your professional or ethical responsibility or interfere with your ability to provide information or assistance to your patients. You further agree to provide Covered Services to State Health Plan Members so as to provide health or medical care in conformity with accepted and prevailing practices and standards.

2.1.4.2. Open Communication Regarding Treatment. We acknowledge your right to openly communicate with State Health Plan Members regarding treatment options available to them, including discharge planning and any right to appeal any adverse coverage decision, regardless of Benefit Plan limitations or exclusions.

2.1.4.3. Non-Discrimination. You agree not to discriminate against State Health Plan Members on the basis of race, color, ethnicity, national origin, sexual orientation, gender, sex, age, religion, marital status, citizenship, disability, health status, health insurance coverage, mental health status, source of payment, veteran status, or any other basis deemed unlawful under federal, state, or local law.

2.1.4.4. Quality Concerns and Grievance and Appeals Process. You agree to notify us of any case that would result in medical care being provided or denied to a State Health Plan Member that you believe to be inappropriate and contrary to accepted professional or ethical standards of medical practice as a result of our administrative or utilization management processes, the availability of the North Carolina State Health Plan Network, or our benefit determinations. You agree to cooperate with and assist State Health Plan Members, and other Practitioners if applicable, in our Grievance and Appeals Process.

2.1.4.5. Equipment, Goods and Supplies. You agree that all equipment, goods and supplies used in carrying out your duties under this Agreement will at all times remain properly serviced and maintained.

2.1.5. Accessibility Standards. You agree to comply with the accessibility standards to arrange for call coverage or other back-up to provide service, as stated in the applicable Site of Service Exhibit attached hereto.

2.2. Licensure, Accreditation and Insurance.

2.2.1. Licensure and Certification

2.2.1.1. Application. You represent and warrant that you have completed our Application, unless we have otherwise waived the Application requirement, and all of the information in it is true and correct to the best of your knowledge. Your completed Application, if required by us, is incorporated herein by reference as if fully set forth.

2.2.1.2. Licensure. You hereby represent that you are presently licensed accordingly, as specified in the Site of Service Exhibit, under North Carolina and any other applicable law

2.2.1.3. Certifications and Accreditations. You hereby represent that you have, and will maintain in good standing, certifications and accreditations as may be required by law or us, as specified in the Site of Service Exhibit

2.2.1.4. DEA Number. You hereby represent and warrant that you and/or your Practitioners presently have valid Drug Enforcement Administration Number as appropriate for your scope of practice.

2.2.1.5. Qualified Workers. You hereby represent that all employees, agents, and independent contractors engaged or hired by you are qualified and if applicable, duly licensed.

2.2.1.6. Exclusion or Debarment.

2.2.1.6.1. You hereby represent that you, including but not limited to, any of your employees, agents, Practitioners, assigns or subcontractors, have not been excluded or debarred, (i) by the Secretary of Health and Human Services from participation in any federal health care program pursuant to Section 1128 of the Social Security Act, or successor law or any other applicable law, or (ii) by any other federal or state agency possessing authority to debar individuals or entities from being government contractors, and that you, including but not limited to, any of your employees, agents, assigns or subcontractors, are not, to your knowledge, under investigation for any such exclusion or debarment. You represent that you, including but not limited to, any of your employees, agents, Practitioners, assigns or subcontractors, are not named on the United States Department of the Treasury's Specially Designated Nationals or Blocked Persons list. In the event that you, including but not limited to, any of your employees, agents, Practitioners, assigns or subcontractors, are excluded or debarred by a federal or state agency or listed on the Specially Designated Nationals or Blocked Persons list, we may terminate this Agreement or that Practitioner's participation under this Agreement effective immediately upon Written Notice to you.

2.2.1.6.2. You hereby represent that you, including but not limited to your employees, agents, Practitioners, assigns or subcontractors, are not ineligible to contract with the State of North Carolina pursuant to N.C.G.S. § 147-86.82 as (a) a 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 or (b) a 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. If you, including but not limited to any of your employees, agents, Practitioners, assigns or subcontractors, are or become ineligible to contract with the State of North Carolina by reason of (a) or (b) above, this Agreement shall be void *ab initio*.

2.2.1.6.3. You may not subcontract or employ any person or entity excluded or debarred from government contracting.

2.2.1.6.4. You agree to refund us, and as applicable, State Health Plan Members, any applicable state or federal funds we or State Health Plan Members have paid you pursuant to this Agreement after you, including but not limited to any of your applicable employees, agents, Practitioners, assigns or subcontractors have been excluded or debarred or otherwise prohibited from receiving state or federal funds.

2.2.2. Credential Verification Program.

2.2.2.1. Maintenance of License. You agree to maintain, and submit to us upon request, evidence of licensure, accreditation, registration, certification, and all other credentials sufficient to meet all applicable federal and state laws and regulations and our credential verification program requirements.

2.2.2.2. Compliance with Credential Verification Program You agree to comply with our credential verification program and to assist in the credentialing and recredentialing process. You further agree that we may review any and all records and documents which bear upon your credentials, whether in your possession or in the possession of other individuals or organizations.

2.2.3. Insurance. You, at your sole cost and expense, agree to procure and maintain such policies of general liability, professional liability and other insurance as is necessary to insure you and any of your employees or agents against any claim or claims for damages arising by reason of personal injuries or death in connection with the performance of services provided by you, the use of your property and facilities, and the activities performed by you in connection with this Agreement. Each of such policies will meet or exceed the limits that were stated in Blue Cross and Blue Shield of North Carolina's credentialing criteria as of your most recent credentialing by us. You must provide copies of such policies or documentation of self-insurance to us upon request.

2.2.4. Notice of Changes. You agree to provide us Written Notice of subsequent changes in status of any information relating to your credentials, licenses, privileges, and certifications of the Practitioners performing services hereunder, or other information as noted in the Site of Service Exhibit, as well as changes in professional liability or other insurance as soon as possible but no later than ten (10) business days of your discovery of any such changes.

2.2.5. Other Required Notices. You agree to provide us prompt, but in no event, unless otherwise indicated below, less than thirty (30) days, Written Notice of the occurrence of any of the following:

2.2.5.1. Any change in your Notice Contact or alternative Notice Contact, including but not limited to, your billing or payment addresses;

2.2.5.2. In the event of a change in your physical location, a change in your name, or a transfer, conveyance, or other change in control and/or ownership (hereinafter "transfer"), you agree to give us not less than thirty (30) days prior Written Notice of such transfer, such notice to include the effective date of the transfer and a detailed explanation of the circumstances surrounding and reasons for the transfer;

2.2.5.3. Legal or governmental action against you, including such action against any of your Practitioners, employees, agents, assigns or subcontractors, including, but not limited to, an action for professional negligence or one involving an alleged violation of law or against any license or certificate required pursuant to **Section 2.2.1**, which, if successful, would, in your reasonable opinion, materially impair your ability to carry out the duties and obligations assumed under this Agreement;

2.2.5.4. Your insolvency or pendency of bankruptcy;

2.2.5.5. Any other problem or situation that would in your reasonable opinion, materially impair your ability to carry out the duties and obligations assumed under this Agreement.

2.2.5.6. Any changes to your Practitioners' DEA numbers or hospital privileges pursuant to **Sections 2.2.1.3. and 2.2.1.4**..

2.2.5.7. Any change in or new assignment of a National Provider Identifier. You further agree to provide such National Provider Identifier to us at any time upon our written request.

2.2.5.8. Exclusion or debarment as set out in **Section 2.2.1.6** or the initiation of any such action that might reasonably lead to such federal or state exclusion or debarment. Such notice shall be provided to us no later than two (2) business days after you learn of the exclusion or debarment or initiation of actions that might reasonably lead to exclusion or debarment, or ten (10) calendar days after the publication of the relevant government exclusion or debarment list, whichever occurs first.

2.2.6. Your Third Party Contact Information. You agree to give us the name and contact information, including the name or title of the primary contact, the phone number, mailing address, physical location and applicable electronic mail address, of any third party that conducts claims filing, medical billing, management, or consultation for the purposes of this Agreement. You further agree to promptly notify us, but in no event no later than thirty (30) business days, following any change in any information provided to us pursuant to this **Section 2.2.6.**

2.3. Policies and Procedures, and Applicable Law.

2.3.1. Your Compliance with Our Programs, Policies, and Procedures. You agree to participate in and comply with all of our Policies and Procedures, as may be enacted and revised by us from time to time with no fewer than sixty (60) days' prior notice, unless state or federal laws or regulations require a change within a shorter time period, including, but not limited to, utilization review and management programs, credential verification programs, provider accessibility standards or policies, quality improvement and management programs, the Grievance and Appeals Process, provider sanction policies, referral policies, billing policies, claims submission policies, reimbursement policies, coordination of benefit and third party liability policies, excess payments and underpayments policies, billing and refund policies, retroactive adjustment policies, pre-admission certification policies, admission certification policies, length of stay assignment programs, concurrent review programs, prior approval programs, procedure code auditing programs, and administrative requirements. Different Policies and Procedures may apply with respect to different Benefit Plans as described in the Provider Manual. In addition, differing Policies and Procedures may be adopted and applied by an Affiliate or by another Blue Cross and/or Blue Shield plan, or through the Blue Cross and Blue Shield Association, as applicable based on the State Health Plan Member's status. The Policies and Procedures applicable to a given Covered Service shall be those referenced in the Provider Manual in effect as of the date of service. The most recently dated Provider Manual that has been provided to you will be considered the most current, even if we have not updated the Provider Manual following the stated end date.

2.3.1.1. Policies and Procedures will be provided to you by hard copy, CD, or other electronic format or by posting the Policies and Procedures on our Website.

2.3.1.2. Policies and Procedures are intended to supplement this Agreement and are not intended to conflict with or override any term of this Agreement. In the event of a conflict between this Agreement and our Policies and Procedures, this Agreement shall govern.

2.3.1.3. Non-Compliance. If you fail to comply with this Agreement or our Policies and Procedures referenced in this Agreement as you are required to do by this **Section 2.3.**, we may pursue any contractual right of redress including but not limited to recovery, offset, imposition of sanctions pursuant to our provider sanctions policy, practitioner suspension, service exclusion, and termination of contract, and we reserve all legal rights of redress in law or equity.

2.3.2. Your Compliance with Applicable Law and Industry Standards. You represent that you have established procedures to comply with applicable laws and regulations of state, federal and other agencies having jurisdiction over you, as well as industry standards in North Carolina. You agree not to commit fraud or abuse.

2.4. Directory and Marketing Materials.

2.4.1. Directories and Marketing Materials. You hereby authorize us to include information about you, including but not limited to, your name, address, and other biographical information submitted to us by you in our provider directories, benefit plan materials, and other information that is made available to State Health Plan Members and others, as well as the directories of other Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association. You further agree to provide us information upon request that we determine, at our discretion, will be included in the directories. However, you will be included only in provider directories for the Benefit Plans in which you participate. You agree that we may provide pertinent information about you in marketing and information materials made available to State Health Plan Members and others. Such information may include, among other things, summary information, description of available services, and information regarding cost and quality. You may review and provide comments regarding any such materials solely created and made available by us that reference you prior to those materials being made available to State Health Plan Members and others provided, however, information gathered through third parties, surveys, public comment tools, member claims, or our Agreement with you will not be provided for your review in advance as determined in our reasonable discretion. Any materials of any nature whatsoever developed by you or on your behalf which make reference to us will be first submitted in writing by notice to us for our prior written approval, not to be unreasonably withheld, except, however, you may list your participation under this Agreement by strictly following the brand regulation guidelines described in the Provider Manual. You agree not to use the name of the State of North Carolina, Department of State Treasurer, the State Health Plan, or the North Carolina State Health Plan Network as part of any commercial advertising or marketing products or services.

2.4.2. Information about You. You may send Written Notice to us of an inaccuracy of information that is derived from data supplied by you or from applicable agreements between us that is posted on our Web site or contained in printed materials prepared by us. If we do not dispute that there is an inaccuracy, we shall take steps reasonably necessary to update the website within fifteen (15) business days after receipt of your notice and to revise written materials before the next edition of such materials being printed, to the extent there is sufficient time to make such revisions before the next printing, to reflect any corrections necessary to make the information accurate unless we dispute that there is an inaccuracy. If we dispute that there is an inaccuracy, we will so notify you within the same time periods specified in this **Section 2.4.2.**, including the basis on which we dispute that there is an inaccuracy.

3. OUR SERVICES AND OBLIGATIONS.

3.1. Certificate of Authority. We represent that we have maintained and continue to maintain appropriate licensure and authorization necessary to operate as a health insurer or health maintenance organization, as applicable, under the North Carolina General Statutes. We represent that we have established procedures to comply with applicable laws and regulations of state, federal, and other agencies having jurisdiction over us, including any that may have jurisdiction when we serve as a third party administrator for self-funded clients.

3.2. Administrative Services.

3.2.1. Marketing and Administration. We agree to perform or to have performed on our behalf, certain marketing, enrollment, administrative, accounting and other functions we may deem necessary to the administration of the Benefit Plans and the performance of this Agreement. We agree to make best efforts to furnish identification cards to State Health Plan Members prior to the State Health Plan Member's effective date and to educate State Health Plan Members on our Policies and Procedures through State Health Plan Member handbooks and toll-free telephone access to a State Health Plan Member services department.

3.2.2. Provider Directories. For the Benefit Plans in which you participate, we agree to list you in our applicable provider directories that are made available to State Health Plan Members as long as you meet our credentialing requirements and provide the necessary information. However, should either party issue Written Notice of termination, our obligation to list you in the applicable provider directories will not apply during such termination notice period. Providing false information or failing to provide information necessary for inclusion in our provider directories is grounds for termination with cause in accordance with **Section 5.2.1**.

3.2.3. State Health Plan Member Eligibility Verification. We agree to provide a means that allows you to verify State Health Plan Member eligibility before rendering services, based on current information held by us. Such verification may be subject to retroactive adjustments pursuant to **Section 4.6.**

3.2.4. State Health Plan Member Relationship. The parties agree that we are responsible for making judgments and decisions concerning whether certain services or supplies are Medically Necessary under the applicable medical policies and Covered Services under the Benefit Plan and the extent to which payment may or may not be made thereunder.

3.2.5. Provider Manual. We agree to provide you with access to a Provider Manual, containing current information concerning benefit exclusions and Policies and Procedures, in accordance with **Section 2.3**. We agree to update such information as changes in requirements are made, consistent with the notice provisions stated in **Section 2.3**.

3.2.6. Reporting. We agree to provide the appropriate reporting necessary for you to complete any program, quality, or other obligations as set forth herein and mutually agreed by the parties. To the extent your compensation is related to efficiency criteria, we agree to provide performance feedback reports or information to you.

3.2.7. Insurance. We, at our sole cost and expense, agree to procure and maintain such policies of general liability and other insurance as are necessary to insure us and our employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the use of any property and facilities provided by us and the activities performed by us in connection with this Agreement. Such policies will be made available to you for your examination at our corporate office during normal business hours.

3.2.8. Payors. Because we are not responsible under the terms of our agreement with the State Health Plan for funding the payments for Covered Services provided to State Health Plan Members, we will not be required to advance or fund such payments notwithstanding any provision of this Agreement to the contrary. As a governmental entity, the State Health Plan is obligated by law to fund such payments and is acting as a payor rather than an employer.

3.2.9. Credentialing and Recredentialing. We agree to assess and verify all credentialing Applications and recredentialing information and to notify the applicant of our decision within sixty (60) days of receipt of all required information.

4. PAYMENT TO YOU.

4.1. Payment. For Covered Services provided to State Health Plan Members during the term of this Agreement at the sites of service listed in the Site of Service Exhibit you will be paid in accordance with the attached Reimbursement Exhibit(s), and as otherwise set forth in this Agreement. We agree to pay and you agree to accept as payment in full for Covered Services delivered to State Health Plan Members during the term of this Agreement the amount specified in the attached Reimbursement Exhibit(s), in effect on the date the service or supply is rendered, and as otherwise set forth in this Agreement, except to the extent that we are required to assign payment to the Division of Medical Assistance of the Department of Health and Human Services pursuant to N.C.G.S. 108A-55.4, or successor thereto. We represent that we have established procedures to comply with the provisions of N.C.G.S. 58-3-227 and 58-50-270 through 58-50-285 or successor law, which describes our obligations to provide information regarding fees, and descriptions of our claim submission and reimbursement policies.

4.1.2. Sites of Service. All sites of service subject to the terms of this Agreement are listed on the Site of Service Exhibit. You agree to provide us with Written Notice thirty (30) days in advance of your proposed additions and deletions to the sites of service listed herein.

4.1.3. Electronic Funds Transfer. All payments by us under this Agreement shall be made by electronic funds transfer (EFT) except as otherwise stated in this Agreement. You are required to provide us with the information required to make payment by EFT as a condition of participation in the North Carolina State Health Plan Network. If erroneous transfer(s) occur because of your incorrect submission of EFT information, we will be deemed to have made payment to you and you shall be responsible for any recovery of erroneously directed funds; if the transfer fails, any prompt payment timeframes will not begin until we receive correct EFT information.

4.2. Billing.

4.2.1. Time for Claims Submission. To be eligible for payment, claims must be received by us by the later of one hundred and eighty (180) days from the date of service or 180 days from the date of discharge from a facility, unless (i) such longer period of time is set forth in the Provider Manual or (ii) we have agreed in writing to waive this provision due to circumstances that limited your ability to submit a claim within such time period, including but not limited to delays caused by coordination of benefits.

4.2.2. Electronic Submission. You agree to submit all claims to us electronically unless we specifically request a paper claim.

4.2.3. Electronic explanation of payment. You agree to access explanations of payment from us through the use of electronic media and electronic communications. You acknowledge that, for your records, you are able to view and retain explanations of payment by printing and/or downloading and saving them in the manner you deem appropriate.

4.3. Processing of Claims. We agree to make reasonable efforts to process all claims for benefits for services and/or supplies provided to State Health Plan Members submitted by you, within thirty (30) days of our receipt of all necessary information. Except for retroactive adjustments to eligibility records pursuant to **Section 4.6**, we agree that we will not retroactively deny payment of properly submitted claims that have been pre-authorized through our utilization management processes, so long as our authorization was not based on a material misrepresentation knowingly provided by you, a State Health Plan Member, or other provider. Further, we represent that we have established billing, claim submission, and claim processing procedures to comply with the provisions of N.C.G.S. § 58-3-225, entitled "Prompt Claim Payments Under Health Benefit Plans." You acknowledge and agree not to hold claims for processing by us at a later date unless specifically directed to do so by us.

4.4. Deductibles, Coinsurance and Copayments. You agree to collect from State Health Plan Members applicable Deductibles, Coinsurance, and Copayments, and you agree that our payment in accordance with **Section 4.1** may be reduced by such amounts. The maximum amount of a State Health Plan Member's Copayment will be the lesser of the amount specified in the State Health Plan Member's Benefit Plan or the amount to which you are otherwise entitled pursuant to this Agreement. You agree not to waive any portion of a State Health Plan Member's applicable Deductible, Coinsurance or Copayment that may be required pursuant to the State Health Plan Member's Benefit Plan, unless (a) you have undertaken reasonable collection efforts and are unable to collect the Deductible, Coinsurance, or Copayment or (b) you have determined that the particular State Health Plan Member is indigent. Any such amounts waived by you contrary to this **Section 4.4** will be deducted from the amount you are otherwise entitled to pursuant to this Agreement.

4.5. Hold Harmless.

4.5.1. Payment in Full. You agree to accept the amounts due in accordance with the attached Reimbursement Exhibit(s), including applicable Deductibles, Coinsurance and Copayments, as payment in full for Medically Necessary Covered Services provided to State Health Plan Members of the Benefit Plans corresponding to the Reimbursement Exhibit(s). The amounts due may differ based on the specific product as a result of different benefit designs and claims adjudication methodologies. In no event, including but not limited to our non-payment or insolvency or breach of this Agreement, will you seek payment from a State Health Plan Member or third party for Medically Necessary Covered Services provided to State Health Plan Members, including but not limited to subrogation and workers' compensation, except as otherwise provided in this **Section 4.5**.

4.5.2. Timeliness of Claim Submission. You agree not to bill, charge, seek compensation or remuneration or reimbursement, or collect from the State Health Plan Member or us any amount for services or supplies provided to a State Health Plan Member for which a claim was not submitted to us in accordance with **Section 4.2.1**.

4.5.3. State Health Plan Member Contributions and Third Party Liability. This **Section 4.5** will not prohibit the collection of any Deductible, Copayment, or Coinsurance in accordance with **Section 4.4**. In addition, this **Section 4.5** will not prohibit the billing and collection of amounts payable by third party carriers when such parties are responsible for paying for Covered Services in accordance with our coordination of benefits and third party liability policies.

4.5.4. Survival. You further agree that the provisions of this **Section 4.5** will survive termination of this Agreement regardless of the causes giving rise to such termination, will be construed to be for the State Health Plan Members' benefit, and will supersede any oral or written contrary agreement now existing or hereafter entered into between you and a State Health Plan Member or persons acting on behalf of a State Health Plan Member.

4.5.5. Non-Covered Services. You agree not to bill, charge, or seek compensation, remuneration, or reimbursement from any State Health Plan Member, us, or any third party for health care services and/or supplies provided to State Health Plan Members which are determined by us not to be Covered Services, Medically Necessary, or are not payable due to your failure to follow our applicable Policies and Procedures, except as provided in **Section 4.5.6**.

4.5.6. State Health Plan Member's Written Authorization Required. Notwithstanding the provisions of **Section 4.5.5**, you may seek compensation from the State Health Plan Member for non-Medically Necessary Services or other non-Covered Services only if you obtain the written authorization of the State Health Plan Member prior to rendering the services. Such authorization must reference the specific services and/or supplies to be provided, contain the State Health Plan Member's acknowledgment that such services and/or supplies may not be covered by his or her Benefit Plan, and indicate the State Health Plan Member's agreement to pay for such services and/or supplies apart from his or her Benefit Plan. You further agree to provide us with a copy of any and all such written authorizations upon request. Notwithstanding this **Section 4.5.6**, you may not seek compensation for services that are not payable due to your failure to follow our applicable Policies and Procedures or for services for which you have been reimbursed pursuant to this Agreement. You further agree that such

authorization shall be given regarding a particular service at issue in the specific treatment of a State Health Plan Member, and not as a matter of general or standard procedures in all cases.

4.6. Retroactive Eligibility Adjustments. You agree to accept and abide by retroactive adjustments made by us to our State Health Plan Member eligibility records and associated adjustments to your reimbursement. We agree to use best efforts to make retroactive adjustments within ninety (90) days after the date the claim was processed. You agree that if Medically Necessary Covered Services were provided to a State Health Plan Member during any retroactive adjustment period for which that State Health Plan Member is added as an eligible State Health Plan Member, you will reimburse the State Health Plan Member for any payments made by the State Health Plan Member for such services and/or supplies within forty-five (45) days of receiving the retroactive adjustment, except for any applicable Deductibles, Coinsurance, and/or Copayments. Further, you agree to reimburse any payments made by us for any services provided to ineligible members within forty-five (45) days of receiving the retroactive adjustment.

4.7. Coordination of Benefits and Third Party Liability. Notwithstanding any provision of this Agreement to the contrary, you agree that payment to you for Covered Services (i) for which we determine that you have other than primary liability based upon the coordination of benefits provision of the State Health Plan Member's applicable State Health Plan Member's Health Benefit Plan or (ii) for which we have partial liability; shall not be made by us of any amount which when added to all third party benefit payments would exceed the amount you are otherwise entitled to receive as payment under this Agreement or the applicable State Health Plan Member's Benefit Plan, or which you are otherwise required to accept as payment in full. You agree neither to bill nor attempt to collect any additional amounts from us or the State Health Plan Member, except for any remaining Deductible, Coinsurance, and/or Copayment amounts due according to the applicable State Health Plan Member's Benefit Plan. You agree that payment by us in accordance with this Agreement shall fully discharge us, the State Health Plan Member, and all third parties from any and all liability for your charges, including, but not limited to, subrogation and workers' compensation, except for any charges for Deductible, Coinsurance, and/or Copayment amounts due and owing by the State Health Plan Member. You agree not to attempt to collect any additional monies from us, the State Health Plan Member, or any third party for services rendered, including, but not limited to, subrogation and workers' compensation, except for any charges for Deductible, Coinsurance, and/or Copayment amounts due and owing by the State Health Plan Member. Notwithstanding anything to the contrary in this Agreement, you may pursue coordination of benefits as allowed by law from any third party payor that is secondary to us.

4.8. Payments and Overpayments.

4.8.1. Government Payer. You acknowledge and agree that the State Health Plan is a government payer and all claim payments made under this contract are paid using funds of the State of North Carolina.

4.8.2. State Health Plan Member Overpayment. You agree that you will implement policies, procedures, and/or processes to identify any Overpayments made to you by State Health Plan Members, and that you will remit any such Overpayment to the State Health Plan Member within sixty (60) days once identified.

4.9. Identity Verification. You agree that, in order to guard against improper use of State Health Plan benefits and with the exception of Emergency Services, you will make a reasonable attempt to verify that the identity of the individual seeking service from you matches the identity of the State Health Plan Member described on the State Health Plan identification card before providing Covered Services. When a State Health Plan Member requires Emergency Services, you agree to make a reasonable attempt to verify the identity of the State Health Plan Member as soon as practicable.

4.10. 42 C.F.R. Part 2 Compliance. If you (a) qualify as a substance use disorder "program" as defined in 42 C.F.R. § 2.11, (b) receive, store, process, have access to, maintain, or otherwise deal with "patient identifying information" or "records" as defined in 42 C.F.R. § 2.11, and (c) are "federally assisted" as defined in 42 C.F.R. § 2.11, you acknowledge and agree that you are fully bound by and will fully comply with 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.

4.11. HIE Compliance. You agree to fully comply with the Statewide Health Information Exchange Act set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. In the event that we reject, return, or otherwise decline to pay or process any claim submitted under this Agreement as a result of non-compliance with the Statewide Health Information Exchange Act, you agree that you will not seek payment from the State Health Plan Member.

5. TERM AND TERMINATION.

5.1. Effective Date and Term. This Agreement will become binding when fully executed and will, along with the applicable Reimbursement Exhibit(s), have an effective date of January 1, 2020 for an initial term of one year subject to the termination rights contained herein. Thereafter, this Agreement will automatically renew for successive one-year renewal terms unless amended or terminated as hereinafter provided. For the sake of clarity and to avoid confusion, this Agreement will govern the provision of services to State Health Plan Members beginning on January 1, 2020. Prior to that date, the terms of this Agreement shall not apply to or govern the reimbursement for any services that you provide to State Health Plan Members.

5.2. Termination.

5.2.1. Termination With Cause. This Agreement may be terminated at any time by either party, with cause, upon providing Written Notice of intent to terminate due to material breach of this Agreement and allowing the breaching party no fewer than thirty (30) days to cure. If at the end of such 30-day period the breach has not been cured, the non-breaching party may terminate immediately or, in the non-breaching party's discretion, such later time upon Written Notice to the breaching party.

5.2.2. Termination Without Requirement of Cause. This Agreement may be terminated by us without requirement of cause upon no fewer than ninety (90) days' prior Written Notice to you. After an initial term of one (1) year from the effective date, this Agreement may be terminated by you, without requirement of cause, upon no fewer than one hundred and eighty (180) days' prior Written Notice to us.

5.2.3. Other Termination Provisions. Notwithstanding any other terms of this Agreement, this Agreement may be terminated immediately by us at our sole option and discretion upon any of the following occurrences:

5.2.3.1. failure to notify us pursuant to this Agreement, when such failure to notice may materially disadvantage us or State Health Plan Members;

5.2.3.2. failure to comply with our credential verification program;

5.2.3.3. failure to notify us of Debarment or Exclusion;

5.2.3.4. material changes in your ownership or control, including dissolution or other cessation of your business or professional functions, insolvency, bankruptcy, or a change in your physical location;

5.2.3.5. the existence of any problem or situation that would, in our sole discretion impair your ability to carry out the duties and obligations assumed under this Agreement;

5.2.3.6. your failure to comply with applicable laws and industry standards as set forth in **Section 2.3.2.**;

5.2.3.7. the existence of any problem or situation that would, in our sole discretion, adversely impact State Health Plan Members;

5.2.4. Termination Due to Alteration of Healthcare Insurance. Notwithstanding any other terms of this agreement, we may terminate this Agreement by providing at least thirty (30) days prior Written Notice of termination if, in connection with any state or federal legislation, regulation, or court order, the State Health Plan alters the nature of products it offers or the manner in which the State Health Plan conducts business.

5.3. Your Obligations After Termination or Our Insolvency.

5.3.1. Continuing Care. You agree that upon termination of this Agreement or our insolvency, you will remain obligated to continue to provide medical care pursuant to applicable state and federal statutes and consistent with requirements in the Provider Manual to State Health Plan Members that are receiving ongoing care until we can arrange for the State Health Plan Member to select another provider or ninety (90) days from the date of termination, whichever occurs first. You further agree that upon termination of this Agreement or our insolvency, you will be obligated to continue inpatient care until the State Health Plan Member is ready for discharge. In the event of our insolvency, you will be obligated to continue to provide Covered Services for the period for which the State Health Plan Member's premium has been paid. You agree to continue to be obligated to the terms of this Agreement for any such continuing care required under this **Section 5.3.1**. If a given State Health Plan Member falls into more than one of the above categories such that a conflict is created as to the length of time that you are required to provide care, the longer time period shall apply.

5.3.2. Transfer of Duties and Records. You agree that upon termination of this Agreement or our insolvency, you will cooperate in the orderly transfer of administrative duties and medical records to the State Health Plan Member's new provider after obtaining the State Health Plan Member's authorization, and will be responsible for the cost of transferring medical records or copies thereof.

5.3.3. Survival. The provisions of this **Section 5.3** will survive termination of this Agreement.

5.4. Dormancy. In the event you become contracted into the North Carolina State Health Plan Network through a third party after the effective date of this Agreement, this Agreement will automatically enter a state of dormancy for the applicable Benefit Plan(s). Unless otherwise terminated by either party, this Agreement may then be reactivated if we provide no fewer than ninety (90) days advance Written Notice.

5.5. Rescission. In the event that we provide you with a "Notice of Rescission" prior to January 1, 2020, this Agreement will terminate immediately without cause and such termination shall be retroactive to the date on which this Agreement first became binding. In such circumstance, neither this Agreement nor any of the terms herein shall have any force and effect; specifically, neither **Section 6.6.1** nor any other term in this Agreement will supersede or otherwise affect your participation in any of our network(s) under a separate agreement between the parties.

6. GENERAL PROVISIONS

6.1. Records.

6.1.1. Maintenance and Audit. You agree to maintain legible, complete, timely, accurate, and professionally adequate and appropriate medical and other health records relating to services and/or supplies provided to State Health Plan Members in accordance with our Policies and Procedures, accepted industry standards, and as may be required by law. You agree to maintain medical records on the same basis as for all other patients, and to make such information available to us and other North Carolina State Health Plan Network providers when necessary for the treatment and evaluation of State Health Plan Members or as otherwise required by our Policies and Procedures or determined by us, as permitted by law or the terms and conditions governing the State Health Plan Member's Benefit Plan. You agree that we or our designated representative have the right upon thirty (30) days prior Written Notice, to inspect and audit at reasonable times your medical and financial records relating to services and/or supplies provided to State Health Plan Members and the administration of this Agreement. You agree that all data submitted to us on State Health Plan Members shall be accurate, complete, and truthful, and to provide us with records necessary to confirm the accuracy, completeness, and truthfulness of such data. You further agree there will be no charge or other administrative fee to us, our designated representative, or the State Health Plan Member related to our performance of any audit or your duplication and submission of copies of such records reasonably requested in the performance of such audits. Such right of audit may be for the purpose of complying with requests of the North Carolina Department of Insurance, verifying services provided, verifying contract compliance, or such other lawful purposes as we may require or as are provided for in our Policies and Procedures. Notwithstanding the above, no prior written notice shall be required when we inspect and audit based on suspected fraud or abuse.

6.1.2. Access to Records. You agree to release medical records at no charge to us, and upon request you agree to release medical records to the North Carolina Department of Insurance in conjunction with its regulation of us. We warrant that we have the contractual right with State Health Plan Members to obtain any and all patient information from you for the purpose of making benefit determinations. You agree to obtain any additional State Health Plan Member authorization you determine to be needed for you to release medical records to us. In addition, during and after the term hereof, the North Carolina State Auditor shall have access to persons and records related to this Agreement to verify accounts and data affecting fees or performance under this Agreement.

6.1.3. Patient Confidentiality. Both parties agree to maintain the confidentiality of State Health Plan Member records and personal information and to use State Health Plan Member information only in connection with lawful purposes. Both parties agree that they cannot use or disclose State Health Plan Member records and personal information in any way that is not explicitly authorized by this Agreement or by applicable law. Both parties further agree to comply with the privacy and security obligations set forth by any applicable state or federal law, including (as applicable), but not limited to those set forth in North Carolina's Insurance Information and Privacy Protection Act (Article 39, Chapter 58 of the North Carolina General Statutes), the Gramm-Leach-Bliley Act, and the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any regulations promulgated thereunder. In the event of a conflict between or among any applicable laws or regulations described in this **Section 6.1.3.** in which you cannot perform so that all relevant legal authorities are given effect, you shall notify us and we will confer in good faith to reach mutual agreement about which law will govern the performance under this Agreement. To the extent that the privacy and/or security requirements of applicable law conflict with the provisions of this Agreement, the requirements of the applicable law shall prevail.

6.1.4. Access to Electronic Medical Records. You agree to provide us reasonable access to electronic medical records subject to any data use agreement between the parties and in compliance with applicable state and federal laws.

6.1.5. Survival. The provisions of this **Section 6.1** will survive termination of this Agreement.

6.2. Notices.

6.2.1. Method of Delivery and Date of Receipt. Notices given under this Agreement may be given by one or more of the following methods and will be deemed received by the receiving party as follows: (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States Postal Services; (ii) on the date the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this Agreement prohibits the use of an electronic medium for a communication other than a Proposed Change to a Fee Schedule, as defined in **Section 6.6.4.**, if agreed to by the parties. Notice given pursuant to an electronic medium is deemed received by the receiving party on the date the notice is transmitted or made available electronically.

6.2.2. Notice Contact. "Notice Contact" means the name or title and address of the person designated on the signature page, below, to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between the parties shall be provided. Each party to this Agreement shall designate its Notice Contact and shall include the name or title and address of the person to whom the notice shall be sent.

6.2.2.1. Nothing in this Agreement prohibits the parties from mutually agreeing to alternative Notice Contacts.

6.2.2.2. A party may change its Notice Contact or alternative Notice Contact by providing Written Notice to the other party at the Notice Contact or an alternative Notice Contact designated by the other party for this purpose, or as mutually agreed by both parties. A party shall provide Written Notice to the other party's Notice Contact of a change in its Notice Contact no later than thirty (30) days after such change.

6.2.3. Electronic Notices. The parties mutually agree that they may use an electronic medium for communication when this Agreement does not require Written Notice. Other than notices requiring Written Notice, you accept Electronic Communications provided by us as reasonable and proper notice, for the purpose of any and all laws, rules, and regulations, and agree that such electronic form fully satisfies any requirement that such communications be provided to you in writing or in a form that you may keep.

6.3. Independent Relationship.

6.3.1. Independent Contractors. The parties agree that both are independent legal entities engaged in the operation of their own respective businesses. In the performance of the obligations of this Agreement, each party will be at all times acting and performing as an independent contractor with respect to the other party, and no party will have or exercise any control or direction over the method by which the other party will perform such work or render or perform such services and functions. Neither party is, nor is to be considered the agent or employee of the other party for any purposes whatsoever. You further represent and warrant that you are not an intermediary as may be determined by the North Carolina Department of Insurance.

6.3.2. Association Relationship. You hereby expressly acknowledge your understanding that this Agreement constitutes a contract between the parties, that Blue Cross and Blue Shield of North Carolina is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, (the "Association") permitting us to use the Blue Cross and/or Blue Shield service marks in the State of North Carolina, and that Blue Cross and Blue Shield of North Carolina is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Agreement based upon representations by any person other than us and that no person, entity, or organization other than us will be held accountable or liable to you for any of our obligations to you created under this Agreement. This paragraph will not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Agreement.

6.3.3. Rights of Third Parties. This Agreement is a contract between the parties and will not be construed, interpreted, or deemed to confer any rights whatsoever to any third party or parties.

6.4. Assignment and Novation.

6.4.1. Assignment, Delegation, or Transfer by You. No assignment, delegation or transfer of the rights, duties, or obligations of this Agreement, or any part of it, will be made by you without our prior written consent, such written consent to be requested by Written Notice no fewer than ninety (90) days' prior to the proposed assignment, delegation, or transfer.

6.4.2. Assignment or Delegation by Us. Except as specifically provided elsewhere in this Agreement, no assignment of the rights, duties, or obligations of this Agreement, or any part of it, may be made by us without your prior written consent; provided, however, that we may assign this Agreement, in whole or in part, to an Affiliate, including but not limited to our subsidiaries; another Blue Cross and/or Blue Shield Plan or corporate affiliate thereof; or other successor in interest in connection with a merger, sale, or transfer of substantially all of our assets or in connection with a reorganization. We will give you no fewer than ninety (90) days' prior Written Notice of the delegation or transfer of any of our duties or obligations under this Agreement.

6.4.3. Novation to State Health Plan. You agree that we shall have the unqualified right, which may be exercised in our sole and absolute discretion, to novate this Agreement, along with all of our rights and obligations hereunder, to the State Health Plan on or after January 1, 2022. We will give you no fewer than ninety (90) days' prior Written Notice of any such novation that specifies the effective date of the novation and, with such notice, we will provide you with a revised form of this Agreement that (a) replaces all references to Blue Cross and Blue Shield of North Carolina with references to the State Health Plan and/or its Third Party Administrator, (b) otherwise eliminates any and all reference to the "Blue Cross" and/or "Blue Shield" marks, and (c) removes and/or modifies any provisions that are not applicable to the State Health Plan. You agree that this Agreement will be deemed amended – without the need for any further action by any party – as of the effective date of the novation to encompass such changes to this Agreement and that such amendment shall be a condition precedent to the effectiveness of such novation.

6.5. Informal Resolution. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

6.5.1. Contacting Us. In the event that a dispute under this Agreement cannot be addressed to your satisfaction by our customer services department, you should contact our Network Management department.

6.6. Entire Agreement and Amendments.

6.6.1. Entire Agreement. This Agreement, together with the attached Exhibits, Provider Manual, and documents incorporated by reference, constitutes the entire Agreement between the parties with respect to the provision of services to State Health Plan Members. Except as otherwise expressly provided in this Agreement, any prior agreements between Blue Cross and Blue Shield of North Carolina and you (or portions thereof), promises, negotiations, or representations, either oral or written, relating to the provision of services to State Health Plan Members covered under this Agreement shall

have no further force and effect beginning on January 1, 2020, but only with respect to the provision of services to State Health Plan Members. In other words, neither this Agreement, this **Section 6.6.1**, nor any other provision in this Agreement will have any effect on any other agreement between the Parties that relates to the provision of services to individuals or entities whose insurance coverage is provided by an entity other than the State Health Plan. This Agreement will only supersede any such agreement to the extent that such agreement would otherwise address the provision of services to State Health Plan Members by you.

6.6.2. Counterparts. This Agreement may be executed in any number of counterparts, and by each of the undersigned on separate counterparts, and each such counterpart shall be deemed to be an original, but all such counterparts put together shall constitute but one and the same Agreement.

6.6.3. Amendments. This Agreement may be amended by written mutual agreement of the parties, or as follows:

6.6.3.1. Changes in Law. In the event that we determine that federal and/or state law or regulation or applicable accrediting organization requires amendments to this Agreement, we agree to provide you no fewer than sixty (60) days' prior Written Notice of such amendments and upon expiration of such sixty (60) day period, this Agreement will be automatically amended to include the amendments set forth in our Written Notice.

6.6.3.2. Benefit Plans. The Benefit Plans subject to this Agreement are those the self-funded plans offered by the State Health Plan. Additional specified benefit plans or products offered by the State Health Plan may be added to or excluded from this Agreement by us by providing no fewer than sixty (60) days' prior Written Notice to you. If you object to such notice you may, within thirty (30) days of such notice, give us ninety (90) days' prior Written Notice of termination of this Agreement. If you object, we will either at our discretion (i) withdraw our proposed change in which case your Written Notice of termination will have no force or effect; or (ii) accept your Written Notice of termination and not apply the proposed change to you during the termination notice period.

6.6.3.3. All Other Terms. We may amend any terms of this Agreement, other than changes to the Fee Schedules addressed in **Section 6.6.4.**, by providing no fewer than sixty (60) days' prior Written Notice to you. If you object to such notice you may, within thirty (30) days of such notice, give us ninety (90) days' prior Written Notice of termination of this Agreement. If you object, we will either at our discretion (i) withdraw our proposed change in which case your Written Notice of termination will have no force or effect; or (ii) accept your Written Notice of termination and not apply the proposed change to you during the termination notice period.

6.6.4. Changes in Fee Schedules.

6.6.4.1. We shall give Written Notice to your Notice Contact pursuant to N.C.G.S. §§ 58-50-270 through 58-50-285 or successor thereto of a proposed change to the terms of this Agreement, including terms incorporated by reference, that modifies the Fee Schedule and that is not a change required by federal or State law, rule, regulation, administrative hearing, or court order ("Proposed Change to a Fee Schedule"). The Proposed Change to a Fee Schedule shall be dated, labeled

"Amendment," signed by us, and include an effective date for the Proposed Change to a Fee Schedule. The effective date shall be at least sixty (60) days from the date of receipt of the Proposed Change to a Fee Schedule, or greater if otherwise required by this Agreement.

6.6.4.2. We shall give you at least sixty (60) days from the date of receipt of the Proposed Change to a Fee Schedule to object to the Proposed Change. If you do not object to us by Written Notice within sixty (60) days from the date of the receipt of the Proposed Change to a Fee Schedule, the Proposed Change to a Fee Schedule shall be effective upon the effective date specified in the Proposed Change to a Fee Schedule unless we give Written Notice to you that we will not implement the Proposed Change to a Fee Schedule as to you. If you object to the Proposed Change to a Fee Schedule, then the Proposed Change to a Fee Schedule is not effective and, notwithstanding any other provisions of this Agreement, we shall be entitled to terminate this Agreement upon sixty (60) days Written Notice to you.

6.6.4.3. The parties may negotiate contract terms that provide for mutual consent to a Proposed Change to a Fee Schedule, a process for reaching mutual consent, or alternative Notice Contacts.

6.7. Governing Law and Forum. This Agreement shall, in all instances and under all circumstances, be governed by, and construed in accordance with, the laws of the State of North Carolina, excluding its choice of law and/or conflicts of law provisions. The parties hereby consent and agree that the venue for any legal action under or relating to this Agreement shall be an appropriate venue in North Carolina. Notwithstanding the aforementioned, you consent to change of venue in accordance with N.C.G.S. § 1-83, to Wake County, North Carolina, at our sole election. You agree that any dispute arising out of this agreement with an amount in controversy of at least one million dollars ($1,000,000) may be designated at our sole election as a mandatory complex business case pursuant to N.C.G.S. § 7A-45.4(a)(9) and you hereby consent to jurisdiction of said dispute in the North Carolina Business Court. Notwithstanding any other language or provision of this Agreement, nothing herein is intended nor shall be interpreted as a waiver of any right or remedy, or claim or defense based on the principle of sovereign immunity or other State or federal constitutional provision or principle, available to the Plan, as a political subdivision of the State of North Carolina, under applicable law.

6.8. Waiver and Severability.

6.8.1. Waiver. The waiver of either party of a breach or violation of any provision of this Agreement will not be construed to be a waiver of any subsequent breach thereof.

6.8.2. Severability. In the event any provision of this Agreement conflicts with or is rendered invalid or unenforceable by the laws under which this Agreement is to be construed, or if any other provision is held invalid by a court with jurisdiction over the parties to this Agreement, such provision will be deleted from this Agreement and this Agreement will be construed to give effect to the remaining provisions of it.

6.9. Transparency of this Agreement and Confidentiality of Other Proprietary Information.

6.9.1. General. You acknowledge and agree that this Agreement, including any associated Reimbursement Exhibit(s), are not confidential, proprietary, or otherwise subject to the North Carolina Trade Secret Protection Act, Article 24 of Chapter 66 of the North Carolina General Statutes. This Agreement and its associated Reimbursement Exhibit(s) shall be a public record under the North Carolina Public Records Act, Chapter 132 of the North Carolina General Statutes.

6.9.2. Other Blue Cross and Blue Shield of North Carolina Information. Notwithstanding **Section 6.9.1** and with the exception of this Agreement and its associated Reimbursement Exhibit(s), you agree that: (i) any documents, information, or data from the Blue Cross and Blue Shield Association or other Blues Plan, (ii) any of our programs, policies, or data, and (iii) our trade secret information shall be and remain confidential. (Collectively, Subsections (i) through (iii) above are referred to as the "Confidential Information.") You will not disclose the Confidential Information to any third party without our prior written consent, except for your attorney(s), agent(s), and consultant(s) ("Approved Third Parties"), subject to the restrictions in **Section 6.9.3**, unless such disclosure is required by law, including ERISA, for licensure or for compliance with any accreditation requirements. Your consultants, attorneys, and agents may only use the Confidential Information on your behalf for the purposes and obligations set forth in this Agreement. You agree not to solicit or accept Confidential Information pertaining to any providers that are not a party to this Agreement.

6.9.3. Trade Secret Information. You agree that the Confidential Information includes our proprietary and trade secret information, as defined under Article 24, Chapter 66 of the North Carolina General Statutes ("Trade Secret Information"), and that release of our Trade Secret Information to any third party other than Approved Third Parties is not permissible and may constitute violation of applicable laws. Our Trade Secret Information includes information which we identify as Trade Secret Information or that a third party would reasonably consider to be a Trade Secret.

6.9.4. Disclosure to Approved Third Parties**.** You may not disclose Confidential Information to any Approved Third Party until such party has first executed an agreement with you with terms at least as stringent as those in this Agreement, to keep confidential all Confidential Information that you disclose to them. Upon request, you agree to provide copies of your Approved Third Party agreement(s) to us.

6.9.5. Survival. The provisions of this **Section 6.9** shall survive termination of this Agreement.

6.10. Headings. The headings of sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

6.11. Exclusive Contract. This Agreement is not exclusive and either party may freely contract and enter into other similar arrangements with other persons, firms, or entities. Nothing contained herein will be interpreted to restrict either party from participating in any health care delivery system or program. Nothing in this Agreement will guarantee you any minimum or specific number of State Health Plan Members.

6.12. Force Majeure. Neither party shall be required to meet an obligation under this Agreement where the inability to meet such obligation is the result of any act of God, governmental act, act of terrorism, war, fire, flood, earthquake or other natural disaster, explosion or civil commotion ("Force Majeure"). The performance of a party's obligations under this Agreement, to the extent affected by the delay, shall be suspended for the period during which the cause or the party's substantial inability to perform arising from the cause persists. If the performance of any obligation under this Agreement is excused or delayed by Force Majeure and that obligation is a condition precedent for the performance of an obligation by the other party, performance of the obligation by the second party shall be excused or delayed to the same extent as the performance of the obligation by the first party.

6.13. Construction. Notwithstanding that one Party may have prepared the initial draft of this Agreement or played the greater role in preparation of subsequent drafts of this Agreement, each Party agrees that it has negotiated at arm's length and had the opportunity for its legal counsel to review and revise this Agreement. Accordingly, both Parties shall be deemed the drafter of this Agreement and this Agreement shall be construed as though jointly prepared by the Parties, without favor to either Party. Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement or of any amendments, attachments, schedules, exhibits, or any other documents incorporated into this Agreement.

Mailed Notices to us will be addressed as follows: Blue Cross and Blue Shield of North Carolina P.O. Box 2291 Durham, NC 27702 Attn: Vice President, Network Management	Mailed Notices and Electronic notice, if sent by e-mail, to you will be addressed using the notice contact information that appears on the following signature page.

SIGNATURE PAGES FOLLOW

PAGE LEFT BLANK INTENTIONALLY AS A PLACEHOLDER
FOR THE PROVIDER SIGNATURE PAGE

PAGE LEFT BLANK INTENTIONALLY AS A PLACEHOLDER
FOR THE BLUE CROSS NC SIGNATURE PAGE

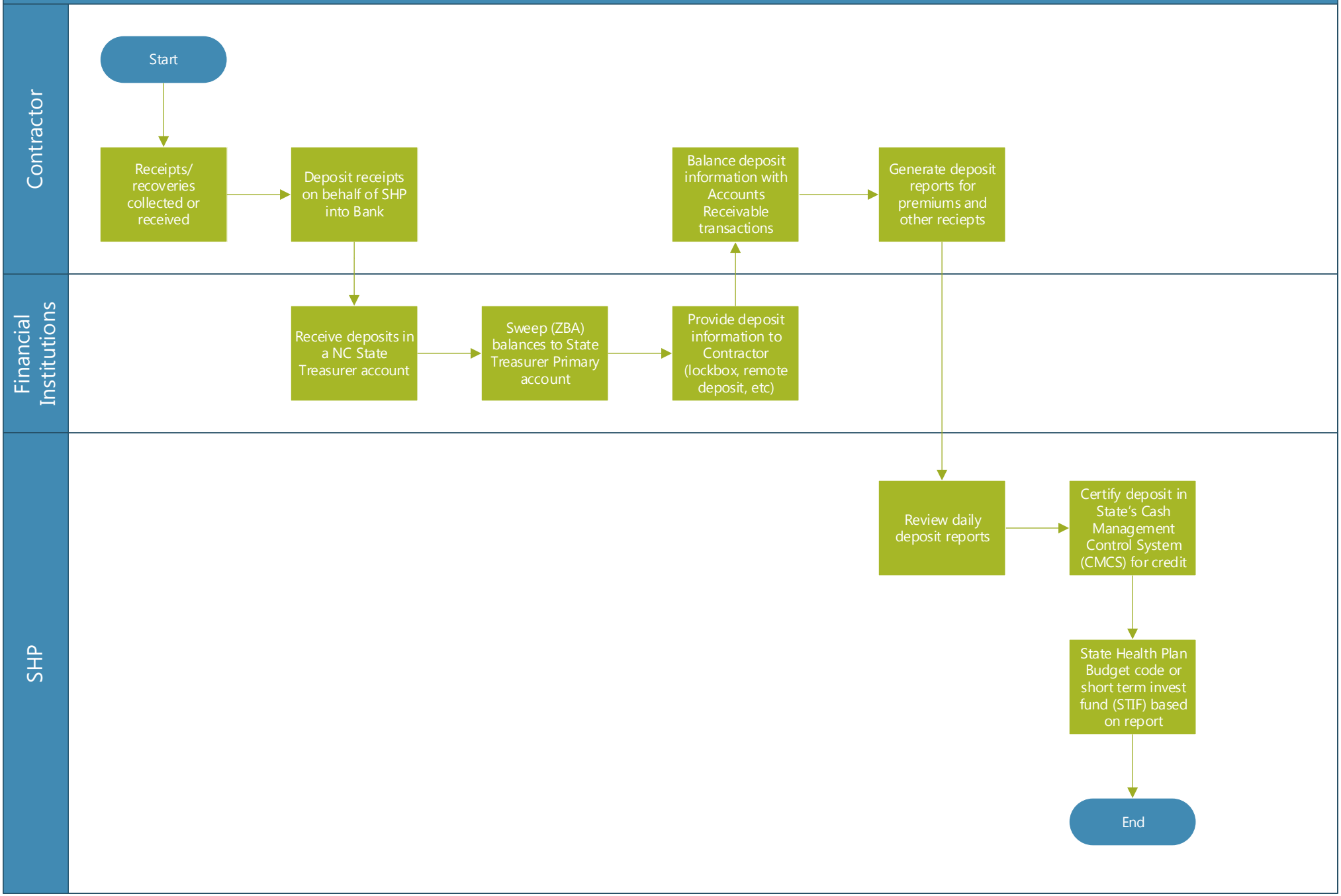
Exhibit 1

LIST OF EXHIBITS

Site of Service Exhibit
Practitioner Roster Exhibit
Reimbursement Exhibit (Fee Schedule)

Daily Deposit of State Funds through NCDST/ State Health Plan

Exhibit 2



Disbursement of Funds through State Health Plan

Exhibit 2

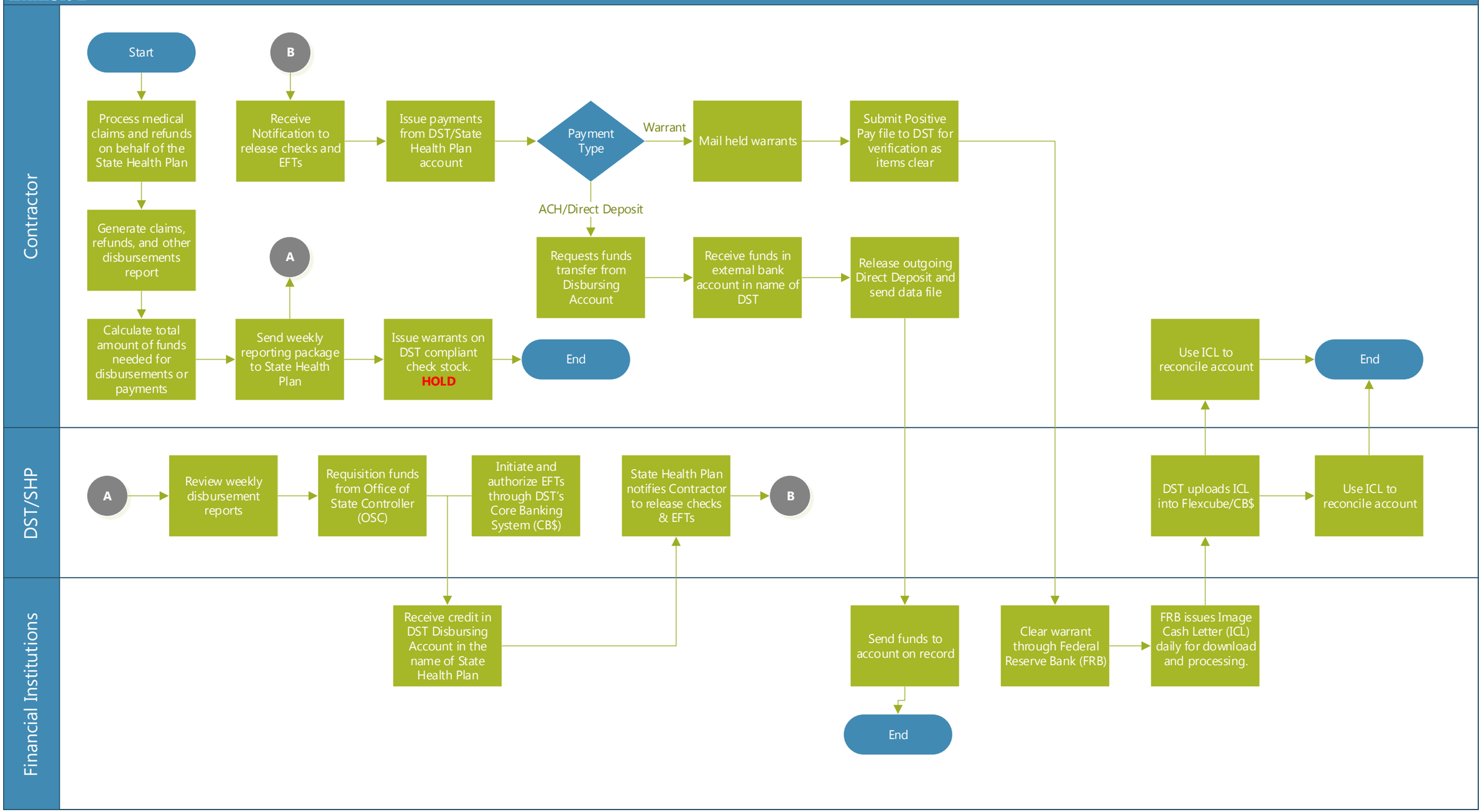


Exhibit 3

TPA Escheats Process

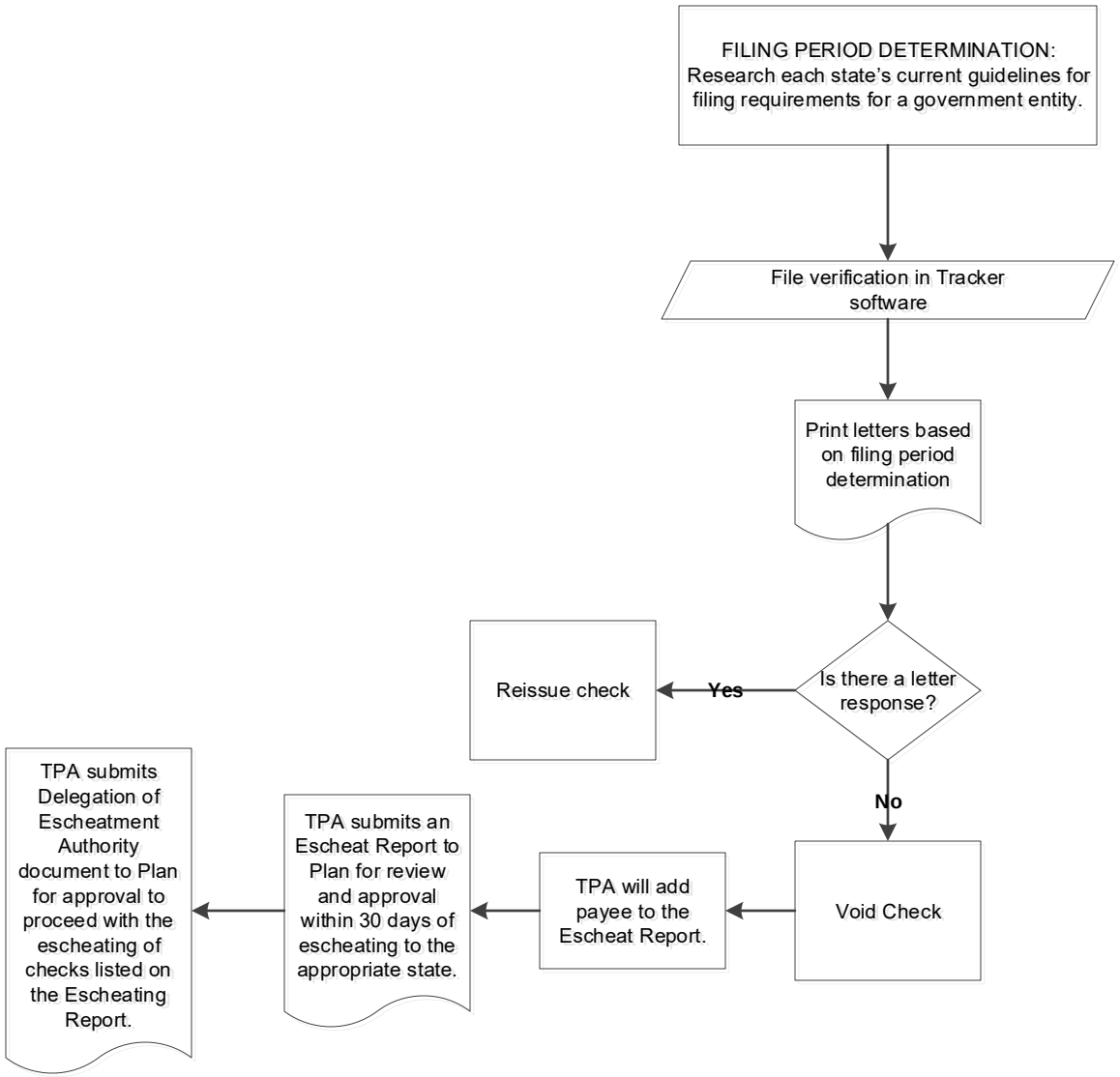


Exhibit 4

North Carolina State Health Plan Network Master Reimbursement Exhibit

Attachment - Consolidated Reimbursement Exhibit

Unless specifically noted elsewhere in this Agreement, the provisions in this Reimbursement Exhibit will govern the pricing and reimbursement of all services that are provided to State Health Plan Members under this Agreement and for which a pricing methodology is set forth or designated below.

Nothing in this Reimbursement Exhibit will obligate us to make payment to you on a claim for a service or supply that is not covered under the terms of the applicable Benefit Plan. Furthermore, the determination of a code-specific reimbursement rate/pricing methodology does not guarantee payment for the service.

1. GENERAL CLAIM REQUIREMENTS

a. Unless explicitly stated otherwise, all claims filed for items or services provided to State Health Plan Members must comply with all applicable Medicare billing guidelines[1].

2. PROFESSIONAL SERVICES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all professional services provided to State Health Plan Members under this Agreement.

a. General Pricing Principles

i. New Codes Introduced After Effective Date of This Agreement: Fees for services represented by CPT/HCPCS codes that are introduced after the effective date will be determined based on the hierarchy and criteria applicable to the Service Category on the new code.

ii. The Pricing Development and Maintenance Policy (the "Blue Cross NC Pricing Policy"), incorporated herein by reference, provides detailed information on access to the various pricing sources, and the process we use to develop, maintain, and update the reimbursement rates.

iii. Determination of the applicable reimbursement rate/pricing methodology is based on place of service.

iv. Except for services identified by Medicare as CLIA Excluded or CLIA Waiver, In-Office Laboratory Service fees will be limited to those services for which you have provided Blue Cross and Blue Shield of North Carolina with evidence of CLIA certification.

[1] Medicare billing guidelines can be accessed at:
1. https://www.cms.gov/Medicare/Medicare.html
2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html

b. *General Pricing Methodology for HCPCS Level I ("CPT") and Level II Codes*

Unless a service or code is excluded or subject to a different pricing methodology/source below, fees will be determined based upon HCPCS Level I ("CPT") or Level II codes using the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:

(i) 160% of Current North Carolina Medicare Part B Physician Fee Schedule[2] or if not available:

(ii) 160% of Optum Insight[2] as licensed by Blue Cross and Blue Shield of North Carolina or if none of the above sources contains a price for the applicable code, the Allowed Amount will be based upon:

(iii) Individual Consideration in accordance with the Blue Cross NC Pricing Policy, or if no price can be determined:

(iv) 50% of your Reasonable Charge

c. *Pricing Methodology for Specialty Pharmacy Medications*

i. All specialty pharmacy medications will be priced at 105% of the applicable price set by the Blue Cross and Blue Shield of North Carolina Specialty Pharmacy Drugs pricing hierarchy in the Blue Cross NC Pricing Policy.

d. *Pricing Methodology for Certain Designated Services*

Unless otherwise noted, the following services will be priced in accordance with the designated hierarchy and criteria as set forth in the Blue Cross NC Pricing Policy. The specific codes associated with the services and subject to the designated hierarchy are listed on the CCS/BETOS Fee Schedule Category and Code Listings, which are available through Blue Cross and Blue Shield of North Carolina's website.

BETOS/CCS Service Category	Service Category Description	Hierarchy/Criteria or Fixed Rate
200	Nonoperative Urinary System Measurements	160%
202	Electrocardiogram	160%
203	Electrographic Cardiac Monitoring	160%
205	Arterial Blood Gases	160%
206	Microscopic Examination (Bacterial Smear, Culture, Toxicology)	160%

[2] The "Current North Carolina Medicare Part B Physician Fee Schedule" will be the first Medicare fee schedule file published by CMS for an effective date of January 1. The Medicare Part B Physician Fee Schedule can be accessed at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

[3] You may obtain Optum Insight pricing information by contacting Blue Cross NC

212	Diagnostic Physical Therapy	160%
213	Physical Therapy Exercises, Manipulation, And Other Procedures	160%
215	Other Physical Therapy And Rehabilitation	160%
218	Psychological And Psychiatric Evaluation And Therapy	160%
219	Alcohol And Drug Rehabilitation/Detoxification	160%
220	Ophthalmologic And Otologic Diagnosis And Treatment	160%
222	Blood Transfusion	160%
227	Other Diagnostic Procedures (Interview, Evaluation, Consultation)	160%
228	Prophylactic vaccinations and inoculations	North Carolina State Health Plan Pricing Policy
233	Laboratory - Chemistry And Hematology	160%
234	Pathology	160%
235	Other Laboratory	160%
236	Home Health Services	125%
240	Medications (Injections, infusions and other forms)	North Carolina State Health Plan Pricing Policy
241	Visual Aids And Other Optical Supplies	DME Vision Hierarchy
242	Hearing devices and audiology supplies	DME Hearing Hierarchy
243	DME and Supplies	DMEPOS Hierarchy
243V	DME and Supplies – Vendor Only	DMEPOS Hierarchy
O1B	Chiropractic	160%
O1G	Immunizations/Vaccinations (Administration)	2018 Medicare Rates at 160%
T1A	Lab Tests - Routine Venipuncture (Non-Medicare Fee Schedule)	160%

e. *Services Excluded from Pricing under this Reimbursement Exhibit*

The following services and codes are excluded from reimbursement under this Agreement

(i) Routine Vision: CPT Codes 92002, 92004, 92012, S0620, S0621

3. ACUTE CARE HOSPITALS AND AMBULATORY SURGERY CENTERS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in an acute care hospital or ambulatory surgery center.

a. *Billing Requirements*

i. All services must be billed in accordance with applicable Medicare billing guidelines issued by CMS.

ii. All services must be billed on a UB04 or CMS-1500 or successor claim form, as

applicable, consistent with CMS implementation date and Medicare billing guidelines.

iii. Blue Cross and Blue Shield of North Carolina will update DRG, ICD-10 diagnosis, ICD-10 procedure, revenue, CPT, and HCPCS codes and code categorizations as new codes are created, without requiring amendment to this Agreement. Updates by CMS will be implemented no later than 30 days from their effective date with CMS, and will not result in claims reprocessing.

iv. Hospital billed CRNA services shall be filed on a CMS-1500 or successor claim form according to Medicare billing guidelines with the appropriate modifier(s), and reimbursement will be based on the Medicare CRNA fee schedule.

v. Blue Cross and Blue Shield of North Carolina will recognize and reimburse Level II HCPCS codes that have replaced Level I CPT codes by OPPS.

b. Inpatient Services

i. For acute care hospitals that qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy,[3] inpatient services will be priced based on 200% of the then current Medicare rate schedule based on the applicable CMS Medicare Inpatient Prospective Payment (IPPS) rates of Medicare Severity Diagnosis Related Groups (MS-DRGs) published on the CMS website on the date of the Member's discharge geographically adjusted, including associated add-on and outlier payments.

ii. For acute care hospitals that do not qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, inpatient services will be priced based on 175% of the then current Medicare rate schedule based on the applicable CMS Medicare Inpatient Prospective Payment (IPPS) rates of Medicare Severity Diagnosis Related Groups (MS-DRGs) published on the CMS website on the date of the Member's discharge geographically adjusted, including associated add-on and outlier payments.

iii. For services reimbursed under DRG methodology, outlier payments will be included as applicable.

iv. Blue Cross and Blue Shield of North Carolina will reimburse outlier claims consistent with CMS outlier methodology. Blue Cross and Blue Shield of North Carolina reserves the right to conduct retrospective review of claims and make necessary adjustments to such claims if certain services rendered are determined to be non-Covered Services or otherwise non-reimbursable under this Agreement.

[3] The State Health Plan Pricing Policy can be accessed online at: www.bluecrossnc.com/providers/ncstatehealthplannetwork and in the The Blue BookSM Provider e-Manual available at https://www.bluecrossnc.com/providers/emanuals/provider-blue-book

v. Provider agrees to submit claims but not be compensated for those hospital services that are non-reimbursable as identified in CMS' Hospital-Acquired Conditions and Present on Admission Indicator Reporting program, or successor program, in accordance with CMS payment policies.

vi. Blue Cross and Blue Shield of North Carolina will reimburse acute and post-acute transfer cases consistent with CMS methodology.

vii. Interim billing will not be payable under this Agreement.

viii. After an initial claim is submitted, replacement claims will be accepted, but separate claims for items or services that should have been billed on the initial claim, but were not, will not be accepted.

ix. Claim level lesser of logic does not apply to claims payment

c. *Outpatient Services*

i. For acute care hospitals that qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, outpatient services identified by CMS Outpatient Prospective Payment System (OPPS) Status codes will be priced based on 235% of the then current Medicare APC allowable rates, geographically adjusted.

ii. For acute care hospitals that do not qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, outpatient services identified by CMS Outpatient Prospective Payment System (OPPS) Status codes will be priced based on 225% of the then current Medicare APC allowable rates, geographically adjusted.

iii. Payment for outpatient services will follow CMS packaging rules and discounting policies.

iv. Outpatient payment rates under the APC reimbursement will be consistent with CMS reimbursement levels for the same outpatient services. Outpatient services included in APC Status code A will be reimbursed per the applicable Medicare fee schedule unless specified otherwise above.

v. For services reimbursed under APC methodology, outlier payments will be included as applicable.

vi. Blue Cross and Blue Shield of North Carolina will reimburse outlier claims consistent with CMS outlier methodology. Blue Cross and Blue Shield of North Carolina reserves the right to conduct retrospective review of claims and make necessary adjustments to such claims if certain services rendered are determined to be non-Covered Services or otherwise non-reimbursable under this Agreement.

vii. Interim billing will not be payable under this Agreement.

viii. After an initial claim is submitted, replacement claims will be accepted, but separate claims for items or services that should have been billed on the initial claim, but were not, will not be accepted.

ix. Claim level lesser of logic does not apply to payment. Line level lesser of logic will apply for items reimbursed under the Medicare fee schedule for a specific claim.

d. *Ambulatory Surgery Centers*

All outpatient services provided in an ambulatory surgery center will be priced based on 200% of the then current Medicare ASC allowable rates, geographically adjusted.

e. *Certain Facility Fees Excluded*

i. The following codes and code combinations are excluded from reimbursement/payment under this Agreement:

(i) Procedure codes G0463, 99201-99205 and 99211-99215 when billed in combination with revenue codes 0280, 0480, 0760-0769 or 0960-0989.

(ii) Services billed with the revenue codes 0510-0529

4. DIALYSIS FACILITIES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a dialysis facility.

a. 200% of current rate under the Medicare End State Renal Disease Prospective Payment System.

5. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in an FQHC.

a. For professional services billed on a CMS-1500 or successor form, 160%, and for technical services billed on a UB-04 form, 200% of current rate under the Medicare FQHC Prospective Payment System.

6. HOME HEALTH

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all home health services provided to State Health Plan Members under this Agreement.

a. 125% of current rate under the Medicare Home Health Prospective Payment System.

7. MEDICAL REHABILITATION HOSPITALS AND MEDICAL REHABILITATION DISTINCT PART UNITS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in medical rehab hospitals and medical rehab distinct part units:

a. *Inpatient Services*

i. 155% of current rate under the Medicare Inpatient Rehabilitation Facility Prospective Payment System.

b. *Outpatient Services at Medical Rehab Hospitals*

i. 200% of the then current Medicare APC allowable rates under the Outpatient Prospective Payment System, geographically adjusted.

8. INPATIENT PSYCHIATRIC HOSPITALS AND PSYCHIATRIC DISTINCT PART UNITS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in inpatient psychiatric hospitals and psychiatric distinct part units.

a. *Inpatient Services*

i. 155% of current rate under the Medicare Inpatient Psychiatric Facility Prospective Payment System.

b. *Outpatient Services at Inpatient Psychiatric Hospitals*

i. 200% of the then current Medicare APC allowable rates under the Outpatient Prospective Payment System, geographically adjusted.

9. LONG TERM ACUTE CARE HOSPITALS (LTAC)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a long term acute care hospital.

a. *Inpatient Services*

i. 155% of current rate under the Medicare Long Term Care Hospital Prospective Payment System.

b. *Outpatient Services*

i. 200% of the then current Medicare APC allowable rates under the Outpatient Prospective Payment System, geographically adjusted.

10. SKILLED NURSING FACILITIES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a skilled nursing facility.

a. 155% of current rate under the Medicare Skilled Nursing Prospective Payment System.

11. CRITICAL ACCESS HOSPITALS (CAH)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a critical access hospital.

a. For inpatient services, 200%, and for outpatient services, 235% of rate paid to the CAH under original Medicare at the time the claim is processed.

b. Any components of a CAH claim that are priced by Medicare based on 101% of the CAH's "reasonable cost" CAH claims will be paid based solely on the interim rate(s) in effect at the time the claim is processed and will not be subject to a final settlement after the applicable cost reports are filed.

12. REFERENCE LABORATORY SERVICES

Laboratory services billed under Place of Service 81 are not reimbursable under this Agreement.

13. ALL OTHER SERVICES

a. Any service that is not covered by Medicare (but is reimbursable under this Agreement) or is not subject to another pricing methodology or hierarchy as set forth in this Attachment shall be priced

based on a percentage of charge, case rate, per diem, fee schedule, per unit price or other applicable methodology specified in the North Carolina State Health Plan Pricing Policy.

North Carolina State Health Plan Pricing Policy (the "Plan Policy")
Published: June 21, 2019
Effective: January 1, 2020

This State Health Plan Pricing Policy applies to Blue Cross and Blue Shield of North Carolina's ("Blue Cross NC's") calculation of certain contractual allowances ("fees") for items and services delivered to and billed for Members of the North Carolina State Health Plan (the "Plan") under the North Carolina State Health Plan Network Participation Agreement (the "Plan NPA").

Rural Hospital Designation

For purposes of certain fee calculations that Blue Cross NC performs on behalf of the Plan under the Plan NPA, each facility listed on Schedule 1 to this Plan Policy is deemed a "Rural Hospital." Any facility or other provider that is not listed on Schedule 1 does not qualify for reimbursement as a "Rural Hospital" under the Plan NPA. Notwithstanding any contradictory provision in the Plan NPA or this Plan Policy that would allow for more frequent updates, Schedule 1 will be updated no more than once per year and any such update shall be made prior to November 1 of the calendar year in which it is made for an effective date of January 1st of the following year. For the sake of clarity, if Schedule 1 is updated in 2020, such update will issue prior to November 1, 2020 for an effective date of January 1, 2021.

General Pricing Principles

1. These general pricing principles apply to the pricing of all services for the Plan with the exception of professional services. The applicable principles for professional services are addressed in the separate "Pricing Development and Maintenance Policy BETOS/CCS."

2. When Plan pricing is based on rates published by Medicare, such rates will be updated at least once per year. Any updated rates will be effective when fully implemented for the Plan and will not be applied retroactively to claims that have previously been processed.

    a. On the effective date of this Plan Policy, all claims submitted on behalf of Plan Members will be priced in accordance with the most current rates that have been implemented for the Plan at that time.

3. For purposes of the Plan NPA and except where expressly stated otherwise, all references to "current" Medicare rates, rate schedules, fee schedules, or otherwise are referring to the applicable rates that have been fully implemented for the Plan at the time a claim is processed.

4. Nothing in this Pricing Policy will obligate the Plan to make payment on a claim for a service or supply that is not covered under the terms of the applicable Benefit Plan. Furthermore, the determination of a code-specific fee does not guarantee payment for the service.

5. In the event that any external pricing source reference listed in this Plan Policy changes (e.g. a new Medicare intermediary is selected), references in this Plan Policy will be deemed to refer to the superseding source.

Pricing For "All Other Services"

1. The pricing for All Other Services under Section 13 of the North Carolina State Health Plan Network Master Reimbursement Exhibit ("AOS Pricing") may be reviewed and/or updated from time to time.

2. Any updates to the AOS Pricing shall be made upon no less than 60-days notice in accordance with Section 2.3.1 of the Plan NPA.

3. Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated in the same manner as general codes.

4. Drug services that are not otherwise subject to pricing under an applicable pricing methodology may be priced using the National Drug Code for drugs that are filed using general or unlisted codes, or codes that may be used for multiple drugs.

5. DMEPOS items or services, which are not otherwise subject to pricing under an applicable pricing methodology, that are filed using general or unlisted codes must include the applicable manufacturer's invoice and will be priced at the lesser of your reasonable charge or 10% above the invoice price.

6. AOS Pricing is as follows:

    a. ***OCE #18 Codes*** - Certain procedures that CMS does not price or pay – and that are subject to denial under edit #18 in the Outpatient Code Editor ("OCE") – when performed in an outpatient setting will be priced in accordance with a clinically-comparable Ambulatory Payment Classification ("APC"). The relevant codes are listed under "Section I - OCE #18 Codes" in the attached Schedule 2.

    b. ***Misc. OCE Codes*** – Certain procedures that CMS does not price or pay – and that are subject to denial under OCE edits #9, 28, 50, 61, 62, 72 – will be priced at a fixed fee associated with the relevant code listed under "Section II – Misc. OCE Codes" in the attached Schedule 2.

    c. ***Addendum EE Codes*** – Certain procedures that CMS does not price or pay when performed in an ambulatory surgery center – and that are identified on Addendum EE published by CMS – will be priced based on a fixed case rate associated with the relevant code listed under "Section III – Addendum EE Codes" in the attached Schedule 2.

    d. ***All Other Codes*** – Any procedure or code that is subject to AOS Pricing, but cannot be priced in accordance with any of the foregoing provisions of this Plan Policy, will be priced based on Individual Consideration or, if no price can be determined, 50% of your reasonable charge, which shall be determined in accordance with Section 8, below.

7. Fee Determination for General or Unlisted Code and Codes designated Individual Consideration

    a. If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, a fee will be assigned for the more specific code to determine the fee under an applicable reimbursement policy.

b. The assignment of a fee for a given general or unlisted code does not preclude the assignment of a different fee for a subsequent service or procedure under the same code. The determination of a fee for a service billed for a given general or unlisted code may vary from a previously determined fee based on new or additional information that subsequently becomes available regarding the service in question or other similar services.

c. If a general code (e.g. 21499) or unlisted code is submitted because a code specific to the service or procedure is nonexistent, or a code is submitted where no pricing source is available, a fee will be assigned to the code. Pricing will be based upon fees paid to comparable providers for similar services under a similar health benefit plan and/or by applying a 12-month claims review to determine average allowed.

d. Some procedures charged separately by you may be combined into one procedure for reimbursement purposes under applicable policies and guidelines. Clinical judgment may be used to make these determinations, and medical records may be used to determine the specific service(s) rendered.

e. Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated in the same manner as general codes.

8. **Fee Determination Based on a Percentage of Your Reasonable Charge**

a. When application of the Plan Policy results in a fee for a given service based upon a percentage of your reasonable charge, you are obligated to ensure that: (1) all such charges billed are reasonable; (2) all such charges are consistent with your fiduciary duty to your patient and the Plan; (3) no charges are excessive in any respect; and (4) all such charges are consistent with and no greater than the amount regularly charged to other health plans.

Drug Services BETOS/CCS Categories 228 and 240

1. Drug Service fees will be updated on a quarterly basis.

2. Fees will be determined based upon the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:
   a. 105% of Blue Cross NC Specialty Pharmacy Drugs[1]
   b. 125% of CDC Private Sector Price[2]
   c. 100% of NC Medicare Part B Drug Fee Schedule, or if not available[3];
   d. 105% Wholesale Acquisition Cost, or if not available;
   e. 95% of Average Wholesale Price

If none of the above sources contain a price for the applicable code, the Allowed Amount will be based upon:

   f. Individual Consideration

[1] The Specialty Pharmacy Drug list with Drug Class (category) is available on the BlueCrossNC.com website on the following link: http://www.bcbsnc.com/assets/providers/public/pdfs/specialty_pharmacy_drugs_list.pdf

[2] All vaccines contained on the CDC Price List will be cross-walked to a CPT code. If more than one CDC listed Brandname/Tradename vaccine maps to a single CPT code, BCBSNC will apply the mean (average) Private Sector Cost/Dose price as the fee for the applicable CPT code. If the CDC Vaccine Price List contains more than one Private Sector Cost/Dose price for a particular Brandname/Tradename vaccine, BCBSNC will apply the lowest Private Sector Cost/Dose price when determining the fee.

[3] 1st published Medicare file to be effective on January 1.

Mid-Level Provider Reimbursement

1. The reimbursement rate for physician's assistants, nurse practitioners, family practice nurses, and nurse midwives will be 85% of the evaluation and management service categories' reimbursement rate.

2. The reimbursement rate for providers of behavioral health care services who do not hold a Medical Doctor (MD), Doctor of Philosophy in Psychology (PhD), or Doctor of Psychology (PsyD) degree will be 75% of the reimbursement rate for providers who hold a MD, PhD, or PsyD degree.

Hospice

The reimbursed rate for Hospice will be a Per Diem Rate based on Revenue Codes.

Revenue Code	Rate
651 – Routine Home Care Per Diem	$169.28
652 – Continuous Home Care Hourly Rate (Beginning with 9th Hour)	$35.85
655 – Inpatient Respite Care Per Diem	$156.96
656 – General Inpatient Care Non-Respite Per Diem	$661.02

Private Duty Nursing

Private duty nursing will be reimbursed at an hourly rate.

Revenue Code	Rate
552 – RN Hourly Rate	$55.00
559 – LPN Hourly Rate	$52.00

Birthing Centers

Birthing centers will be reimbursed using case rates.

Revenue Code & CPT/HCPCS Code	Rate
724 & CPT Code 59409 – Birthing Center Inclusive Rate	$3,160
724 & HCPCS Code S4005 – Interim Labor Facility Global	$1,920

Mobile Lithotripsy

Mobile Lithotripsy will be reimbursed using case rates.

Revenue Code & CPT/HCPCS Code	Rate
790 & CPT Code 50590	$4,200

Intensive Outpatient Programs

Intensive Outpatient Programs will be reimbursed with a Global Per Diem Rate. Global rate includes facility, professional, and ancillary services.

Revenue Code	Rate
905 – Intensive Outpatient – Psychiatric Global Per Diem	$266.00
906 – Intensive Outpatient – Chemical Dependency Global Per Diem	$245.00
912 – Partial Hospitalization Global Per Diem	$520.00
913 – Partial Hospitalization Global Per Diem	$520.00

Residential Psychiatric Treatment Centers

Residential Nervous and Mental Health Treatment Centers will be reimbursed at a per diem rate.

Service Type	Rate
Psychiatric Admission Per Diem	$840.00
Residential Treatment Admission Per Diem	$568.00

Alcohol Rehabilitation

Alcohol rehabilitation hospitals will be reimbursed at a per diem rate.

Revenue Code	Rate
126 – Inpatient Detox Per Diem	$630.00
128 – Inpatient Rehab Per Diem	$498.00
1002 – Inpatient Residential Treatment Chemical Dependency Per Diem	$422.00
906 – Outpatient Chemical Dependency Per Diem	$191.00
912 – Outpatient Partial Hospitalization Per Diem	$361.00

Chemical Dependency

Residential Chemical Dependency will be reimbursed at a per diem rate.

Revenue Code	Rate
129, 1001, or 1002 – Inpatient Per Diem	$510.00
949 – Outpatient Rehab Per Diem	$47.50

Qualified Non-physician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure

Where a single anesthesia procedure involves both a physician medical direction service, and the service of the medically directed qualified non-physician anesthetist, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. For the single medically directed service, the physician will use the QY modifier and the qualified non-physician anesthetist will use the QX modifier.

North Carolina State Health Plan Pricing Policy
Schedule 1 - Rural Hospitals - Effective 1/1/2020

Alamance Regional Medical Center
Alleghany Memorial Hospital
Angel Medical Center
Annie Penn Hospital
Ashe Memorial Hospital, Inc.
Atrium Anson Hospital
Atrium Blue Ridge Hospital
Atrium Cleveland Hospital
Atrium Kings Mountain Hospital
Atrium Lincoln Hospital
Atrium Northeast Hospital
Atrium Stanly Hospital
Atrium Union Hospital
Betsy Johnson Regional Hospital
Bladen County Hospital
Blue Ridge Regional Hospital
Caldwell Memorial Hospital
Cape Fear Valley Hoke Hospital
Cape Fear Valley Medical Center
CarolinaEast Medical Center
CaroMont Regional Medical Center
Carteret General Hospital
Catawba Valley Medical Center
Central Carolina Hospital
Central Harnett Hospital
Charles A. Cannon, Jr. Memorial Hospital
Chatham Hospital
Columbus Regional Medical Center
Davie County Hospital
Davis Regional Medical Center

North Carolina State Health Plan Pricing Policy
Schedule 1 - Rural Hospitals - Effective 1/1/2020

Erlanger Western Carolina Hospital
FirstHealth Montgomery Memorial Hospital
FirstHealth Moore Regional Hospital
Frye Regional Medical Center
Granville Medical Center
Halifax Regional Medical Center
Harris Regional Medical Center
Haywood Regional Medical Center
Highlands-Cashiers Hospital
Hugh Chatham Memorial Hospital
Iredell Memorial Hospital
J. Arthur Dosher Memorial Hospital
Johnston Memorial Hospital
Lake Norman Regional Medical Center
Lenoir Memorial Hospital
Lexington Memorial Hospital
Margaret R. Pardee Memorial Hospital
Maria Parham Medical Center
Martin General Hospital
McDowell Hospital
Mission Hospital
Nash General Hospital
New Hanover Regional Medical Center
Northern Hospital of Surry County
Novant Health Brunswick Medical Center
Novant Health Rowan Medical Center
Novant Health Thomasville Medical Center
Onslow Memorial Hospital
Park Ridge Health/Advent Health
Pender Memorial Hospital

North Carolina State Health Plan Pricing Policy
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Person Memorial Hospital
Randolph Hospital
Rutherford Regional Medical Center
Sampson Regional Medical Center
Scotland Memorial Hospital
Sentara Albemarle Medical Center
Southeastern Regional Medical Center
St. Luke's Hospital
Swain Community Hospital
The Outer Banks Hospital
Transylvania Regional Hospital
UNC Medical Center
UNC Rockingham Health Care
Vidant Beaufort Hospital
Vidant Bertie Hospital
Vidant Chowan Hospital
Vidant Duplin Hospital
Vidant Edgecombe Hospital
Vidant Medical Center
Vidant Roanoke-Chowan Hospital
Washington County Hospital
Watauga Medical Center, Inc.
Wayne Memorial Hospital
Wilkes Regional Medical Center
Wilson Medical Center

North Carolina State Health Plan Pricing Policy
Schedule 2 - AOS Pricing Codes Effective Date: 1/1/2020

	HCPCS Code	Short Description
Section I - OCE #18 Codes:	TBD	
Section II - Misc. OCE Codes:	TBD	
Section III - Addendum EE Codes:	00176	Anesth pharyngeal surgery
	00192	Anesth facial bone surgery
	00211	Anesth cran surg hemotoma
	00214	Anesth skull drainage
	00215	Anesth skull repair/fract
	00474	Anesth surgery of rib
	00524	Anesth chest drainage
	00540	Anesth chest surgery
	00542	Anesthesia removal pleura
	00546	Anesth lung chest wall surg
	00560	Anesth heart surg w/o pump
	00561	Anesth heart surg <1 yr
	00562	Anesth hrt surg w/pmp age 1+
	00567	Anesth cabg w/pump
	00580	Anesth heart/lung transplnt
	00604	Anesth sitting procedure
	00632	Anesth removal of nerves
	00670	Anesth spine cord surgery
	0075T	Perq stent/chest vert art
	0076T	S&i stent/chest vert art
	00792	Anesth hemorr/excise liver
	00794	Anesth pancreas removal
	00796	Anesth for liver transplant
	00802	Anesth fat layer removal
	00844	Anesth pelvis surgery
	00846	Anesth hysterectomy
	00848	Anesth pelvic organ surg
	00864	Anesth removal of bladder
	00865	Anesth removal of prostate
	00866	Anesth removal of adrenal
	00868	Anesth kidney transplant
	00882	Anesth major vein ligation
	00904	Anesth perineal surgery
	00908	Anesth removal of prostate
	00932	Anesth amputation of penis
	00934	Anesth penis nodes removal
	00936	Anesth penis nodes removal
	00944	Anesth vaginal hysterectomy
	0095T	Rmvl artific disc addl crvcl

HCPCS Code	Short Description
0098T	Rev artific disc addl
01140	Anesth amputation at pelvis
01150	Anesth pelvic tumor surgery
01212	Anesth hip disarticulation
01214	Anesth hip arthroplasty
01232	Anesth amputation of femur
01234	Anesth radical femur surg
01272	Anesth femoral artery surg
01274	Anesth femoral embolectomy
01402	Anesth knee arthroplasty
01404	Anesth amputation at knee
01442	Anesth knee artery surg
01444	Anesth knee artery repair
01486	Anesth ankle replacement
01502	Anesth lwr leg embolectomy
01634	Anesth shoulder joint amput
01636	Anesth forequarter amput
01638	Anesth shoulder replacement
0163T	Lumb artif diskectomy addl
0164T	Remove lumb artif disc addl
01652	Anesth shoulder vessel surg
01654	Anesth shoulder vessel surg
01656	Anesth arm-leg vessel surg
0165T	Revise lumb artif disc addl
01756	Anesth radical humerus surg
0184T	Exc rectal tumor endoscopic
01990	Support for organ donor
0202T	Post vert arthrplst 1 lumbar
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0235T	Trluml perip athrc visceral
0254T	Evasc rpr iliac art bifur
0266T	Implt/rpl crtd sns dev total
0267T	Implt/rpl crtd sns dev lead
0268T	Implt/rpl crtd sns dev gen
0312T	Laps impltj nstim vagus
0345T	Transcath mtral vlve repair
0375T	Total disc arthrp ant appr
0404T	Trnscrv uterin fibroid abltj
0451T	Insj/rplcmt aortic ventr sys
0452T	Insj/rplcmt dev vasc seal

HCPCS Code	Short Description
0453T	Insj/rplcmt mech-elec ntrfce
0454T	Insj/rplcmt subq electrode
0455T	Remvl aortic ventr cmpl sys
0456T	Remvl aortic dev vasc seal
0457T	Remvl mech-elec skin ntrfce
0458T	Remvl subq electrode
0459T	Relocaj rplcmt aortic ventr
0460T	Repos aortic ventr dev eltrd
0461T	Repos aortic contrpulsj dev
0483T	Tmvi percutaneous approach
0484T	Tmvi transthoracic exposure
0494T	Prep & cannulj cdvr don lung
0495T	Mntr cdvr don lng 1st 2 hrs
0496T	Mntr cdvr don lng ea addl hr
0505T	Ev fempop artl revsc
0515T	Insj wcs lv compl sys
0516T	Insj wcs lv eltrd only
0517T	Insj wcs lv pg compnt
0518T	Rmvl pg compnt wcs
0519T	Rmvl & rplcmt pg compnt wcs
0520T	Rmvl&rplcmt pg wcs new eltrd
11004	Debride genitalia & perineum
11005	Debride abdom wall
11006	Debride genit/per/abdom wall
11008	Remove mesh from abd wall
15756	Free myo/skin flap microvasc
15757	Free skin flap microvasc
15758	Free fascial flap microvasc
15999	Removal of pressure sore
16036	Escharotomy addl incision
17999	Skin tissue procedure
19260	Removal of chest wall lesion
19271	Revision of chest wall
19272	Extensive chest wall surgery
19305	Mast radical
19306	Mast rad urban type
19307	Mast mod rad
19361	Breast reconstr w/lat flap
19364	Breast reconstruction
19367	Breast reconstruction
19368	Breast reconstruction
19369	Breast reconstruction
19499	Breast surgery procedure

HCPCS Code	Short Description
20100	Explore wound neck
20101	Explore wound chest
20102	Explore wound abdomen
20660	Apply rem fixation device
20661	Application of head brace
20664	Application of halo
20802	Replantation arm complete
20805	Replant forearm complete
20808	Replantation hand complete
20816	Replantation digit complete
20824	Replantation thumb complete
20827	Replantation thumb complete
20838	Replantation foot complete
20955	Fibula bone graft microvasc
20956	Iliac bone graft microvasc
20957	Mt bone graft microvasc
20962	Other bone graft microvasc
20969	Bone/skin graft microvasc
20970	Bone/skin graft iliac crest
20999	Musculoskeletal surgery
21045	Extensive jaw surgery
21049	Excis uppr jaw cyst w/repair
21089	Prepare face/oral prosthesis
21141	Lefort i-1 piece w/o graft
21142	Lefort i-2 piece w/o graft
21143	Lefort i-3/> piece w/o graft
21145	Lefort i-1 piece w/ graft
21146	Lefort i-2 piece w/ graft
21147	Lefort i-3/> piece w/ graft
21151	Lefort ii w/bone grafts
21154	Lefort iii w/o lefort i
21155	Lefort iii w/ lefort i
21159	Lefort iii w/fhdw/o lefort i
21160	Lefort iii w/fhd w/ lefort i
21172	Reconstruct orbit/forehead
21175	Reconstruct orbit/forehead
21179	Reconstruct entire forehead
21180	Reconstruct entire forehead
21182	Reconstruct cranial bone
21183	Reconstruct cranial bone
21184	Reconstruct cranial bone
21188	Reconstruction of midface
21193	Reconst lwr jaw w/o graft

HCPCS Code	Short Description
21194	Reconst lwr jaw w/graft
21195	Reconst lwr jaw w/o fixation
21196	Reconst lwr jaw w/fixation
21247	Reconstruct lower jaw bone
21255	Reconstruct lower jaw bone
21256	Reconstruction of orbit
21261	Revise eye sockets
21263	Revise eye sockets
21268	Revise eye sockets
21299	Cranio/maxillofacial surgery
21343	Open tx dprsd front sinus fx
21344	Open tx compl front sinus fx
21346	Opn tx nasomax fx w/fixj
21347	Opn tx nasomax fx multple
21348	Opn tx nasomax fx w/graft
21365	Opn tx complx malar fx
21366	Opn tx complx malar w/grft
21385	Opn tx orbit fx transantral
21386	Opn tx orbit fx periorbital
21387	Opn tx orbit fx combined
21395	Opn tx orbit periorbt w/grft
21408	Opn tx orbit fx w/bone grft
21422	Treat mouth roof fracture
21423	Treat mouth roof fracture
21431	Treat craniofacial fracture
21432	Treat craniofacial fracture
21433	Treat craniofacial fracture
21435	Treat craniofacial fracture
21436	Treat craniofacial fracture
21470	Treat lower jaw fracture
21499	Head surgery procedure
21510	Drainage of bone lesion
21615	Removal of rib
21616	Removal of rib and nerves
21620	Partial removal of sternum
21627	Sternal debridement
21630	Extensive sternum surgery
21632	Extensive sternum surgery
21705	Revision of neck muscle/rib
21740	Reconstruction of sternum
21742	Repair stern/nuss w/o scope
21743	Repair sternum/nuss w/scope
21750	Repair of sternum separation

HCPCS Code	Short Description
21825	Treat sternum fracture
21899	Neck/chest surgery procedure
22010	I&d p-spine c/t/cerv-thor
22015	I&d abscess p-spine l/s/ls
22100	Remove part of neck vertebra
22101	Remove part thorax vertebra
22110	Remove part of neck vertebra
22112	Remove part thorax vertebra
22114	Remove part lumbar vertebra
22116	Remove extra spine segment
22206	Incis spine 3 column thorac
22207	Incis spine 3 column lumbar
22208	Incis spine 3 column adl seg
22210	Incis 1 vertebral seg cerv
22212	Incis 1 vertebral seg thorac
22214	Incis 1 vertebral seg lumbar
22216	Incis addl spine segment
22220	Incis w/discectomy cervical
22222	Incis w/discectomy thoracic
22224	Incis w/discectomy lumbar
22226	Revise extra spine segment
22318	Treat odontoid fx w/o graft
22319	Treat odontoid fx w/graft
22325	Treat spine fracture
22326	Treat neck spine fracture
22327	Treat thorax spine fracture
22328	Treat each add spine fx
22532	Lat thorax spine fusion
22533	Lat lumbar spine fusion
22534	Lat thor/lumb addl seg
22548	Neck spine fusion
22556	Thorax spine fusion
22558	Lumbar spine fusion
22586	Prescrl fuse w/ instr l5-s1
22590	Spine & skull spinal fusion
22595	Neck spinal fusion
22600	Neck spine fusion
22610	Thorax spine fusion
22630	Lumbar spine fusion
22632	Spine fusion extra segment
22633	Lumbar spine fusion combined
22634	Spine fusion extra segment
22800	Post fusion </6 vert seg

HCPCS Code	Short Description
22802	Post fusion 7-12 vert seg
22804	Post fusion 13/> vert seg
22808	Ant fusion 2-3 vert seg
22810	Ant fusion 4-7 vert seg
22812	Ant fusion 8/> vert seg
22818	Kyphectomy 1-2 segments
22819	Kyphectomy 3 or more
22830	Exploration of spinal fusion
22841	Insert spine fixation device
22843	Insert spine fixation device
22844	Insert spine fixation device
22846	Insert spine fixation device
22847	Insert spine fixation device
22848	Insert pelv fixation device
22849	Reinsert spinal fixation
22850	Remove spine fixation device
22852	Remove spine fixation device
22855	Remove spine fixation device
22857	Lumbar artif diskectomy
22861	Revise cerv artific disc
22862	Revise lumbar artif disc
22864	Remove cerv artif disc
22865	Remove lumb artif disc
22899	Spine surgery procedure
22999	Abdomen surgery procedure
23200	Resect clavicle tumor
23210	Resect scapula tumor
23220	Resect prox humerus tumor
23335	Shoulder prosthesis removal
23470	Reconstruct shoulder joint
23472	Reconstruct shoulder joint
23473	Revis reconst shoulder joint
23474	Revis reconst shoulder joint
23900	Amputation of arm & girdle
23920	Amputation at shoulder joint
23929	Shoulder surgery procedure
24150	Resect distal humerus tumor
24900	Amputation of upper arm
24920	Amputation of upper arm
24930	Amputation follow-up surgery
24931	Amputate upper arm & implant
24935	Revision of amputation
24940	Revision of upper arm

HCPCS Code	Short Description
24999	Upper arm/elbow surgery
25170	Resect radius/ulnar tumor
25900	Amputation of forearm
25905	Amputation of forearm
25909	Amputation follow-up surgery
25915	Amputation of forearm
25920	Amputate hand at wrist
25924	Amputation follow-up surgery
25927	Amputation of hand
25999	Forearm or wrist surgery
26551	Great toe-hand transfer
26553	Single transfer toe-hand
26554	Double transfer toe-hand
26556	Toe joint transfer
26989	Hand/finger surgery
26992	Drainage of bone lesion
27005	Incision of hip tendon
27006	Incision of hip tendons
27025	Incision of hip/thigh fascia
27027	Buttock fasciotomy
27030	Drainage of hip joint
27036	Excision of hip joint/muscle
27054	Removal of hip joint lining
27057	Buttock fasciotomy w/dbrdmt
27070	Part remove hip bone super
27071	Part removal hip bone deep
27075	Resect hip tumor
27076	Resect hip tum incl acetabul
27077	Resect hip tum w/innom bone
27078	Rsect hip tum incl femur
27090	Removal of hip prosthesis
27091	Removal of hip prosthesis
27120	Reconstruction of hip socket
27122	Reconstruction of hip socket
27125	Partial hip replacement
27130	Total hip arthroplasty
27132	Total hip arthroplasty
27134	Revise hip joint replacement
27137	Revise hip joint replacement
27138	Revise hip joint replacement
27140	Transplant femur ridge
27146	Incision of hip bone
27147	Revision of hip bone

HCPCS Code	Short Description
27151	Incision of hip bones
27156	Revision of hip bones
27158	Revision of pelvis
27161	Incision of neck of femur
27165	Incision/fixation of femur
27170	Repair/graft femur head/neck
27175	Treat slipped epiphysis
27176	Treat slipped epiphysis
27177	Treat slipped epiphysis
27178	Treat slipped epiphysis
27179	Revise head/neck of femur
27181	Treat slipped epiphysis
27185	Revision of femur epiphysis
27187	Reinforce hip bones
27222	Treat hip socket fracture
27226	Treat hip wall fracture
27227	Treat hip fracture(s)
27228	Treat hip fracture(s)
27232	Treat thigh fracture
27235	Treat thigh fracture
27236	Treat thigh fracture
27240	Treat thigh fracture
27244	Treat thigh fracture
27245	Treat thigh fracture
27248	Treat thigh fracture
27253	Treat hip dislocation
27254	Treat hip dislocation
27258	Treat hip dislocation
27259	Treat hip dislocation
27268	Cltx thigh fx w/mnpj
27269	Optx thigh fx
27280	Fusion of sacroiliac joint
27282	Fusion of pubic bones
27284	Fusion of hip joint
27286	Fusion of hip joint
27290	Amputation of leg at hip
27295	Amputation of leg at hip
27299	Pelvis/hip joint surgery
27303	Drainage of bone lesion
27365	Resect femur/knee tumor
27412	Autochondrocyte implant knee
27445	Revision of knee joint
27447	Total knee arthroplasty

HCPCS Code	Short Description
27448	Incision of thigh
27450	Incision of thigh
27454	Realignment of thigh bone
27455	Realignment of knee
27457	Realignment of knee
27465	Shortening of thigh bone
27466	Lengthening of thigh bone
27468	Shorten/lengthen thighs
27470	Repair of thigh
27472	Repair/graft of thigh
27477	Surgery to stop leg growth
27485	Surgery to stop leg growth
27486	Revise/replace knee joint
27487	Revise/replace knee joint
27488	Removal of knee prosthesis
27495	Reinforce thigh
27506	Treatment of thigh fracture
27507	Treatment of thigh fracture
27511	Treatment of thigh fracture
27513	Treatment of thigh fracture
27514	Treatment of thigh fracture
27519	Treat thigh fx growth plate
27535	Treat knee fracture
27536	Treat knee fracture
27540	Treat knee fracture
27556	Treat knee dislocation
27557	Treat knee dislocation
27558	Treat knee dislocation
27580	Fusion of knee
27590	Amputate leg at thigh
27591	Amputate leg at thigh
27592	Amputate leg at thigh
27596	Amputation follow-up surgery
27598	Amputate lower leg at knee
27599	Leg surgery procedure
27645	Resect tibia tumor
27646	Resect fibula tumor
27702	Reconstruct ankle joint
27703	Reconstruction ankle joint
27712	Realignment of lower leg
27715	Revision of lower leg
27722	Repair/graft of tibia
27724	Repair/graft of tibia

HCPCS Code	Short Description
27725	Repair of lower leg
27727	Repair of lower leg
27880	Amputation of lower leg
27881	Amputation of lower leg
27882	Amputation of lower leg
27886	Amputation follow-up surgery
27888	Amputation of foot at ankle
27899	Leg/ankle surgery procedure
28360	Reconstruct cleft foot
28800	Amputation of midfoot
28805	Amputation thru metatarsal
28899	Foot/toes surgery procedure
29799	Casting/strapping procedure
29867	Allgrft implnt knee w/scope
29868	Meniscal trnspl knee w/scpe
29999	Arthroscopy of joint
30999	Nasal surgery procedure
31225	Removal of upper jaw
31230	Removal of upper jaw
31241	Nsl/sins ndsc w/artery lig
31290	Nasal/sinus endoscopy surg
31291	Nasal/sinus endoscopy surg
31292	Nasal/sinus endoscopy surg
31293	Nasal/sinus endoscopy surg
31294	Nasal/sinus endoscopy surg
31299	Sinus surgery procedure
31360	Removal of larynx
31365	Removal of larynx
31367	Partial removal of larynx
31368	Partial removal of larynx
31370	Partial removal of larynx
31375	Partial removal of larynx
31380	Partial removal of larynx
31382	Partial removal of larynx
31390	Removal of larynx & pharynx
31395	Reconstruct larynx & pharynx
31584	Laryngoplasty fx rdctj fixj
31587	Laryngoplasty cricoid split
31599	Larynx surgery procedure
31600	Incision of windpipe
31601	Incision of windpipe
31610	Incision of windpipe
31660	Bronch thermoplsty 1 lobe

HCPCS Code	Short Description
31661	Bronch thermoplsty 2/> lobes
31725	Clearance of airways
31760	Repair of windpipe
31766	Reconstruction of windpipe
31770	Repair/graft of bronchus
31775	Reconstruct bronchus
31780	Reconstruct windpipe
31781	Reconstruct windpipe
31785	Remove windpipe lesion
31786	Remove windpipe lesion
31800	Repair of windpipe injury
31805	Repair of windpipe injury
31899	Airways surgical procedure
32035	Thoracostomy w/rib resection
32036	Thoracostomy w/flap drainage
32096	Open wedge/bx lung infiltr
32097	Open wedge/bx lung nodule
32098	Open biopsy of lung pleura
32100	Exploration of chest
32110	Explore/repair chest
32120	Re-exploration of chest
32124	Explore chest free adhesions
32140	Removal of lung lesion(s)
32141	Remove/treat lung lesions
32150	Removal of lung lesion(s)
32151	Remove lung foreign body
32160	Open chest heart massage
32200	Drain open lung lesion
32215	Treat chest lining
32220	Release of lung
32225	Partial release of lung
32310	Removal of chest lining
32320	Free/remove chest lining
32440	Remove lung pneumonectomy
32442	Sleeve pneumonectomy
32445	Removal of lung extrapleural
32480	Partial removal of lung
32482	Bilobectomy
32484	Segmentectomy
32486	Sleeve lobectomy
32488	Completion pneumonectomy
32491	Lung volume reduction
32501	Repair bronchus add-on

HCPCS Code	Short Description
32503	Resect apical lung tumor
32504	Resect apical lung tum/chest
32505	Wedge resect of lung initial
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
32540	Removal of lung lesion
32551	Insertion of chest tube
32560	Treat pleurodesis w/agent
32561	Lyse chest fibrin init day
32562	Lyse chest fibrin subq day
32601	Thoracoscopy diagnostic
32604	Thoracoscopy wbx sac
32606	Thoracoscopy w/bx med space
32607	Thoracoscopy w/bx infiltrate
32608	Thoracoscopy w/bx nodule
32609	Thoracoscopy w/bx pleura
32650	Thoracoscopy w/pleurodesis
32651	Thoracoscopy remove cortex
32652	Thoracoscopy rem totl cortex
32653	Thoracoscopy remov fb/fibrin
32654	Thoracoscopy contrl bleeding
32655	Thoracoscopy resect bullae
32656	Thoracoscopy w/pleurectomy
32658	Thoracoscopy w/sac fb remove
32659	Thoracoscopy w/sac drainage
32661	Thoracoscopy w/pericard exc
32662	Thoracoscopy w/mediast exc
32663	Thoracoscopy w/lobectomy
32664	Thoracoscopy w/ th nrv exc
32665	Thoracoscop w/esoph musc exc
32666	Thoracoscopy w/wedge resect
32667	Thoracoscopy w/w resect addl
32668	Thoracoscopy w/w resect diag
32669	Thoracoscopy remove segment
32670	Thoracoscopy bilobectomy
32671	Thoracoscopy pneumonectomy
32672	Thoracoscopy for lvrs
32673	Thoracoscopy w/thymus resect
32674	Thoracoscopy lymph node exc
32800	Repair lung hernia
32810	Close chest after drainage
32815	Close bronchial fistula
32820	Reconstruct injured chest

HCPCS Code	Short Description
32850	Donor pneumonectomy
32851	Lung transplant single
32852	Lung transplant with bypass
32853	Lung transplant double
32854	Lung transplant with bypass
32855	Prepare donor lung single
32856	Prepare donor lung double
32900	Removal of rib(s)
32905	Revise & repair chest wall
32906	Revise & repair chest wall
32940	Revision of lung
32997	Total lung lavage
32999	Chest surgery procedure
33015	Incision of heart sac
33020	Incision of heart sac
33025	Incision of heart sac
33030	Partial removal of heart sac
33031	Partial removal of heart sac
33050	Resect heart sac lesion
33120	Removal of heart lesion
33130	Removal of heart lesion
33140	Heart revascularize (tmr)
33141	Heart tmr w/other procedure
33202	Insert epicard eltrd open
33203	Insert epicard eltrd endo
33236	Remove electrode/thoracotomy
33237	Remove electrode/thoracotomy
33238	Remove electrode/thoracotomy
33243	Remove eltrd/thoracotomy
33244	Remove elctrd transvenously
33250	Ablate heart dysrhythm focus
33251	Ablate heart dysrhythm focus
33254	Ablate atria lmtd
33255	Ablate atria w/o bypass ext
33256	Ablate atria w/bypass exten
33257	Ablate atria lmtd add-on
33258	Ablate atria x10sv add-on
33259	Ablate atria w/bypass add-on
33261	Ablate heart dysrhythm focus
33265	Ablate atria lmtd endo
33266	Ablate atria x10sv endo
33272	Rmvl of subq defibrillator
33300	Repair of heart wound

HCPCS Code	Short Description
33305	Repair of heart wound
33310	Exploratory heart surgery
33315	Exploratory heart surgery
33320	Repair major blood vessel(s)
33321	Repair major vessel
33322	Repair major blood vessel(s)
33330	Insert major vessel graft
33335	Insert major vessel graft
33340	Perq clsr tcat l atr apndge
33361	Replace aortic valve perq
33362	Replace aortic valve open
33363	Replace aortic valve open
33364	Replace aortic valve open
33365	Replace aortic valve open
33366	Trcath replace aortic valve
33367	Replace aortic valve w/byp
33368	Replace aortic valve w/byp
33369	Replace aortic valve w/byp
33390	Valvuloplasty aortic valve
33391	Valvuloplasty aortic valve
33404	Prepare heart-aorta conduit
33405	Replacement aortic valve opn
33406	Replacement aortic valve opn
33410	Replacement aortic valve opn
33411	Replacement of aortic valve
33412	Replacement of aortic valve
33413	Replacement of aortic valve
33414	Repair of aortic valve
33415	Revision subvalvular tissue
33416	Revise ventricle muscle
33417	Repair of aortic valve
33418	Repair tcat mitral valve
33420	Revision of mitral valve
33422	Revision of mitral valve
33425	Repair of mitral valve
33426	Repair of mitral valve
33427	Repair of mitral valve
33430	Replacement of mitral valve
33440	Rplcmt a-valve tlcj autol pv
33460	Revision of tricuspid valve
33463	Valvuloplasty tricuspid
33464	Valvuloplasty tricuspid
33465	Replace tricuspid valve

HCPCS Code	Short Description
33468	Revision of tricuspid valve
33470	Revision of pulmonary valve
33471	Valvotomy pulmonary valve
33474	Revision of pulmonary valve
33475	Replacement pulmonary valve
33476	Revision of heart chamber
33477	Implant tcat pulm vlv perq
33478	Revision of heart chamber
33496	Repair prosth valve clot
33500	Repair heart vessel fistula
33501	Repair heart vessel fistula
33502	Coronary artery correction
33503	Coronary artery graft
33504	Coronary artery graft
33505	Repair artery w/tunnel
33506	Repair artery translocation
33507	Repair art intramural
33510	Cabg vein single
33511	Cabg vein two
33512	Cabg vein three
33513	Cabg vein four
33514	Cabg vein five
33516	Cabg vein six or more
33517	Cabg artery-vein single
33518	Cabg artery-vein two
33519	Cabg artery-vein three
33521	Cabg artery-vein four
33522	Cabg artery-vein five
33523	Cabg art-vein six or more
33530	Coronary artery bypass/reop
33533	Cabg arterial single
33534	Cabg arterial two
33535	Cabg arterial three
33536	Cabg arterial four or more
33542	Removal of heart lesion
33545	Repair of heart damage
33548	Restore/remodel ventricle
33572	Open coronary endarterectomy
33600	Closure of valve
33602	Closure of valve
33606	Anastomosis/artery-aorta
33608	Repair anomaly w/conduit
33610	Repair by enlargement

HCPCS Code	Short Description
33611	Repair double ventricle
33612	Repair double ventricle
33615	Repair modified fontan
33617	Repair single ventricle
33619	Repair single ventricle
33620	Apply r&l pulm art bands
33621	Transthor cath for stent
33622	Redo compl cardiac anomaly
33641	Repair heart septum defect
33645	Revision of heart veins
33647	Repair heart septum defects
33660	Repair of heart defects
33665	Repair of heart defects
33670	Repair of heart chambers
33675	Close mult vsd
33676	Close mult vsd w/resection
33677	Cl mult vsd w/rem pul band
33681	Repair heart septum defect
33684	Repair heart septum defect
33688	Repair heart septum defect
33690	Reinforce pulmonary artery
33692	Repair of heart defects
33694	Repair of heart defects
33697	Repair of heart defects
33702	Repair of heart defects
33710	Repair of heart defects
33720	Repair of heart defect
33722	Repair of heart defect
33724	Repair venous anomaly
33726	Repair pul venous stenosis
33730	Repair heart-vein defect(s)
33732	Repair heart-vein defect
33735	Revision of heart chamber
33736	Revision of heart chamber
33737	Revision of heart chamber
33750	Major vessel shunt
33755	Major vessel shunt
33762	Major vessel shunt
33764	Major vessel shunt & graft
33766	Major vessel shunt
33767	Major vessel shunt
33768	Cavopulmonary shunting
33770	Repair great vessels defect

HCPCS Code	Short Description
33771	Repair great vessels defect
33774	Repair great vessels defect
33775	Repair great vessels defect
33776	Repair great vessels defect
33777	Repair great vessels defect
33778	Repair great vessels defect
33779	Repair great vessels defect
33780	Repair great vessels defect
33781	Repair great vessels defect
33782	Nikaidoh proc
33783	Nikaidoh proc w/ostia implt
33786	Repair arterial trunk
33788	Revision of pulmonary artery
33800	Aortic suspension
33802	Repair vessel defect
33803	Repair vessel defect
33813	Repair septal defect
33814	Repair septal defect
33820	Revise major vessel
33822	Revise major vessel
33824	Revise major vessel
33840	Remove aorta constriction
33845	Remove aorta constriction
33851	Remove aorta constriction
33852	Repair septal defect
33853	Repair septal defect
33860	Ascending aortic graft
33863	Ascending aortic graft
33864	Ascending aortic graft
33870	Transverse aortic arch graft
33875	Thoracic aortic graft
33877	Thoracoabdominal graft
33880	Endovasc taa repr incl subcl
33881	Endovasc taa repr w/o subcl
33883	Insert endovasc prosth taa
33884	Endovasc prosth taa add-on
33886	Endovasc prosth delayed
33889	Artery transpose/endovas taa
33891	Car-car bp grft/endovas taa
33910	Remove lung artery emboli
33915	Remove lung artery emboli
33916	Surgery of great vessel
33917	Repair pulmonary artery

HCPCS Code	Short Description
33920	Repair pulmonary atresia
33922	Transect pulmonary artery
33924	Remove pulmonary shunt
33925	Rpr pul art unifocal w/o cpb
33926	Repr pul art unifocal w/cpb
33927	Impltj tot rplcmt hrt sys
33928	Rmvl & rplcmt tot hrt sys
33929	Rmvl rplcmt hrt sys f/trnspl
33930	Removal of donor heart/lung
33933	Prepare donor heart/lung
33935	Transplantation heart/lung
33940	Removal of donor heart
33944	Prepare donor heart
33945	Transplantation of heart
33946	Ecmo/ecls initiation venous
33947	Ecmo/ecls initiation artery
33948	Ecmo/ecls daily mgmt-venous
33949	Ecmo/ecls daily mgmt artery
33951	Ecmo/ecls insj prph cannula
33952	Ecmo/ecls insj prph cannula
33953	Ecmo/ecls insj prph cannula
33954	Ecmo/ecls insj prph cannula
33955	Ecmo/ecls insj ctr cannula
33956	Ecmo/ecls insj ctr cannula
33957	Ecmo/ecls repos perph cnula
33958	Ecmo/ecls repos perph cnula
33959	Ecmo/ecls repos perph cnula
33962	Ecmo/ecls repos perph cnula
33963	Ecmo/ecls repos perph cnula
33964	Ecmo/ecls repos perph cnula
33965	Ecmo/ecls rmvl perph cannula
33966	Ecmo/ecls rmvl prph cannula
33967	Insert i-aort percut device
33968	Remove aortic assist device
33969	Ecmo/ecls rmvl perph cannula
33970	Aortic circulation assist
33971	Aortic circulation assist
33973	Insert balloon device
33974	Remove intra-aortic balloon
33975	Implant ventricular device
33976	Implant ventricular device
33977	Remove ventricular device
33978	Remove ventricular device

HCPCS Code	Short Description
33979	Insert intracorporeal device
33980	Remove intracorporeal device
33981	Replace vad pump ext
33982	Replace vad intra w/o bp
33983	Replace vad intra w/bp
33984	Ecmo/ecls rmvl prph cannula
33985	Ecmo/ecls rmvl ctr cannula
33986	Ecmo/ecls rmvl ctr cannula
33987	Artery expos/graft artery
33988	Insertion of left heart vent
33989	Removal of left heart vent
33990	Insert vad artery access
33991	Insert vad art&vein access
33992	Remove vad different session
33993	Reposition vad diff session
33999	Cardiac surgery procedure
34001	Removal of artery clot
34051	Removal of artery clot
34101	Removal of artery clot
34111	Removal of arm artery clot
34151	Removal of artery clot
34201	Removal of artery clot
34203	Removal of leg artery clot
34401	Removal of vein clot
34421	Removal of vein clot
34451	Removal of vein clot
34471	Removal of vein clot
34501	Repair valve femoral vein
34502	Reconstruct vena cava
34510	Transposition of vein valve
34520	Cross-over vein graft
34530	Leg vein fusion
34701	Evasc rpr a-ao ndgft
34702	Evasc rpr a-ao ndgft rpt
34703	Evasc rpr a-unilac ndgft
34704	Evasc rpr a-unilac ndgft rpt
34705	Evac rpr a-biiliac ndgft
34706	Evasc rpr a-biiliac rpt
34707	Evasc rpr ilio-iliac ndgft
34708	Evasc rpr ilio-iliac rpt
34709	Plmt xtn prosth evasc rpr
34710	Dlyd plmt xtn prosth 1st vsl
34711	Dlyd plmt xtn prosth ea addl

HCPCS Code	Short Description
34712	Tcat dlvr enhncd fixj dev
34808	Endovas iliac a device addon
34812	Opn fem art expos
34813	Femoral endovas graft add-on
34820	Opn ilac art expos
34830	Open aortic tube prosth repr
34831	Open aortoiliac prosth repr
34832	Open aortofemor prosth repr
34833	Opn ilac art expos cndt crtj
34834	Opn brach art expos
34841	Endovasc visc aorta 1 graft
34842	Endovasc visc aorta 2 graft
34843	Endovasc visc aorta 3 graft
34844	Endovasc visc aorta 4 graft
34845	Visc & infraren abd 1 prosth
34846	Visc & infraren abd 2 prosth
34847	Visc & infraren abd 3 prosth
34848	Visc & infraren abd 4+ prost
35001	Repair defect of artery
35002	Repair artery rupture neck
35005	Repair defect of artery
35011	Repair defect of artery
35013	Repair artery rupture arm
35021	Repair defect of artery
35022	Repair artery rupture chest
35045	Repair defect of arm artery
35081	Repair defect of artery
35082	Repair artery rupture aorta
35091	Repair defect of artery
35092	Repair artery rupture aorta
35102	Repair defect of artery
35103	Repair artery rupture aorta
35111	Repair defect of artery
35112	Repair artery rupture spleen
35121	Repair defect of artery
35122	Repair artery rupture belly
35131	Repair defect of artery
35132	Repair artery rupture groin
35141	Repair defect of artery
35142	Repair artery rupture thigh
35151	Repair defect of artery
35152	Repair ruptd popliteal art
35180	Repair blood vessel lesion

HCPCS Code	Short Description
35182	Repair blood vessel lesion
35184	Repair blood vessel lesion
35189	Repair blood vessel lesion
35190	Repair blood vessel lesion
35201	Repair blood vessel lesion
35206	Repair blood vessel lesion
35211	Repair blood vessel lesion
35216	Repair blood vessel lesion
35221	Repair blood vessel lesion
35226	Repair blood vessel lesion
35231	Repair blood vessel lesion
35236	Repair blood vessel lesion
35241	Repair blood vessel lesion
35246	Repair blood vessel lesion
35251	Repair blood vessel lesion
35256	Repair blood vessel lesion
35261	Repair blood vessel lesion
35266	Repair blood vessel lesion
35271	Repair blood vessel lesion
35276	Repair blood vessel lesion
35281	Repair blood vessel lesion
35286	Repair blood vessel lesion
35301	Rechanneling of artery
35302	Rechanneling of artery
35303	Rechanneling of artery
35304	Rechanneling of artery
35305	Rechanneling of artery
35306	Rechanneling of artery
35311	Rechanneling of artery
35321	Rechanneling of artery
35331	Rechanneling of artery
35341	Rechanneling of artery
35351	Rechanneling of artery
35355	Rechanneling of artery
35361	Rechanneling of artery
35363	Rechanneling of artery
35371	Rechanneling of artery
35372	Rechanneling of artery
35390	Reoperation carotid add-on
35400	Angioscopy
35500	Harvest vein for bypass
35501	Art byp grft ipsilat carotid
35506	Art byp grft subclav-carotid

HCPCS Code	Short Description
35508	Art byp grft carotid-vertbrl
35509	Art byp grft contral carotid
35510	Art byp grft carotid-brchial
35511	Art byp grft subclav-subclav
35512	Art byp grft subclav-brchial
35515	Art byp grft subclav-vertbrl
35516	Art byp grft subclav-axilary
35518	Art byp grft axillary-axilry
35521	Art byp grft axill-femoral
35522	Art byp grft axill-brachial
35523	Art byp grft brchl-ulnr-rdl
35525	Art byp grft brachial-brchl
35526	Art byp grft aor/carot/innom
35531	Art byp grft aorcel/aormesen
35533	Art byp grft axill/fem/fem
35535	Art byp grft hepatorenal
35536	Art byp grft splenorenal
35537	Art byp grft aortoiliac
35538	Art byp grft aortobi-iliac
35539	Art byp grft aortofemoral
35540	Art byp grft aortbifemoral
35556	Art byp grft fem-popliteal
35558	Art byp grft fem-femoral
35560	Art byp grft aortorenal
35563	Art byp grft ilioiliac
35565	Art byp grft iliofemoral
35566	Art byp fem-ant-post tib/prl
35570	Art byp tibial-tib/peroneal
35571	Art byp pop-tibl-prl-other
35583	Vein byp grft fem-popliteal
35585	Vein byp fem-tibial peroneal
35587	Vein byp pop-tibl peroneal
35600	Harvest art for cabg add-on
35601	Art byp common ipsi carotid
35606	Art byp carotid-subclavian
35612	Art byp subclav-subclavian
35616	Art byp subclav-axillary
35621	Art byp axillary-femoral
35623	Art byp axillary-pop-tibial
35626	Art byp aorsubcl/carot/innom
35631	Art byp aor-celiac-msn-renal
35632	Art byp ilio-celiac
35633	Art byp ilio-mesenteric

HCPCS Code	Short Description
35634	Art byp iliorenal
35636	Art byp spenorenal
35637	Art byp aortoiliac
35638	Art byp aortobi-iliac
35642	Art byp carotid-vertebral
35645	Art byp subclav-vertebrl
35646	Art byp aortobifemoral
35647	Art byp aortofemoral
35650	Art byp axillary-axillary
35654	Art byp axill-fem-femoral
35656	Art byp femoral-popliteal
35661	Art byp femoral-femoral
35663	Art byp ilioiliac
35665	Art byp iliofemoral
35666	Art byp fem-ant-post tib/prl
35671	Art byp pop-tibl-prl-other
35681	Composite byp grft pros&vein
35682	Composite byp grft 2 veins
35683	Composite byp grft 3/> segmt
35685	Bypass graft patency/patch
35686	Bypass graft/av fist patency
35691	Art trnsposj vertbrl carotid
35693	Art trnsposj subclavian
35694	Art trnsposj subclav carotid
35695	Art trnsposj carotid subclav
35697	Reimplant artery each
35700	Reoperation bypass graft
35701	Exploration carotid artery
35721	Exploration femoral artery
35741	Exploration popliteal artery
35800	Explore neck vessels
35820	Explore chest vessels
35840	Explore abdominal vessels
35860	Explore limb vessels
35870	Repair vessel graft defect
35879	Revise graft w/vein
35881	Revise graft w/vein
35883	Revise graft w/nonauto graft
35884	Revise graft w/vein
35901	Excision graft neck
35903	Excision graft extremity
35905	Excision graft thorax
35907	Excision graft abdomen

HCPCS Code	Short Description
36299	Vessel injection procedure
36460	Transfusion service fetal
36660	Insertion catheter artery
36823	Insertion of cannula(s)
36838	Dist revas ligation hemo
37140	Revision of circulation
37145	Revision of circulation
37160	Revision of circulation
37180	Revision of circulation
37181	Splice spleen/kidney veins
37182	Insert hepatic shunt (tips)
37183	Remove hepatic shunt (tips)
37191	Ins endovas vena cava filtr
37192	Redo endovas vena cava filtr
37193	Rem endovas vena cava filter
37195	Thrombolytic therapy stroke
37213	Thromblytic art/ven therapy
37214	Cessj therapy cath removal
37215	Transcath stent cca w/eps
37217	Stent placemt retro carotid
37218	Stent placemt ante carotid
37244	Vasc embolize/occlude bleed
37501	Vascular endoscopy procedure
37565	Ligation of neck vein
37600	Ligation of neck artery
37605	Ligation of neck artery
37606	Ligation of neck artery
37615	Ligation of neck artery
37616	Ligation of chest artery
37617	Ligation of abdomen artery
37618	Ligation of extremity artery
37619	Ligation of inf vena cava
37660	Revision of major vein
37788	Revascularization penis
37799	Vascular surgery procedure
38100	Removal of spleen total
38101	Removal of spleen partial
38102	Removal of spleen total
38115	Repair of ruptured spleen
38120	Laparoscopy splenectomy
38129	Laparoscope proc spleen
38207	Cryopreserve stem cells
38208	Thaw preserved stem cells

HCPCS Code	Short Description
38209	Wash harvest stem cells
38210	T-cell depletion of harvest
38211	Tumor cell deplete of harvst
38212	Rbc depletion of harvest
38213	Platelet deplete of harvest
38214	Volume deplete of harvest
38215	Harvest stem cell concentrte
38240	Transplt allo hct/donor
38380	Thoracic duct procedure
38381	Thoracic duct procedure
38382	Thoracic duct procedure
38531	Open bx/exc inguinofem nodes
38562	Removal pelvic lymph nodes
38564	Removal abdomen lymph nodes
38589	Laparoscope proc lymphatic
38720	Removal of lymph nodes neck
38724	Removal of lymph nodes neck
38746	Remove thoracic lymph nodes
38747	Remove abdominal lymph nodes
38765	Remove groin lymph nodes
38770	Remove pelvis lymph nodes
38780	Remove abdomen lymph nodes
38999	Blood/lymph system procedure
39000	Exploration of chest
39010	Exploration of chest
39200	Resect mediastinal cyst
39220	Resect mediastinal tumor
39401	Mediastinoscpy w/medstnl bx
39402	Mediastinoscpy w/lmph nod bx
39499	Chest procedure
39501	Repair diaphragm laceration
39503	Repair of diaphragm hernia
39540	Repair of diaphragm hernia
39541	Repair of diaphragm hernia
39545	Revision of diaphragm
39560	Resect diaphragm simple
39561	Resect diaphragm complex
39599	Diaphragm surgery procedure
40799	Lip surgery procedure
40899	Mouth surgery procedure
41130	Partial removal of tongue
41135	Tongue and neck surgery
41140	Removal of tongue

HCPCS Code	Short Description
41145	Tongue removal neck surgery
41150	Tongue mouth jaw surgery
41153	Tongue mouth neck surgery
41155	Tongue jaw & neck surgery
41599	Tongue and mouth surgery
41899	Dental surgery procedure
42299	Palate/uvula surgery
42426	Excise parotid gland/lesion
42699	Salivary surgery procedure
42842	Extensive surgery of throat
42844	Extensive surgery of throat
42845	Extensive surgery of throat
42894	Revision of pharyngeal walls
42953	Repair throat esophagus
42961	Control throat bleeding
42971	Control nose/throat bleeding
42999	Throat surgery procedure
43020	Incision of esophagus
43045	Incision of esophagus
43100	Excision of esophagus lesion
43101	Excision of esophagus lesion
43107	Removal of esophagus
43108	Removal of esophagus
43112	Esphg tot w/thrcm
43113	Removal of esophagus
43116	Partial removal of esophagus
43117	Partial removal of esophagus
43118	Partial removal of esophagus
43121	Partial removal of esophagus
43122	Partial removal of esophagus
43123	Partial removal of esophagus
43124	Removal of esophagus
43135	Removal of esophagus pouch
43279	Lap myotomy heller
43280	Laparoscopy fundoplasty
43281	Lap paraesophag hern repair
43282	Lap paraesoph her rpr w/mesh
43283	Lap esoph lengthening
43286	Esphg tot w/laps moblj
43287	Esphg dstl 2/3 w/laps moblj
43288	Esphg tot thrsc moblj
43289	Laparoscope proc esoph
43300	Repair of esophagus

HCPCS Code	Short Description
43305	Repair esophagus and fistula
43310	Repair of esophagus
43312	Repair esophagus and fistula
43313	Esophagoplasty congenital
43314	Tracheo-esophagoplasty cong
43320	Fuse esophagus & stomach
43325	Revise esophagus & stomach
43327	Esoph fundoplasty lap
43328	Esoph fundoplasty thor
43330	Esophagomyotomy abdominal
43331	Esophagomyotomy thoracic
43332	Transab esoph hiat hern rpr
43333	Transab esoph hiat hern rpr
43334	Transthor diaphrag hern rpr
43335	Transthor diaphrag hern rpr
43336	Thorabd diaphr hern repair
43337	Thorabd diaphr hern repair
43338	Esoph lengthening
43340	Fuse esophagus & intestine
43341	Fuse esophagus & intestine
43351	Surgical opening esophagus
43352	Surgical opening esophagus
43360	Gastrointestinal repair
43361	Gastrointestinal repair
43400	Ligate esophagus veins
43401	Esophagus surgery for veins
43405	Ligate/staple esophagus
43410	Repair esophagus wound
43415	Repair esophagus wound
43420	Repair esophagus opening
43425	Repair esophagus opening
43460	Pressure treatment esophagus
43496	Free jejunum flap microvasc
43499	Esophagus surgery procedure
43500	Surgical opening of stomach
43501	Surgical repair of stomach
43502	Surgical repair of stomach
43510	Surgical opening of stomach
43520	Incision of pyloric muscle
43605	Biopsy of stomach
43610	Excision of stomach lesion
43611	Excision of stomach lesion
43620	Removal of stomach

HCPCS Code	Short Description
43621	Removal of stomach
43622	Removal of stomach
43631	Removal of stomach partial
43632	Removal of stomach partial
43633	Removal of stomach partial
43634	Removal of stomach partial
43635	Removal of stomach partial
43640	Vagotomy & pylorus repair
43641	Vagotomy & pylorus repair
43644	Lap gastric bypass/roux-en-y
43645	Lap gastr bypass incl smll i
43647	Lap impl electrode antrum
43648	Lap revise/remv eltrd antrum
43651	Laparoscopy vagus nerve
43652	Laparoscopy vagus nerve
43659	Laparoscope proc stom
43770	Lap place gastr adj device
43771	Lap revise gastr adj device
43772	Lap rmvl gastr adj device
43773	Lap replace gastr adj device
43774	Lap rmvl gastr adj all parts
43775	Lap sleeve gastrectomy
43800	Reconstruction of pylorus
43810	Fusion of stomach and bowel
43820	Fusion of stomach and bowel
43825	Fusion of stomach and bowel
43830	Place gastrostomy tube
43831	Place gastrostomy tube
43832	Place gastrostomy tube
43840	Repair of stomach lesion
43843	Gastroplasty w/o v-band
43845	Gastroplasty duodenal switch
43846	Gastric bypass for obesity
43847	Gastric bypass incl small i
43848	Revision gastroplasty
43850	Revise stomach-bowel fusion
43855	Revise stomach-bowel fusion
43860	Revise stomach-bowel fusion
43865	Revise stomach-bowel fusion
43880	Repair stomach-bowel fistula
43881	Impl/redo electrd antrum
43882	Revise/remove electrd antrum
43999	Stomach surgery procedure

HCPCS Code	Short Description
44005	Freeing of bowel adhesion
44010	Incision of small bowel
44015	Insert needle cath bowel
44020	Explore small intestine
44021	Decompress small bowel
44025	Incision of large bowel
44050	Reduce bowel obstruction
44055	Correct malrotation of bowel
44110	Excise intestine lesion(s)
44111	Excision of bowel lesion(s)
44120	Removal of small intestine
44121	Removal of small intestine
44125	Removal of small intestine
44126	Enterectomy w/o taper cong
44127	Enterectomy w/taper cong
44128	Enterectomy cong add-on
44130	Bowel to bowel fusion
44132	Enterectomy cadaver donor
44133	Enterectomy live donor
44135	Intestine transplnt cadaver
44136	Intestine transplant live
44137	Remove intestinal allograft
44139	Mobilization of colon
44140	Partial removal of colon
44141	Partial removal of colon
44143	Partial removal of colon
44144	Partial removal of colon
44145	Partial removal of colon
44146	Partial removal of colon
44147	Partial removal of colon
44150	Removal of colon
44151	Removal of colon/ileostomy
44155	Removal of colon/ileostomy
44156	Removal of colon/ileostomy
44157	Colectomy w/ileoanal anast
44158	Colectomy w/neo-rectum pouch
44160	Removal of colon
44180	Lap enterolysis
44186	Lap jejunostomy
44187	Lap ileo/jejuno-stomy
44188	Lap colostomy
44202	Lap enterectomy
44203	Lap resect s/intestine addl

HCPCS Code	Short Description
44204	Laparo partial colectomy
44205	Lap colectomy part w/ileum
44206	Lap part colectomy w/stoma
44207	L colectomy/coloproctostomy
44208	L colectomy/coloproctostomy
44210	Laparo total proctocolectomy
44211	Lap colectomy w/proctectomy
44212	Laparo total proctocolectomy
44213	Lap mobil splenic fl add-on
44227	Lap close enterostomy
44238	Laparoscope proc intestine
44300	Open bowel to skin
44310	Ileostomy/jejunostomy
44314	Revision of ileostomy
44316	Devise bowel pouch
44320	Colostomy
44322	Colostomy with biopsies
44345	Revision of colostomy
44346	Revision of colostomy
44602	Suture small intestine
44603	Suture small intestine
44604	Suture large intestine
44605	Repair of bowel lesion
44615	Intestinal stricturoplasty
44620	Repair bowel opening
44625	Repair bowel opening
44626	Repair bowel opening
44640	Repair bowel-skin fistula
44650	Repair bowel fistula
44660	Repair bowel-bladder fistula
44661	Repair bowel-bladder fistula
44680	Surgical revision intestine
44700	Suspend bowel w/prosthesis
44715	Prepare donor intestine
44720	Prep donor intestine/venous
44721	Prep donor intestine/artery
44799	Unlisted px small intestine
44800	Excision of bowel pouch
44820	Excision of mesentery lesion
44850	Repair of mesentery
44899	Bowel surgery procedure
44900	Drain appendix abscess open
44950	Appendectomy

HCPCS Code	Short Description
44955	Appendectomy add-on
44960	Appendectomy
44970	Laparoscopy appendectomy
44979	Laparoscope proc app
45110	Removal of rectum
45111	Partial removal of rectum
45112	Removal of rectum
45113	Partial proctectomy
45114	Partial removal of rectum
45116	Partial removal of rectum
45119	Remove rectum w/reservoir
45120	Removal of rectum
45121	Removal of rectum and colon
45123	Partial proctectomy
45126	Pelvic exenteration
45130	Excision of rectal prolapse
45135	Excision of rectal prolapse
45136	Excise ileoanal reservior
45395	Lap removal of rectum
45397	Lap remove rectum w/pouch
45399	Unlisted procedure colon
45400	Laparoscopic proc
45402	Lap proctopexy w/sig resect
45499	Laparoscope proc rectum
45540	Correct rectal prolapse
45550	Repair rectum/remove sigmoid
45562	Exploration/repair of rectum
45563	Exploration/repair of rectum
45800	Repair rect/bladder fistula
45805	Repair fistula w/colostomy
45820	Repair rectourethral fistula
45825	Repair fistula w/colostomy
45999	Rectum surgery procedure
46705	Repair of anal stricture
46710	Repr per/vag pouch sngl proc
46712	Repr per/vag pouch dbl proc
46715	Rep perf anoper fistu
46716	Rep perf anoper/vestib fistu
46730	Construction of absent anus
46735	Construction of absent anus
46740	Construction of absent anus
46742	Repair of imperforated anus
46744	Repair of cloacal anomaly

HCPCS Code	Short Description
46746	Repair of cloacal anomaly
46748	Repair of cloacal anomaly
46751	Repair of anal sphincter
46999	Anus surgery procedure
47010	Open drainage liver lesion
47015	Inject/aspirate liver cyst
47100	Wedge biopsy of liver
47120	Partial removal of liver
47122	Extensive removal of liver
47125	Partial removal of liver
47130	Partial removal of liver
47133	Removal of donor liver
47135	Transplantation of liver
47140	Partial removal donor liver
47141	Partial removal donor liver
47142	Partial removal donor liver
47143	Prep donor liver whole
47144	Prep donor liver 3-segment
47145	Prep donor liver lobe split
47146	Prep donor liver/venous
47147	Prep donor liver/arterial
47300	Surgery for liver lesion
47350	Repair liver wound
47360	Repair liver wound
47361	Repair liver wound
47362	Repair liver wound
47370	Laparo ablate liver tumor rf
47371	Laparo ablate liver cryosurg
47379	Laparoscope procedure liver
47380	Open ablate liver tumor rf
47381	Open ablate liver tumor cryo
47399	Liver surgery procedure
47400	Incision of liver duct
47420	Incision of bile duct
47425	Incision of bile duct
47460	Incise bile duct sphincter
47480	Incision of gallbladder
47490	Incision of gallbladder
47550	Bile duct endoscopy add-on
47570	Laparo cholecystoenterostomy
47579	Laparoscope proc biliary
47600	Removal of gallbladder
47605	Removal of gallbladder

HCPCS Code	Short Description
47610	Removal of gallbladder
47612	Removal of gallbladder
47620	Removal of gallbladder
47700	Exploration of bile ducts
47701	Bile duct revision
47711	Excision of bile duct tumor
47712	Excision of bile duct tumor
47715	Excision of bile duct cyst
47720	Fuse gallbladder & bowel
47721	Fuse upper gi structures
47740	Fuse gallbladder & bowel
47741	Fuse gallbladder & bowel
47760	Fuse bile ducts and bowel
47765	Fuse liver ducts & bowel
47780	Fuse bile ducts and bowel
47785	Fuse bile ducts and bowel
47800	Reconstruction of bile ducts
47801	Placement bile duct support
47802	Fuse liver duct & intestine
47900	Suture bile duct injury
47999	Bile tract surgery procedure
48000	Drainage of abdomen
48001	Placement of drain pancreas
48020	Removal of pancreatic stone
48100	Biopsy of pancreas open
48105	Resect/debride pancreas
48120	Removal of pancreas lesion
48140	Partial removal of pancreas
48145	Partial removal of pancreas
48146	Pancreatectomy
48148	Removal of pancreatic duct
48150	Partial removal of pancreas
48152	Pancreatectomy
48153	Pancreatectomy
48154	Pancreatectomy
48155	Removal of pancreas
48400	Injection intraop add-on
48500	Surgery of pancreatic cyst
48510	Drain pancreatic pseudocyst
48520	Fuse pancreas cyst and bowel
48540	Fuse pancreas cyst and bowel
48545	Pancreatorrhaphy
48547	Duodenal exclusion

HCPCS Code	Short Description
48548	Fuse pancreas and bowel
48551	Prep donor pancreas
48552	Prep donor pancreas/venous
48554	Transpl allograft pancreas
48556	Removal allograft pancreas
48999	Pancreas surgery procedure
49000	Exploration of abdomen
49002	Reopening of abdomen
49010	Exploration behind abdomen
49020	Drainage abdom abscess open
49040	Drain open abdom abscess
49060	Drain open retroperi abscess
49062	Drain to peritoneal cavity
49185	Sclerotx fluid collection
49203	Exc abd tum 5 cm or less
49204	Exc abd tum over 5 cm
49205	Exc abd tum over 10 cm
49215	Excise sacral spine tumor
49220	Multiple surgery abdomen
49255	Removal of omentum
49323	Laparo drain lymphocele
49329	Laparo proc abdm/per/oment
49405	Image cath fluid colxn visc
49412	Ins device for rt guide open
49425	Insert abdomen-venous drain
49428	Ligation of shunt
49491	Rpr hern preemie reduc
49492	Rpr ing hern premie blocked
49605	Repair umbilical lesion
49606	Repair umbilical lesion
49610	Repair umbilical lesion
49611	Repair umbilical lesion
49659	Laparo proc hernia repair
49900	Repair of abdominal wall
49904	Omental flap extra-abdom
49905	Omental flap intra-abdom
49906	Free omental flap microvasc
49999	Abdomen surgery procedure
50010	Exploration of kidney
50020	Renal abscess open drain
50040	Drainage of kidney
50045	Exploration of kidney
50060	Removal of kidney stone

HCPCS Code	Short Description
50065	Incision of kidney
50070	Incision of kidney
50075	Removal of kidney stone
50100	Revise kidney blood vessels
50120	Exploration of kidney
50125	Explore and drain kidney
50130	Removal of kidney stone
50135	Exploration of kidney
50205	Renal biopsy open
50220	Remove kidney open
50225	Removal kidney open complex
50230	Removal kidney open radical
50234	Removal of kidney & ureter
50236	Removal of kidney & ureter
50240	Partial removal of kidney
50250	Cryoablate renal mass open
50280	Removal of kidney lesion
50290	Removal of kidney lesion
50300	Remove cadaver donor kidney
50320	Remove kidney living donor
50323	Prep cadaver renal allograft
50325	Prep donor renal graft
50327	Prep renal graft/venous
50328	Prep renal graft/arterial
50329	Prep renal graft/ureteral
50340	Removal of kidney
50360	Transplantation of kidney
50365	Transplantation of kidney
50370	Remove transplanted kidney
50380	Reimplantation of kidney
50400	Revision of kidney/ureter
50405	Revision of kidney/ureter
50500	Repair of kidney wound
50520	Close kidney-skin fistula
50525	Close nephrovisceral fistula
50526	Close nephrovisceral fistula
50540	Revision of horseshoe kidney
50541	Laparo ablate renal cyst
50542	Laparo ablate renal mass
50543	Laparo partial nephrectomy
50544	Laparoscopy pyeloplasty
50545	Laparo radical nephrectomy
50546	Laparoscopic nephrectomy

HCPCS Code	Short Description
50547	Laparo removal donor kidney
50548	Laparo remove w/ureter
50549	Laparoscope proc renal
50600	Exploration of ureter
50605	Insert ureteral support
50610	Removal of ureter stone
50620	Removal of ureter stone
50630	Removal of ureter stone
50650	Removal of ureter
50660	Removal of ureter
50700	Revision of ureter
50715	Release of ureter
50722	Release of ureter
50725	Release/revise ureter
50728	Revise ureter
50740	Fusion of ureter & kidney
50750	Fusion of ureter & kidney
50760	Fusion of ureters
50770	Splicing of ureters
50780	Reimplant ureter in bladder
50782	Reimplant ureter in bladder
50783	Reimplant ureter in bladder
50785	Reimplant ureter in bladder
50800	Implant ureter in bowel
50810	Fusion of ureter & bowel
50815	Urine shunt to intestine
50820	Construct bowel bladder
50825	Construct bowel bladder
50830	Revise urine flow
50840	Replace ureter by bowel
50845	Appendico-vesicostomy
50860	Transplant ureter to skin
50900	Repair of ureter
50920	Closure ureter/skin fistula
50930	Closure ureter/bowel fistula
50940	Release of ureter
50945	Laparoscopy ureterolithotomy
50949	Laparoscope proc ureter
51060	Removal of ureter stone
51525	Removal of bladder lesion
51530	Removal of bladder lesion
51550	Partial removal of bladder
51555	Partial removal of bladder

HCPCS Code	Short Description
51565	Revise bladder & ureter(s)
51570	Removal of bladder
51575	Removal of bladder & nodes
51580	Remove bladder/revise tract
51585	Removal of bladder & nodes
51590	Remove bladder/revise tract
51595	Remove bladder/revise tract
51596	Remove bladder/create pouch
51597	Removal of pelvic structures
51800	Revision of bladder/urethra
51820	Revision of urinary tract
51840	Attach bladder/urethra
51841	Attach bladder/urethra
51845	Repair bladder neck
51860	Repair of bladder wound
51865	Repair of bladder wound
51900	Repair bladder/vagina lesion
51920	Close bladder-uterus fistula
51925	Hysterectomy/bladder repair
51940	Correction of bladder defect
51960	Revision of bladder & bowel
51980	Construct bladder opening
51990	Laparo urethral suspension
51999	Laparoscope proc bla
53415	Reconstruction of urethra
53448	Remov/replc ur sphinctr comp
53500	Urethrlys transvag w/ scope
53899	Urology surgery procedure
54125	Removal of penis
54130	Remove penis & nodes
54135	Remove penis & nodes
54332	Revise penis/urethra
54336	Revise penis/urethra
54390	Repair penis and bladder
54411	Remov/replc penis pros comp
54417	Remv/replc penis pros compl
54430	Revision of penis
54438	Replantation of penis
54535	Extensive testis surgery
54650	Orchiopexy (fowler-stephens)
54699	Laparoscope proc testis
55559	Laparo proc spermatic cord
55605	Incise sperm duct pouch

HCPCS Code	Short Description
55650	Remove sperm duct pouch
55801	Removal of prostate
55810	Extensive prostate surgery
55812	Extensive prostate surgery
55815	Extensive prostate surgery
55821	Removal of prostate
55831	Removal of prostate
55840	Extensive prostate surgery
55842	Extensive prostate surgery
55845	Extensive prostate surgery
55862	Extensive prostate surgery
55865	Extensive prostate surgery
55866	Laparo radical prostatectomy
55899	Genital surgery procedure
55970	Sex transformation m to f
55980	Sex transformation f to m
56630	Extensive vulva surgery
56631	Extensive vulva surgery
56632	Extensive vulva surgery
56633	Extensive vulva surgery
56634	Extensive vulva surgery
56637	Extensive vulva surgery
56640	Extensive vulva surgery
57106	Remove vagina wall partial
57107	Remove vagina tissue part
57109	Vaginectomy partial w/nodes
57110	Remove vagina wall complete
57111	Remove vagina tissue compl
57112	Vaginectomy w/nodes compl
57270	Repair of bowel pouch
57280	Suspension of vagina
57282	Colpopexy extraperitoneal
57283	Colpopexy intraperitoneal
57284	Repair paravag defect open
57285	Repair paravag defect vag
57292	Construct vagina with graft
57296	Revise vag graft open abd
57305	Repair rectum-vagina fistula
57307	Fistula repair & colostomy
57308	Fistula repair transperine
57311	Repair urethrovaginal lesion
57330	Repair bladder-vagina lesion
57335	Repair vagina

HCPCS Code	Short Description
57423	Repair paravag defect lap
57425	Laparoscopy surg colpopexy
57531	Removal of cervix radical
57540	Removal of residual cervix
57545	Remove cervix/repair pelvis
57555	Remove cervix/repair vagina
58140	Myomectomy abdom method
58146	Myomectomy abdom complex
58150	Total hysterectomy
58152	Total hysterectomy
58180	Partial hysterectomy
58200	Extensive hysterectomy
58210	Extensive hysterectomy
58240	Removal of pelvis contents
58263	Vag hyst w/t/o & vag repair
58267	Vag hyst w/urinary repair
58270	Vag hyst w/enterocele repair
58275	Hysterectomy/revise vagina
58280	Hysterectomy/revise vagina
58285	Extensive hysterectomy
58290	Vag hyst complex
58291	Vag hyst incl t/o complex
58292	Vag hyst t/o & repair compl
58293	Vag hyst w/uro repair compl
58294	Vag hyst w/enterocele compl
58400	Suspension of uterus
58410	Suspension of uterus
58520	Repair of ruptured uterus
58540	Revision of uterus
58548	Lap radical hyst
58575	Laps tot hyst resj mal
58578	Laparo proc uterus
58579	Hysteroscope procedure
58605	Division of fallopian tube
58611	Ligate oviduct(s) add-on
58679	Laparo proc oviduct-ovary
58700	Removal of fallopian tube
58720	Removal of ovary/tube(s)
58740	Adhesiolysis tube ovary
58750	Repair oviduct
58752	Revise ovarian tube(s)
58760	Fimbrioplasty
58770	Create new tubal opening

HCPCS Code	Short Description
58822	Drain ovary abscess percut
58825	Transposition ovary(s)
58920	Partial removal of ovary(s)
58925	Removal of ovarian cyst(s)
58940	Removal of ovary(s)
58943	Removal of ovary(s)
58950	Resect ovarian malignancy
58951	Resect ovarian malignancy
58952	Resect ovarian malignancy
58953	Tah rad dissect for debulk
58954	Tah rad debulk/lymph remove
58956	Bso omentectomy w/tah
58957	Resect recurrent gyn mal
58958	Resect recur gyn mal w/lym
58960	Exploration of abdomen
58999	Genital surgery procedure
59030	Fetal scalp blood sample
59120	Treat ectopic pregnancy
59121	Treat ectopic pregnancy
59130	Treat ectopic pregnancy
59135	Treat ectopic pregnancy
59136	Treat ectopic pregnancy
59140	Treat ectopic pregnancy
59325	Revision of cervix
59350	Repair of uterus
59409	Obstetrical care
59514	Cesarean delivery only
59525	Remove uterus after cesarean
59612	Vbac delivery only
59620	Attempted vbac delivery only
59830	Treat uterus infection
59850	Abortion
59851	Abortion
59852	Abortion
59855	Abortion
59856	Abortion
59857	Abortion
59897	Fetal invas px w/us
59898	Laparo proc ob care/deliver
59899	Maternity care procedure
60252	Removal of thyroid
60254	Extensive thyroid surgery
60260	Repeat thyroid surgery

HCPCS Code	Short Description
60270	Removal of thyroid
60271	Removal of thyroid
60502	Re-explore parathyroids
60505	Explore parathyroid glands
60512	Autotransplant parathyroid
60520	Removal of thymus gland
60521	Removal of thymus gland
60522	Removal of thymus gland
60540	Explore adrenal gland
60545	Explore adrenal gland
60600	Remove carotid body lesion
60605	Remove carotid body lesion
60650	Laparoscopy adrenalectomy
60659	Laparo proc endocrine
60699	Endocrine surgery procedure
61105	Twist drill hole
61107	Drill skull for implantation
61108	Drill skull for drainage
61120	Burr hole for puncture
61140	Pierce skull for biopsy
61150	Pierce skull for drainage
61151	Pierce skull for drainage
61154	Pierce skull & remove clot
61156	Pierce skull for drainage
61210	Pierce skull implant device
61250	Pierce skull & explore
61253	Pierce skull & explore
61304	Open skull for exploration
61305	Open skull for exploration
61312	Open skull for drainage
61313	Open skull for drainage
61314	Open skull for drainage
61315	Open skull for drainage
61316	Implt cran bone flap to abdo
61320	Open skull for drainage
61321	Open skull for drainage
61322	Decompressive craniotomy
61323	Decompressive lobectomy
61332	Explore/biopsy eye socket
61333	Explore orbit/remove lesion
61340	Subtemporal decompression
61343	Incise skull (press relief)
61345	Relieve cranial pressure

HCPCS Code	Short Description
61450	Incise skull for surgery
61458	Incise skull for brain wound
61460	Incise skull for surgery
61480	Incise skull for surgery
61500	Removal of skull lesion
61501	Remove infected skull bone
61510	Removal of brain lesion
61512	Remove brain lining lesion
61514	Removal of brain abscess
61516	Removal of brain lesion
61517	Implt brain chemotx add-on
61518	Removal of brain lesion
61519	Remove brain lining lesion
61520	Removal of brain lesion
61521	Removal of brain lesion
61522	Removal of brain abscess
61524	Removal of brain lesion
61526	Removal of brain lesion
61530	Removal of brain lesion
61531	Implant brain electrodes
61533	Implant brain electrodes
61534	Removal of brain lesion
61535	Remove brain electrodes
61536	Removal of brain lesion
61537	Removal of brain tissue
61538	Removal of brain tissue
61539	Removal of brain tissue
61540	Removal of brain tissue
61541	Incision of brain tissue
61543	Removal of brain tissue
61544	Remove & treat brain lesion
61545	Excision of brain tumor
61546	Removal of pituitary gland
61548	Removal of pituitary gland
61550	Release of skull seams
61552	Release of skull seams
61556	Incise skull/sutures
61557	Incise skull/sutures
61558	Excision of skull/sutures
61559	Excision of skull/sutures
61563	Excision of skull tumor
61564	Excision of skull tumor
61566	Removal of brain tissue

HCPCS Code	Short Description
61567	Incision of brain tissue
61570	Remove foreign body brain
61571	Incise skull for brain wound
61575	Skull base/brainstem surgery
61576	Skull base/brainstem surgery
61580	Craniofacial approach skull
61581	Craniofacial approach skull
61582	Craniofacial approach skull
61583	Craniofacial approach skull
61584	Orbitocranial approach/skull
61585	Orbitocranial approach/skull
61586	Resect nasopharynx skull
61590	Infratemporal approach/skull
61591	Infratemporal approach/skull
61592	Orbitocranial approach/skull
61595	Transtemporal approach/skull
61596	Transcochlear approach/skull
61597	Transcondylar approach/skull
61598	Transpetrosal approach/skull
61600	Resect/excise cranial lesion
61601	Resect/excise cranial lesion
61605	Resect/excise cranial lesion
61606	Resect/excise cranial lesion
61607	Resect/excise cranial lesion
61608	Resect/excise cranial lesion
61610	Transect artery sinus
61611	Transect artery sinus
61612	Transect artery sinus
61613	Remove aneurysm sinus
61615	Resect/excise lesion skull
61616	Resect/excise lesion skull
61618	Repair dura
61619	Repair dura
61623	Endovasc tempory vessel occl
61624	Transcath occlusion cns
61626	Transcath occlusion non-cns
61630	Intracranial angioplasty
61635	Intracran angioplsty w/stent
61645	Perq art m-thrombect &/nfs
61650	Evasc prlng admn rx agnt 1st
61651	Evasc prlng admn rx agnt add
61680	Intracranial vessel surgery
61682	Intracranial vessel surgery

HCPCS Code	Short Description
61684	Intracranial vessel surgery
61686	Intracranial vessel surgery
61690	Intracranial vessel surgery
61692	Intracranial vessel surgery
61697	Brain aneurysm repr complx
61698	Brain aneurysm repr complx
61700	Brain aneurysm repr simple
61702	Inner skull vessel surgery
61703	Clamp neck artery
61705	Revise circulation to head
61708	Revise circulation to head
61710	Revise circulation to head
61711	Fusion of skull arteries
61720	Incise skull/brain surgery
61735	Incise skull/brain surgery
61750	Incise skull/brain biopsy
61751	Brain biopsy w/ct/mr guide
61760	Implant brain electrodes
61850	Implant neuroelectrodes
61860	Implant neuroelectrodes
61863	Implant neuroelectrode
61864	Implant neuroelectrde addl
61867	Implant neuroelectrode
61868	Implant neuroelectrde addl
61870	Implant neuroelectrodes
62000	Treat skull fracture
62005	Treat skull fracture
62010	Treatment of head injury
62100	Repair brain fluid leakage
62115	Reduction of skull defect
62117	Reduction of skull defect
62120	Repair skull cavity lesion
62121	Incise skull repair
62140	Repair of skull defect
62141	Repair of skull defect
62142	Remove skull plate/flap
62143	Replace skull plate/flap
62145	Repair of skull & brain
62146	Repair of skull with graft
62147	Repair of skull with graft
62148	Retr bone flap to fix skull
62161	Dissect brain w/scope
62162	Remove colloid cyst w/scope

HCPCS Code	Short Description
62163	Zneuroendoscopy w/fb removal
62164	Remove brain tumor w/scope
62165	Remove pituit tumor w/scope
62180	Establish brain cavity shunt
62190	Establish brain cavity shunt
62192	Establish brain cavity shunt
62200	Establish brain cavity shunt
62201	Brain cavity shunt w/scope
62220	Establish brain cavity shunt
62223	Establish brain cavity shunt
62256	Remove brain cavity shunt
62258	Replace brain cavity shunt
62351	Implant spinal canal cath
63011	Remove spine lamina 1/2 scrl
63012	Remove lamina/facets lumbar
63015	Remove spine lamina >2 crvcl
63016	Remove spine lamina >2 thrc
63017	Remove spine lamina >2 lmbr
63035	Spinal disk surgery add-on
63040	Laminotomy single cervical
63043	Laminotomy addl cervical
63048	Remove spinal lamina add-on
63050	Cervical laminoplsty 2/> seg
63051	C-laminoplasty w/graft/plate
63057	Decompress spine cord add-on
63064	Decompress spinal cord thrc
63066	Decompress spine cord add-on
63075	Neck spine disk surgery
63076	Neck spine disk surgery
63077	Spine disk surgery thorax
63078	Spine disk surgery thorax
63081	Remove vert body dcmprn crvl
63082	Remove vertebral body add-on
63085	Remove vert body dcmprn thrc
63086	Remove vertebral body add-on
63087	Remov vertbr dcmprn thrclmbr
63088	Remove vertebral body add-on
63090	Remove vert body dcmprn lmbr
63091	Remove vertebral body add-on
63101	Remove vert body dcmprn thrc
63102	Remove vert body dcmprn lmbr
63103	Remove vertebral body add-on
63170	Incise spinal cord tract(s)

HCPCS Code	Short Description
63172	Drainage of spinal cyst
63173	Drainage of spinal cyst
63180	Revise spinal cord ligaments
63182	Revise spinal cord ligaments
63185	Incise spine nrv half segmnt
63190	Incise spine nrv >2 segmnts
63191	Incise spine accessory nerve
63194	Incise spine & cord cervical
63195	Incise spine & cord thoracic
63196	Incise spine&cord 2 trx crvl
63197	Incise spine&cord 2 trx thrc
63198	Incise spin&cord 2 stgs crvl
63199	Incise spin&cord 2 stgs thrc
63200	Release spinal cord lumbar
63250	Revise spinal cord vsls crvl
63251	Revise spinal cord vsls thrc
63252	Revise spine cord vsl thrlmb
63265	Excise intraspinl lesion crv
63266	Excise intrspinl lesion thrc
63267	Excise intrspinl lesion lmbr
63268	Excise intrspinl lesion scrl
63270	Excise intrspinl lesion crvl
63271	Excise intrspinl lesion thrc
63272	Excise intrspinl lesion lmbr
63273	Excise intrspinl lesion scrl
63275	Bx/exc xdrl spine lesn crvl
63276	Bx/exc xdrl spine lesn thrc
63277	Bx/exc xdrl spine lesn lmbr
63278	Bx/exc xdrl spine lesn scrl
63280	Bx/exc idrl spine lesn crvl
63281	Bx/exc idrl spine lesn thrc
63282	Bx/exc idrl spine lesn lmbr
63283	Bx/exc idrl spine lesn scrl
63285	Bx/exc idrl imed lesn cervl
63286	Bx/exc idrl imed lesn thrc
63287	Bx/exc idrl imed lesn thrlmb
63290	Bx/exc xdrl/idrl lsn any lvl
63295	Repair laminectomy defect
63300	Remove vert xdrl body crvcl
63301	Remove vert xdrl body thrc
63302	Remove vert xdrl body thrlmb
63303	Remov vert xdrl bdy lmbr/sac
63304	Remove vert idrl body crvcl

HCPCS Code	Short Description
63305	Remove vert idrl body thrc
63306	Remov vert idrl bdy thrclmbr
63307	Remov vert idrl bdy lmbr/sac
63308	Remove vertebral body add-on
63700	Repair of spinal herniation
63702	Repair of spinal herniation
63704	Repair of spinal herniation
63706	Repair of spinal herniation
63707	Repair spinal fluid leakage
63709	Repair spinal fluid leakage
63710	Graft repair of spine defect
63740	Install spinal shunt
63741	Install spinal shunt
64755	Incision of stomach nerves
64760	Incision of vagus nerve
64804	Remove sympathetic nerves
64809	Remove sympathetic nerves
64818	Remove sympathetic nerves
64866	Fusion of facial/other nerve
64868	Fusion of facial/other nerve
64911	Neurorraphy w/vein autograft
64999	Nervous system surgery
65273	Repair of eye wound
66999	Eye surgery procedure
67299	Eye surgery procedure
67399	Unlisted px extraocular musc
67599	Orbit surgery procedure
67999	Revision of eyelid
68399	Eyelid lining surgery
68899	Tear duct system surgery
69155	Extensive ear/neck surgery
69399	Outer ear surgery procedure
69535	Remove part of temporal bone
69554	Remove ear lesion
69725	Release facial nerve
69799	Middle ear surgery procedure
69949	Inner ear surgery procedure
69950	Incise inner ear nerve
69955	Release facial nerve
69960	Release inner ear canal
69970	Remove inner ear lesion
69979	Temporal bone surgery
75956	Xray endovasc thor ao repr

HCPCS Code	Short Description
75957	Xray endovasc thor ao repr
75958	Xray place prox ext thor ao
75959	Xray place dist ext thor ao
92970	Cardioassist internal
92971	Cardioassist external
92975	Dissolve clot heart vessel
92992	Revision of heart chamber
92993	Revision of heart chamber
93583	Perq transcath septal reduxn
99184	Hypothermia ill neonate
99190	Special pump services
99191	Special pump services
99192	Special pump services
99356	Prolonged service inpatient
99357	Prolonged service inpatient
99462	Sbsq nb em per day hosp
99468	Neonate crit care initial
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care
99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subsq
99480	Ic inf pbw 2501-5000 g subsq
C9600	Perc drug-el cor stent sing
C9601	Perc drug-el cor stent bran
C9602	Perc d-e cor stent ather s
C9603	Perc d-e cor stent ather br
C9604	Perc d-e cor revasc t cabg s
C9605	Perc d-e cor revasc t cabg b
C9606	Perc d-e cor revasc w ami s
C9607	Perc d-e cor revasc chro sin
C9608	Perc d-e cor revasc chro add
C9751	Microwave bronch, 3D, EBUS
G0341	Percutaneous islet celltrans
G0342	Laparoscopy islet cell trans
G0343	Laparotomy islet cell transp
G0412	Open tx iliac spine uni/bil
G0413	Pelvic ring fracture uni/bil
G0414	Pelvic ring fx treat int fix
G0415	Open tx post pelvic fxcture

Exhibit 6: North Carolina State Health Plan Network

Professional Non-Facility Fee Schedule

The North Carolina State Health Plan Network Professional Non-Facility Fee Schedule is publicly available on BCBSNC's website: https://www.bluecrossnc.com/sites/default/files/document/attachment/SHP/SHP%20Professional%20Fee%20Schedule%2007242019.pdf .

Exhibit 7: Pricing Development and Maintenance Policy

Pricing principles for professional services in the North Carolina State Health Plan Network are currently addressed through BlueCross BlueShield of North Carolina's (BCBSNC) "Pricing Development and Maintenance Policy BETOS/CCS." This policy is publicly available on BCBSNC's website: https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/Professional_Pricing_Policy_CCS_BETOS.pdf .

The Plan expects the Vendor to supply a substitute policy containing pricing principles for professional services that are substantially the same and/or achieve the same results for the Plan, unless otherwise agreed to by the Plan. The Plan will approve this pricing policy during implementation.

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
00000	225	280
00602	0	1
00735	1	1
00851	1	3
01001	1	1
01002	1	3
01040	1	1
01061	1	1
01201	2	2
01301	1	1
01342	1	1
01440	0	1
01540	0	1
01545	1	1
01562	1	1
01610	0	1
01701	1	1
01720	2	2
01749	1	1
01776	2	2
01810	2	2
01844	1	1
01852	1	1
01890	1	1
01921	1	1
01938	1	1
01970	0	1
01984	1	1
02026	1	1
02043	1	1
02052	1	1
02061	2	2
02125	0	1
02127	1	1
02130	1	2
02131	2	2
02134	0	1
02135	1	1
02136	1	1
02141	0	1
02143	1	1
02144	0	3
02155	1	1
02169	1	1
02301	2	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
02368	1	2
02446	1	1
02453	1	1
02460	2	2
02468	1	2
02631	1	1
02664	1	1
02703	1	1
02719	1	2
02780	1	3
02827	1	1
02860	1	1
02865	1	1
02889	1	2
02892	1	1
02908	1	1
02915	1	1
02919	1	1
03043	1	1
03045	1	2
03060	1	1
03062	1	1
03101	0	1
03102	1	1
03103	0	1
03110	1	1
03246	1	1
03261	1	1
03755	1	3
03771	1	1
03809	1	1
03824	0	1
03856	0	1
03861	1	1
03862	1	1
03870	1	2
03894	2	2
03903	2	2
04009	0	1
04022	1	1
04032	1	1
04051	1	1
04079	1	1
04280	1	1
04345	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
04449	1	1
04457	1	2
04476	1	1
04605	1	1
04660	1	1
04667	1	1
04743	1	4
04756	1	1
04855	1	1
04901	4	4
04930	1	1
04937	1	1
04938	1	1
05030	1	1
05045	1	1
05403	0	1
05448	1	1
05488	1	1
05641	1	1
05678	1	1
05743	1	1
05753	1	1
05764	1	1
05777	0	1
05836	1	1
06002	3	3
06040	1	1
06066	2	3
06092	1	1
06095	1	1
06237	1	1
06238	0	3
06340	1	5
06378	1	1
06405	1	3
06437	1	1
06457	1	1
06473	1	4
06488	1	1
06492	1	1
06511	2	2
06512	1	1
06515	1	1
06518	1	1
06525	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
06610	1	1
06824	1	1
06878	1	5
06901	1	1
06902	1	4
06906	2	3
06907	1	1
07005	1	1
07040	1	1
07043	2	4
07052	1	1
07066	1	1
07080	1	1
07083	1	1
07104	1	1
07109	0	1
07208	0	1
07302	1	1
07307	1	1
07311	1	2
07432	0	2
07538	1	1
07601	2	2
07628	1	1
07649	1	1
07652	1	1
07717	1	1
07832	1	1
07860	1	1
07882	1	1
07940	1	1
07960	2	2
08003	1	1
08008	2	2
08010	1	1
08021	2	2
08050	1	1
08055	1	1
08056	1	1
08077	2	2
08081	1	1
08086	1	1
08096	1	1
08098	1	2
08361	0	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
08534	1	1
08536	1	1
08540	3	5
08610	1	2
08611	1	1
08638	1	1
08757	1	1
08758	1	1
08759	1	1
08824	1	1
08852	1	1
08854	2	4
08875	1	1
09464	1	1
09701	1	1
10002	1	2
10003	1	1
10010	2	2
10011	1	1
10021	1	1
10023	2	2
10024	1	1
10025	1	1
10026	3	3
10029	1	1
10034	1	1
10040	1	2
10065	1	1
10115	1	1
10128	2	5
10462	1	1
10466	1	1
10468	1	1
10471	1	1
10472	0	1
10475	1	1
10530	1	1
10538	1	1
10549	0	2
10550	0	1
10701	2	2
10708	1	1
10801	1	1
10804	1	1
10954	0	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
10956	1	1
10960	1	1
11201	1	1
11204	1	1
11208	1	6
11209	1	1
11212	2	2
11215	1	1
11218	1	1
11226	1	1
11233	1	1
11237	1	1
11354	0	2
11372	2	4
11375	2	2
11378	1	1
11416	1	1
11436	1	1
11553	1	1
11561	1	1
11590	0	1
11713	1	1
11729	0	1
11743	1	1
11763	1	1
11772	1	1
11776	1	1
11779	1	1
11798	1	1
12010	1	1
12019	1	1
12032	1	2
12110	1	1
12202	0	2
12203	1	1
12206	1	1
12308	1	1
12309	1	3
12481	1	3
12534	1	1
12545	1	1
12575	1	1
12601	1	1
12603	1	1
12804	0	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
12833	1	1
12871	1	1
12887	1	1
12916	1	1
13078	0	3
13080	1	1
13087	1	1
13112	1	1
13207	1	1
13224	1	1
13357	1	1
13365	1	1
13456	1	1
13488	0	3
13607	1	1
13612	1	1
13668	1	1
13760	1	2
13815	1	1
13825	1	1
13839	1	1
13850	1	1
14031	2	4
14033	1	1
14063	0	1
14103	1	1
14207	0	1
14220	1	1
14225	0	1
14227	0	1
14228	1	1
14261	1	1
14482	1	1
14514	1	1
14526	1	1
14532	0	2
14544	1	1
14564	2	2
14607	1	1
14618	1	1
14619	1	1
14624	1	1
14626	1	1
14733	1	1
14757	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
14845	0	1
14869	1	1
15044	2	2
15053	1	1
15071	1	1
15084	2	2
15120	2	2
15137	1	1
15143	1	1
15205	1	1
15217	1	2
15228	1	3
15235	1	1
15237	1	1
15238	1	2
15301	1	1
15317	2	2
15321	1	1
15417	1	1
15613	1	4
15627	2	2
15650	1	3
15701	1	1
15714	1	1
15857	2	2
15904	1	1
15927	1	1
15928	1	1
15931	1	2
15946	1	1
16033	1	1
16037	1	1
16105	2	2
16125	1	1
16148	1	1
16214	1	1
16301	1	1
16327	1	2
16373	2	2
16374	1	1
16502	1	1
16506	1	2
16509	1	3
16620	0	1
16635	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
16823	1	1
16828	1	1
17013	1	1
17022	3	3
17026	1	1
17032	0	1
17036	1	2
17042	1	1
17057	1	1
17078	1	1
17111	1	1
17201	1	1
17252	1	1
17320	1	1
17325	2	3
17340	2	2
17347	1	1
17401	1	2
17527	1	1
17543	2	6
17560	0	1
17603	2	2
17815	1	2
17821	1	1
17837	1	1
17847	1	1
17870	1	2
17929	0	1
17953	1	1
17957	1	1
18017	2	2
18064	1	1
18080	1	1
18092	1	2
18104	1	1
18252	1	1
18337	0	1
18360	1	1
18407	1	1
18426	1	1
18428	1	1
18431	1	2
18433	0	1
18508	1	1
18610	1	4

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
18831	1	1
18901	1	4
18914	1	1
18940	1	1
19001	1	2
19002	1	1
19004	1	1
19006	1	1
19046	1	1
19063	2	2
19073	2	3
19081	1	1
19096	1	1
19104	1	1
19106	1	1
19111	0	1
19118	1	1
19125	1	1
19128	1	2
19131	1	2
19132	1	1
19143	1	1
19146	0	1
19147	0	1
19151	2	2
19330	1	1
19335	1	1
19348	1	1
19365	1	1
19382	2	10
19406	1	1
19446	1	1
19510	1	1
19512	1	1
19525	0	1
19606	0	2
19709	2	2
19711	1	1
19720	1	1
19807	1	1
19901	2	2
19903	1	3
19904	1	1
19930	1	1
19933	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
19939	1	1
19943	1	1
19963	1	1
19966	1	1
20001	2	2
20002	1	3
20008	1	1
20009	1	1
20010	1	2
20011	2	2
20017	2	4
20024	1	1
20032	1	1
20037	1	1
20105	1	1
20106	1	1
20108	1	1
20112	1	1
20142	1	1
20147	1	1
20148	1	1
20152	1	1
20155	2	2
20165	1	1
20170	0	1
20171	2	4
20175	3	4
20187	1	1
20190	1	1
20603	1	1
20645	1	1
20695	1	1
20705	1	1
20707	3	5
20708	1	1
20710	1	1
20715	1	1
20720	1	1
20740	1	1
20744	3	7
20745	1	3
20748	1	1
20749	1	1
20764	1	1
20770	3	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
20772	3	3
20774	3	3
20782	1	1
20794	1	1
20814	2	2
20816	2	2
20833	1	3
20841	1	4
20850	2	5
20851	1	1
20852	1	4
20854	2	3
20855	1	1
20871	1	1
20874	2	4
20878	3	3
20901	1	1
20902	1	1
20904	1	1
20906	2	2
20910	2	2
20912	2	5
21009	1	1
21012	1	1
21015	1	1
21029	0	1
21042	2	3
21043	2	8
21044	4	9
21076	1	1
21113	3	3
21114	1	1
21117	3	3
21128	1	1
21146	1	3
21158	1	1
21204	1	1
21208	2	2
21210	1	1
21215	1	2
21220	1	2
21222	1	1
21224	1	1
21225	1	1
21229	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
21230	1	1
21236	2	2
21638	1	1
21661	1	1
21701	1	1
21702	1	1
21703	1	1
21727	1	4
21801	1	4
21811	1	1
21853	1	1
21875	1	1
22003	1	3
22025	1	1
22026	1	2
22030	1	1
22031	2	2
22032	1	1
22033	1	1
22041	1	1
22042	4	5
22046	2	2
22066	2	2
22079	1	1
22101	1	1
22150	3	3
22152	1	1
22153	1	1
22172	1	1
22180	2	2
22181	1	1
22182	1	1
22193	2	5
22201	0	1
22202	1	2
22204	1	1
22205	1	2
22206	2	2
22304	1	1
22306	1	1
22308	1	1
22309	1	1
22310	0	1
22312	1	1
22314	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
22406	3	3
22407	1	1
22408	1	1
22427	1	1
22443	2	2
22473	1	1
22482	1	1
22485	2	2
22508	2	2
22517	1	1
22520	1	1
22553	2	4
22556	2	2
22572	1	1
22579	1	1
22580	1	1
22601	1	1
22611	1	1
22630	0	1
22652	1	1
22655	1	1
22801	7	17
22802	1	1
22821	2	2
22830	1	3
22835	2	2
22842	1	1
22844	1	1
22901	4	4
22902	2	2
22903	5	8
22911	5	7
22936	4	4
22939	1	1
22942	2	2
22958	3	3
22963	5	6
22967	2	2
22968	1	1
22969	1	1
22973	1	1
22980	5	5
22989	2	2
23015	1	1
23018	1	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
23059	2	5
23060	3	5
23061	2	3
23062	2	2
23063	2	6
23072	1	1
23084	1	1
23089	2	2
23103	2	4
23109	1	1
23112	6	12
23113	2	2
23114	2	4
23116	3	3
23120	2	4
23124	2	3
23139	1	1
23140	2	2
23150	1	1
23173	1	1
23185	6	6
23188	6	6
23192	1	1
23219	1	1
23220	3	3
23221	0	1
23222	1	1
23223	4	4
23225	1	2
23227	3	3
23228	1	1
23229	6	11
23230	1	1
23233	5	5
23234	0	1
23235	4	5
23236	4	6
23238	3	3
23255	1	1
23314	3	3
23315	1	1
23320	27	45
23321	9	10
23322	28	48
23323	17	27

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
23324	5	9
23325	2	5
23356	1	1
23410	1	1
23430	4	4
23432	1	4
23433	2	2
23434	11	17
23435	8	13
23437	3	4
23438	1	4
23439	2	2
23451	7	7
23452	4	4
23453	2	2
23454	7	12
23455	1	2
23456	3	6
23457	2	2
23462	6	7
23464	16	23
23487	1	1
23502	1	1
23503	5	9
23504	4	7
23505	3	3
23507	3	3
23508	2	2
23509	4	4
23510	1	1
23513	0	1
23517	3	7
23518	2	4
23541	1	1
23602	2	2
23606	1	1
23607	1	1
23608	2	4
23661	1	1
23662	1	3
23663	1	1
23666	6	7
23669	6	6
23693	2	2
23701	5	6

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
23702	2	2
23703	11	17
23704	4	4
23707	1	1
23803	3	3
23805	2	2
23824	3	3
23827	1	1
23828	4	4
23829	3	6
23830	1	1
23831	3	3
23834	3	7
23836	1	1
23837	1	2
23841	1	1
23845	4	10
23847	23	35
23851	6	10
23856	1	1
23857	7	10
23860	1	1
23866	1	1
23867	3	3
23868	5	9
23874	4	7
23875	2	2
23876	1	1
23879	3	6
23887	4	8
23889	1	1
23893	2	5
23901	2	2
23915	4	7
23917	21	27
23919	18	24
23920	6	12
23924	2	2
23927	44	61
23944	5	6
23950	7	8
23968	4	5
23970	32	57
23974	2	2
24012	2	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
24014	1	1
24015	2	2
24016	1	1
24018	7	7
24053	49	84
24054	13	14
24055	10	15
24059	1	1
24060	5	7
24069	7	18
24073	2	4
24076	22	32
24078	8	10
24082	1	1
24088	3	4
24089	1	1
24091	1	2
24101	1	1
24102	1	1
24112	54	77
24114	1	1
24115	1	1
24120	3	7
24121	3	6
24124	1	1
24127	1	1
24133	4	4
24134	1	1
24136	1	1
24137	1	1
24139	3	3
24141	2	4
24148	24	38
24149	1	1
24151	3	6
24153	4	5
24165	2	3
24171	44	90
24175	2	2
24176	4	5
24179	1	1
24185	1	1
24201	1	2
24202	1	1
24210	2	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
24211	2	2
24212	3	3
24221	1	1
24228	1	1
24236	2	3
24243	1	1
24244	1	1
24258	1	1
24266	1	1
24292	2	5
24312	2	6
24317	78	138
24324	1	1
24325	1	2
24326	5	10
24328	15	20
24330	6	6
24333	44	67
24343	20	27
24348	14	18
24350	2	2
24351	8	14
24352	6	18
24354	1	5
24361	1	1
24363	15	26
24368	3	4
24370	1	1
24378	5	7
24380	2	6
24381	5	10
24382	2	5
24401	2	2
24437	3	3
24440	1	3
24450	1	5
24465	2	2
24473	2	2
24482	1	1
24487	1	1
24501	1	1
24502	0	1
24503	2	3
24504	1	1
24520	17	18

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
24522	1	1
24523	2	3
24527	6	8
24529	10	12
24530	1	1
24531	9	17
24534	2	2
24538	1	1
24540	87	122
24541	94	139
24543	3	7
24549	5	7
24550	2	2
24551	2	3
24557	5	5
24558	12	16
24563	1	1
24565	2	2
24566	1	1
24572	2	3
24577	1	1
24578	1	1
24580	11	18
24586	26	34
24589	1	1
24592	13	18
24593	1	1
24594	2	2
24597	2	5
24598	16	27
24630	1	1
24651	2	2
24701	4	4
24739	2	2
24740	1	1
24901	1	1
24927	1	1
24966	1	1
25007	1	1
25064	1	1
25082	1	1
25177	1	1
25276	1	1
25302	1	1
25303	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
25304	1	1
25309	1	1
25311	1	1
25401	1	1
25402	1	2
25411	1	1
25425	1	1
25428	1	1
25443	1	1
25508	1	1
25514	1	1
25526	2	6
25550	1	1
25560	2	2
25646	1	1
25649	1	1
25801	1	1
25813	0	2
25839	2	2
25840	2	2
25843	1	1
25978	1	1
26003	1	1
26104	1	1
26147	2	2
26155	1	3
26164	1	1
26209	1	2
26224	2	2
26234	1	1
26241	1	2
26260	1	1
26321	1	1
26377	1	1
26426	1	2
26508	4	6
26537	1	1
26570	1	1
26582	0	2
26662	1	1
26679	1	1
26726	1	1
27006	461	766
27007	108	173
27009	77	122

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27010	10	17
27011	215	354
27012	934	1,541
27013	162	239
27014	19	29
27016	68	114
27017	537	873
27018	262	382
27019	123	187
27020	191	270
27021	588	939
27022	65	85
27023	396	697
27024	125	206
27025	301	413
27027	115	159
27028	771	1,280
27030	1,752	2,800
27040	442	725
27041	379	607
27042	13	22
27043	219	330
27045	324	486
27046	76	99
27047	47	75
27048	243	349
27049	26	38
27050	95	138
27051	208	308
27052	280	395
27053	129	185
27054	84	103
27055	461	731
27101	441	585
27102	12	14
27103	1,031	1,489
27104	822	1,269
27105	820	1,017
27106	1,210	1,850
27107	1,119	1,712
27109	1	1
27110	6	6
27113	3	3
27114	10	19
27115	7	7

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27116	14	17
27117	12	13
27120	4	4
27127	1,187	1,728
27130	6	10
27201	14	20
27202	5	8
27203	552	780
27204	52	73
27205	1,462	2,260
27207	274	412
27208	132	208
27209	172	253
27212	70	94
27213	5	5
27214	452	688
27215	1,680	2,482
27216	24	32
27217	1,015	1,438
27228	12	16
27229	167	226
27230	9	10
27231	124	172
27233	97	169
27235	146	224
27239	292	450
27242	78	105
27243	305	468
27244	429	709
27247	6	6
27248	147	225
27249	559	877
27252	111	165
27253	1,672	2,514
27256	4	4
27258	376	621
27259	5	5
27260	297	378
27261	21	25
27262	431	648
27263	460	703
27265	1,624	2,437
27278	1,809	2,936
27281	102	151
27282	669	1,044

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27283	107	142
27284	1,598	2,514
27285	15	21
27288	493	675
27289	18	20
27291	73	94
27292	1,162	1,772
27293	19	29
27295	1,284	1,973
27298	351	550
27299	143	207
27301	552	872
27302	2,085	3,257
27305	69	85
27306	298	425
27310	243	452
27311	82	113
27312	1,716	2,744
27313	230	371
27314	48	72
27315	82	103
27316	263	406
27317	530	807
27320	1,214	1,742
27323	24	28
27325	293	409
27326	117	167
27330	1,486	2,279
27331	54	76
27332	832	1,246
27340	41	62
27341	279	409
27342	17	19
27343	66	98
27344	757	1,140
27349	373	589
27350	190	286
27351	13	15
27355	98	159
27356	144	210
27357	232	360
27358	407	684
27359	6	7
27360	1,126	1,702
27361	23	29

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27370	453	684
27371	473	702
27373	8	10
27374	37	50
27375	8	16
27376	359	611
27377	495	725
27379	239	313
27401	473	588
27402	54	65
27403	685	1,009
27404	29	34
27405	1,344	1,843
27406	2,182	3,017
27407	1,394	1,972
27408	630	940
27409	560	729
27410	2,260	3,592
27411	4	5
27412	5	7
27413	4	7
27415	17	17
27416	21	25
27417	3	7
27419	21	30
27420	12	16
27425	1	1
27427	3	3
27435	9	17
27438	18	32
27455	1,137	1,840
27501	987	1,527
27502	1,911	3,356
27503	170	263
27504	923	1,429
27505	232	364
27506	32	50
27507	80	107
27508	103	135
27509	319	397
27510	1,482	2,172
27511	1,517	2,326
27512	32	39
27513	1,911	2,992
27514	1,899	3,173

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27515	56	82
27516	3,929	7,188
27517	2,217	3,772
27518	965	1,563
27519	1,771	3,240
27520	2,358	3,590
27521	288	441
27522	850	1,150
27523	557	923
27524	728	1,145
27525	744	1,044
27526	2,465	4,145
27527	1,477	2,538
27528	70	89
27529	3,225	4,751
27530	2,247	3,153
27532	43	47
27533	42	46
27534	1,850	2,433
27536	774	962
27537	1,131	1,530
27539	971	1,640
27540	1,597	2,924
27541	234	351
27542	486	682
27543	6	11
27544	248	360
27545	1,779	2,583
27546	756	1,174
27549	1,065	1,540
27551	115	157
27552	16	22
27553	133	183
27555	39	52
27556	25	30
27557	324	462
27559	125	199
27560	982	1,523
27562	94	158
27563	262	340
27565	1,747	2,363
27568	89	135
27569	504	769
27570	12	18
27571	358	667

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27572	281	425
27573	388	508
27574	624	935
27576	695	972
27577	1,096	1,678
27581	209	309
27582	32	42
27583	318	539
27584	25	30
27586	5	5
27587	2,745	4,642
27588	49	69
27589	379	477
27591	1,222	1,816
27592	859	1,458
27593	18	23
27594	14	17
27596	841	1,320
27597	1,229	1,833
27599	33	54
27601	378	474
27602	20	23
27603	2,748	3,970
27604	2,403	3,366
27605	412	531
27606	2,214	3,099
27607	1,093	1,647
27608	571	863
27609	1,572	2,186
27610	3,783	5,258
27611	71	89
27612	1,931	2,718
27613	1,982	3,013
27614	1,155	1,909
27615	1,923	2,877
27616	2,531	3,809
27617	842	1,209
27619	43	47
27620	68	82
27622	15	19
27623	5	5
27624	28	38
27627	34	40
27628	8	12
27629	24	32

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27636	7	13
27650	7	11
27658	9	12
27661	16	25
27675	17	22
27695	13	18
27699	8	10
27701	710	920
27702	43	51
27703	2,507	3,525
27704	1,663	2,218
27705	1,578	2,269
27707	2,259	3,046
27709	34	42
27712	1,121	1,742
27713	3,817	5,557
27715	19	22
27717	50	63
27722	19	23
27801	465	615
27802	42	58
27803	755	1,128
27804	1,182	1,670
27805	134	181
27806	74	101
27807	306	435
27808	156	253
27809	155	229
27810	158	241
27811	18	23
27812	139	207
27813	43	56
27814	101	143
27816	124	194
27817	321	477
27818	38	47
27819	7	7
27820	120	171
27821	16	20
27822	364	555
27823	244	323
27824	72	106
27825	19	26
27826	63	96
27827	17	25

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27828	475	698
27829	82	115
27830	283	405
27831	105	140
27832	111	156
27833	31	35
27834	3,078	4,292
27835	76	91
27836	50	76
27837	420	738
27839	150	185
27840	21	28
27841	8	8
27842	33	47
27843	29	38
27844	81	109
27845	104	134
27846	187	276
27847	34	52
27849	77	96
27850	282	376
27851	221	313
27852	127	182
27853	12	14
27855	197	261
27856	962	1,471
27857	48	67
27858	3,804	5,975
27860	77	129
27861	7	8
27862	29	41
27863	797	1,196
27864	185	273
27865	97	162
27866	31	40
27867	1	1
27868	20	36
27869	99	128
27870	1,134	1,633
27871	213	304
27872	12	14
27873	22	26
27874	156	193
27875	36	41
27876	61	76

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27877	4	6
27878	36	43
27879	18	23
27880	151	250
27881	10	11
27882	400	563
27883	158	227
27884	82	123
27885	80	110
27886	720	971
27887	5	5
27888	114	163
27889	1,439	2,179
27890	91	129
27891	162	221
27892	997	1,437
27893	1,184	1,536
27894	37	48
27895	19	23
27896	1,068	1,693
27897	47	76
27906	58	80
27907	7	11
27909	2,006	2,863
27910	520	717
27915	39	62
27916	33	54
27917	27	36
27919	76	137
27920	86	128
27921	289	462
27922	38	49
27923	25	31
27924	141	212
27925	298	454
27926	28	46
27927	12	17
27928	143	194
27929	43	53
27932	660	939
27935	65	106
27936	51	69
27937	76	110
27938	82	139
27939	63	116

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
27941	27	37
27942	22	46
27943	42	69
27944	560	881
27946	56	90
27947	31	55
27948	350	582
27949	195	341
27950	25	32
27953	44	68
27954	348	540
27956	19	33
27957	75	94
27958	194	326
27959	119	180
27960	81	127
27962	411	567
27964	15	36
27965	13	19
27966	26	41
27967	30	41
27968	6	12
27969	1	3
27970	166	214
27972	5	7
27973	55	94
27974	56	78
27976	106	144
27978	4	5
27979	70	97
27980	135	223
27981	69	131
27982	3	3
27983	558	773
27985	19	23
27986	71	97
28001	1,077	1,710
28002	36	54
28006	24	37
28007	33	45
28009	63	86
28010	2	6
28012	615	972
28016	293	423
28017	65	102

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28018	325	475
28019	12	16
28020	135	213
28021	560	867
28023	582	909
28024	26	43
28025	1,713	2,651
28026	26	31
28027	2,064	3,299
28031	552	915
28032	104	151
28033	104	148
28034	434	630
28035	1	1
28036	385	675
28037	555	898
28038	14	19
28039	3	3
28040	371	557
28041	48	78
28042	36	62
28043	950	1,456
28052	520	721
28053	16	21
28054	872	1,294
28055	14	16
28056	1,061	1,624
28070	29	32
28071	104	164
28072	36	46
28073	101	146
28074	5	8
28075	770	1,371
28076	17	18
28077	4	4
28078	1,552	2,636
28079	1,022	1,837
28080	177	288
28081	770	1,120
28082	26	36
28083	760	1,111
28086	816	1,265
28088	155	214
28089	15	22
28090	398	624

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28091	116	175
28092	1,093	1,682
28093	39	52
28097	234	403
28098	104	153
28101	16	22
28102	4	7
28103	381	575
28104	708	1,219
28105	1,043	1,715
28106	21	33
28107	239	371
28108	23	34
28109	11	22
28110	1,495	2,445
28111	44	50
28112	753	1,078
28114	224	339
28115	1,033	1,742
28117	839	1,363
28119	107	143
28120	535	838
28123	3	3
28124	309	468
28125	88	116
28126	2	2
28127	267	394
28128	341	523
28129	284	459
28130	4	4
28133	131	194
28134	213	307
28135	201	309
28136	31	46
28137	124	207
28138	348	521
28139	963	1,431
28144	556	774
28145	34	48
28146	998	1,485
28147	750	1,126
28150	911	1,420
28151	32	45
28152	883	1,343
28159	60	85

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28160	147	213
28163	161	259
28164	342	546
28166	283	473
28167	130	201
28168	462	763
28169	14	18
28170	599	850
28173	1,091	2,082
28174	268	380
28202	195	238
28203	300	369
28204	206	234
28205	1,010	1,311
28206	209	230
28207	102	139
28208	607	692
28209	407	509
28210	697	989
28211	511	803
28212	670	859
28213	1,116	1,520
28214	844	1,264
28215	1,385	1,948
28216	1,390	1,884
28217	344	403
28218	2	3
28219	2	2
28221	5	7
28222	3	3
28223	27	49
28224	8	11
28226	629	979
28227	1,278	1,957
28229	9	9
28230	1	2
28231	4	5
28232	2	2
28233	3	3
28235	1	2
28236	3	4
28241	2	2
28247	5	5
28256	10	11
28262	1,037	1,418

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28266	10	10
28269	2,376	3,634
28270	683	1,118
28271	9	18
28273	623	893
28274	1	3
28277	1,074	1,764
28278	465	721
28297	7	7
28299	7	7
28301	447	548
28302	22	26
28303	891	1,178
28304	1,189	1,574
28305	236	335
28306	1,195	1,670
28307	3	3
28309	20	24
28311	1,188	1,617
28312	729	1,055
28314	1,424	1,835
28315	405	557
28318	228	337
28320	492	720
28323	156	220
28325	23	36
28326	361	522
28327	639	983
28328	1,122	1,716
28329	59	77
28330	22	33
28331	7	10
28332	45	61
28333	532	680
28334	1,029	1,630
28335	31	34
28337	689	962
28338	192	269
28339	298	417
28340	476	641
28341	152	229
28342	10	17
28343	40	47
28344	86	126
28345	530	681

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28347	26	33
28348	1,297	1,834
28349	214	312
28350	14	19
28351	161	227
28352	908	1,370
28353	57	73
28355	15	21
28356	176	249
28357	79	104
28358	1,387	1,948
28359	148	186
28360	668	948
28362	6	8
28363	44	51
28364	579	851
28365	668	989
28366	261	437
28367	9	12
28368	27	37
28369	101	147
28370	24	34
28371	215	295
28372	1,040	1,510
28373	93	148
28374	402	651
28375	12	18
28376	1,257	1,645
28377	444	619
28378	6	8
28379	1,187	1,690
28380	62	77
28382	325	498
28383	363	487
28384	330	427
28385	195	294
28386	184	242
28387	407	566
28388	31	41
28390	438	603
28391	283	423
28392	76	106
28393	74	94
28394	126	173
28395	138	199

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28396	125	164
28398	269	356
28399	79	118
28401	692	877
28402	19	26
28403	1,061	1,484
28404	16	19
28405	1,006	1,409
28406	23	26
28407	7	8
28408	11	16
28409	1,457	2,591
28411	1,414	2,257
28412	1,574	2,408
28420	119	192
28421	75	114
28422	216	303
28423	85	115
28424	8	12
28425	482	698
28428	241	373
28429	343	499
28430	124	190
28431	414	588
28432	141	218
28433	265	353
28434	60	81
28435	86	104
28436	52	84
28438	111	164
28439	74	110
28441	124	185
28442	83	112
28443	668	1,216
28444	95	130
28445	254	390
28447	47	58
28448	43	58
28449	95	159
28450	140	200
28451	1,165	1,701
28452	20	26
28453	91	124
28454	96	127
28455	108	179

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28456	150	196
28457	360	578
28458	196	262
28459	68	83
28460	243	343
28461	448	644
28462	319	462
28463	386	562
28464	75	122
28465	290	428
28466	367	556
28467	155	222
28468	91	114
28469	197	278
28470	266	415
28472	1,107	1,601
28478	218	305
28479	203	327
28480	73	124
28501	874	1,124
28502	44	49
28503	33	42
28504	1,426	1,944
28508	62	101
28509	17	19
28510	89	122
28511	40	50
28512	130	201
28513	610	903
28515	115	169
28516	520	767
28518	378	588
28519	16	27
28520	26	42
28521	118	169
28522	2	3
28523	110	168
28524	20	23
28525	218	325
28526	86	106
28527	42	64
28528	26	36
28529	102	146
28530	376	515
28531	84	103

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28532	366	467
28537	9	16
28538	145	209
28539	341	521
28540	1,300	1,884
28541	17	23
28543	1	1
28544	47	51
28546	964	1,337
28547	1	1
28551	924	1,347
28552	4	8
28553	45	69
28554	41	52
28555	197	266
28556	39	53
28557	656	964
28560	799	1,146
28561	29	37
28562	1,424	2,090
28563	9	12
28570	724	1,111
28571	100	134
28572	303	478
28573	80	109
28574	645	982
28575	3	3
28577	19	23
28578	174	262
28579	30	46
28580	753	1,037
28581	17	22
28582	74	112
28583	9	12
28584	511	793
28585	240	338
28586	292	419
28587	16	21
28589	6	11
28590	2,528	4,300
28594	197	284
28601	1,493	2,323
28602	834	1,248
28603	32	40
28604	262	410

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28605	261	461
28606	73	115
28607	2,150	3,574
28608	44	59
28609	195	293
28610	329	515
28611	46	78
28612	466	714
28613	695	1,127
28615	84	131
28616	30	37
28617	113	161
28618	172	301
28619	142	185
28621	394	643
28622	101	165
28623	49	73
28624	66	101
28625	1,233	1,907
28626	188	265
28627	44	66
28628	81	107
28629	10	12
28630	837	1,320
28631	26	35
28634	147	212
28635	149	230
28636	193	307
28637	72	113
28638	610	935
28640	242	366
28641	17	22
28642	186	253
28643	153	220
28644	88	128
28645	1,841	2,790
28646	42	50
28647	14	20
28649	40	61
28650	373	595
28651	299	465
28652	17	23
28653	8	12
28654	131	196
28655	3,947	5,704

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28657	445	648
28658	812	1,230
28659	638	968
28660	88	141
28661	15	22
28662	18	22
28663	36	55
28664	19	28
28665	119	194
28666	25	40
28667	3	3
28668	15	22
28669	100	170
28670	116	183
28671	61	91
28672	2	2
28673	117	191
28675	256	377
28676	193	307
28677	910	1,391
28678	182	283
28679	170	283
28680	166	222
28681	884	1,409
28682	27	38
28683	73	118
28684	136	220
28685	67	97
28687	28	39
28688	1	1
28689	66	94
28690	614	952
28691	11	15
28692	380	590
28693	69	103
28694	400	640
28697	527	831
28698	157	243
28699	2	2
28701	149	215
28702	13	17
28704	620	992
28705	367	544
28707	27	35
28708	5	7

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28709	72	104
28710	8	11
28711	510	738
28712	402	649
28713	417	611
28714	753	1,091
28715	782	1,189
28716	670	977
28717	41	63
28718	10	19
28719	40	49
28720	3	4
28721	435	635
28722	192	304
28723	666	990
28724	20	29
28725	44	69
28726	59	87
28727	23	33
28728	31	38
28729	140	218
28730	303	459
28731	198	297
28732	650	1,006
28733	2	2
28734	832	1,234
28735	10	13
28736	18	27
28737	2	2
28738	18	31
28739	472	685
28740	136	195
28741	43	71
28742	115	188
28743	52	59
28744	59	86
28745	69	108
28746	50	76
28747	34	54
28748	435	622
28749	8	13
28750	8	8
28751	102	155
28752	1,433	2,083
28753	460	609

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28754	333	483
28755	18	30
28756	143	230
28757	8	12
28758	13	16
28759	240	384
28760	5	5
28761	398	577
28762	307	416
28763	63	89
28765	1	1
28766	62	89
28768	184	283
28770	13	18
28771	335	520
28772	59	91
28773	89	147
28774	7	13
28775	6	13
28776	15	21
28777	510	751
28778	384	500
28779	1,133	1,755
28781	31	42
28782	142	206
28783	63	84
28784	1	1
28785	287	472
28786	841	1,254
28787	751	1,118
28788	71	102
28789	214	335
28790	101	129
28791	413	648
28792	683	1,019
28793	33	46
28801	324	443
28802	22	27
28803	779	1,167
28804	645	999
28805	565	874
28806	1,190	1,729
28813	11	14
28814	15	16
28815	18	30

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
28816	26	32
28901	197	316
28902	49	76
28904	235	422
28905	88	140
28906	555	891
28909	26	47
29006	1	2
29010	1	1
29015	1	1
29016	8	9
29020	7	9
29032	2	3
29033	2	2
29036	3	3
29045	1	1
29053	1	1
29056	1	1
29058	4	5
29063	7	7
29067	2	2
29069	1	4
29072	10	15
29073	4	5
29080	1	1
29081	1	1
29101	1	1
29104	1	1
29108	4	8
29115	1	1
29118	2	3
29127	2	2
29128	1	1
29129	1	1
29130	3	3
29135	1	1
29148	2	2
29150	4	4
29153	2	2
29154	4	4
29160	1	1
29161	1	1
29163	1	1
29164	1	2
29168	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
29169	5	5
29171	1	1
29178	2	2
29180	5	6
29201	1	1
29203	7	12
29204	1	1
29205	3	3
29206	6	6
29209	3	3
29210	3	6
29212	8	10
29223	8	10
29224	1	1
29229	17	22
29301	6	6
29302	6	9
29303	3	7
29304	1	1
29306	3	3
29307	5	5
29316	20	33
29322	14	24
29323	20	30
29325	2	3
29330	6	7
29334	2	3
29340	8	12
29341	31	42
29342	1	1
29349	35	50
29353	1	1
29356	27	33
29360	1	1
29365	2	2
29368	2	2
29369	4	4
29372	1	1
29374	1	1
29376	2	2
29379	2	3
29385	2	4
29388	2	2
29403	1	1
29405	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
29407	8	8
29410	3	3
29412	11	12
29414	6	6
29418	1	1
29420	1	1
29429	2	2
29439	1	2
29440	1	1
29442	1	2
29445	2	2
29449	1	1
29451	2	4
29455	3	9
29464	10	17
29466	6	6
29483	6	8
29485	4	7
29486	4	4
29487	1	2
29488	2	2
29492	6	7
29501	13	17
29502	1	1
29505	9	12
29506	14	18
29510	2	2
29511	3	3
29512	53	57
29520	44	53
29525	3	6
29526	27	33
29527	7	7
29528	1	1
29532	6	9
29536	36	57
29540	1	1
29541	1	1
29543	1	1
29544	1	1
29545	16	24
29547	10	17
29550	3	5
29551	2	3
29556	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
29560	2	2
29563	10	12
29565	10	22
29566	87	115
29567	2	3
29568	39	63
29569	57	67
29570	16	21
29571	5	5
29572	35	42
29574	11	13
29575	17	21
29576	25	29
29577	29	41
29579	20	20
29580	1	1
29581	7	7
29582	123	147
29583	1	1
29585	12	14
29588	12	20
29589	1	1
29591	1	1
29592	1	1
29594	3	4
29596	4	4
29597	3	5
29601	3	3
29605	2	2
29607	5	9
29608	1	1
29609	7	8
29611	1	1
29615	9	14
29617	2	5
29620	1	1
29621	5	9
29622	1	1
29625	4	5
29626	6	7
29627	2	2
29630	1	2
29631	5	8
29635	4	5
29639	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
29640	1	2
29642	4	4
29643	0	2
29644	3	4
29646	3	3
29649	3	3
29650	12	18
29651	8	9
29653	1	1
29657	1	1
29661	4	5
29666	2	2
29669	3	3
29670	4	5
29671	1	1
29673	2	2
29676	3	4
29678	5	6
29679	1	1
29680	3	3
29681	6	9
29682	3	6
29684	1	1
29685	2	2
29687	11	11
29689	1	1
29690	8	10
29691	1	1
29692	1	1
29693	2	4
29696	1	1
29697	6	8
29702	34	46
29703	2	2
29704	6	10
29706	10	16
29707	299	485
29708	185	293
29709	18	31
29710	202	336
29712	4	4
29714	1	1
29715	181	287
29716	2	2
29717	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
29718	7	10
29720	129	205
29721	4	5
29727	10	11
29728	47	61
29729	2	2
29730	121	160
29731	1	1
29732	166	234
29733	1	2
29741	5	5
29742	1	1
29743	2	2
29745	56	90
29803	3	3
29812	1	1
29829	1	1
29831	1	1
29845	1	1
29847	1	1
29860	1	1
29901	2	4
29902	1	1
29906	1	1
29907	3	4
29909	8	8
29910	7	8
29920	1	1
29924	2	2
29926	7	8
29928	2	2
29935	1	1
29936	1	1
30008	2	2
30012	1	1
30013	1	1
30014	1	1
30016	1	1
30023	1	1
30024	4	4
30028	1	1
30030	2	2
30032	2	2
30033	3	4
30039	3	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
30040	1	2
30041	1	1
30043	1	1
30044	2	2
30045	2	2
30046	1	1
30047	3	3
30052	1	1
30058	1	1
30060	1	1
30062	3	4
30064	2	2
30066	1	1
30067	2	2
30068	1	4
30072	1	1
30075	1	2
30080	5	6
30082	1	3
30087	4	4
30088	2	2
30092	2	2
30093	1	1
30094	5	8
30096	1	1
30097	2	3
30101	1	1
30102	2	2
30103	1	1
30114	4	4
30117	1	1
30118	1	1
30121	1	1
30126	2	2
30127	3	3
30141	2	2
30143	2	2
30144	2	2
30152	3	3
30157	1	1
30168	1	1
30173	1	1
30175	2	3
30180	1	1
30184	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
30188	3	4
30189	3	3
30213	1	5
30214	1	1
30215	2	2
30233	2	2
30236	1	1
30252	1	2
30253	1	1
30263	0	1
30269	1	1
30281	1	1
30286	1	1
30291	1	1
30296	1	1
30305	1	1
30306	3	3
30308	2	2
30309	2	3
30318	1	4
30319	1	1
30324	2	2
30326	1	1
30327	2	5
30328	1	1
30329	0	1
30331	4	5
30332	1	1
30338	1	1
30340	1	1
30341	1	2
30342	2	7
30346	1	1
30349	1	1
30350	2	2
30360	1	1
30401	1	1
30415	1	1
30453	1	1
30458	2	2
30501	0	1
30504	2	2
30506	2	2
30512	17	33
30513	3	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
30518	2	2
30519	2	2
30523	2	2
30525	2	2
30528	1	1
30533	2	2
30537	4	4
30540	1	1
30542	1	2
30546	17	26
30548	2	2
30549	1	2
30559	8	14
30560	3	4
30562	1	1
30568	2	3
30571	1	1
30576	3	7
30582	18	28
30601	1	1
30605	6	8
30606	2	5
30620	1	1
30622	1	2
30628	1	2
30642	1	1
30655	1	1
30677	3	7
30701	1	1
30705	2	2
30707	0	1
30721	1	1
30725	1	5
30747	2	2
30750	1	1
30809	4	5
30813	0	2
30815	1	1
30817	1	1
30824	1	1
30904	1	1
30906	2	2
30907	2	2
30909	5	5
30916	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
30919	1	1
31015	1	1
31024	1	1
31032	1	2
31057	1	1
31061	4	4
31071	1	1
31079	1	1
31088	3	3
31092	1	1
31093	1	4
31201	0	1
31210	3	3
31220	2	2
31308	1	1
31312	1	1
31322	4	6
31324	2	2
31328	2	2
31401	1	2
31406	3	3
31410	2	2
31419	4	4
31516	1	1
31521	1	1
31522	2	2
31523	1	1
31525	2	2
31527	1	1
31548	1	1
31549	2	2
31558	2	3
31568	1	1
31636	1	1
31716	1	1
31721	1	1
31750	1	1
31763	1	1
31806	1	1
31820	1	1
31833	1	1
31906	1	1
31909	3	3
32003	2	2
32008	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
32024	2	2
32025	3	3
32034	8	11
32043	12	14
32059	1	1
32060	1	2
32064	2	4
32065	3	3
32068	2	2
32073	1	1
32080	6	6
32081	6	6
32084	2	3
32086	3	3
32091	1	1
32092	2	5
32095	2	2
32097	1	1
32112	1	1
32114	2	2
32117	2	2
32118	1	1
32119	2	3
32127	2	2
32128	2	2
32129	1	1
32132	3	3
32137	11	12
32141	3	4
32145	1	1
32148	1	1
32159	3	3
32162	7	7
32163	9	10
32164	4	5
32168	1	1
32169	1	1
32174	6	8
32176	2	2
32204	1	1
32207	1	1
32210	1	1
32216	1	1
32218	2	2
32222	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
32223	2	2
32224	5	7
32225	4	5
32250	2	2
32256	2	2
32257	1	2
32258	3	4
32259	2	5
32266	1	1
32301	2	2
32303	2	2
32304	1	1
32308	1	1
32309	4	4
32310	1	1
32311	4	6
32312	5	5
32317	2	2
32324	1	1
32327	1	1
32401	1	1
32411	1	1
32433	1	1
32439	1	1
32444	1	1
32456	1	1
32502	1	1
32503	2	3
32506	1	1
32507	3	5
32514	1	1
32526	0	2
32533	2	2
32534	2	2
32536	5	5
32539	1	1
32563	2	2
32566	5	5
32570	1	1
32571	2	3
32578	1	1
32601	1	1
32605	4	4
32606	6	6
32607	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
32608	2	2
32615	1	1
32635	2	2
32643	1	1
32653	1	1
32666	1	1
32667	1	1
32693	1	1
32702	1	1
32703	1	1
32708	3	3
32713	1	1
32715	1	1
32720	1	2
32724	2	5
32738	1	1
32746	2	2
32750	2	2
32757	1	1
32759	1	1
32762	1	1
32763	1	1
32765	4	8
32766	1	1
32778	1	1
32779	1	1
32780	1	1
32784	1	1
32789	1	4
32803	1	1
32804	1	1
32805	1	1
32806	1	1
32810	1	3
32817	2	2
32825	1	1
32826	1	2
32827	2	2
32828	3	5
32833	1	1
32835	1	1
32836	1	1
32837	2	2
32901	1	2
32904	4	4

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
32905	2	2
32907	1	1
32909	2	4
32920	1	1
32926	1	1
32931	1	1
32934	1	1
32935	6	6
32936	1	1
32937	1	1
32940	10	10
32949	1	1
32955	1	1
32958	2	2
32960	5	5
32962	3	3
32963	4	4
32965	1	2
32966	2	2
32967	4	4
32968	2	2
33009	1	1
33021	1	1
33025	1	2
33027	3	3
33033	2	2
33037	2	2
33040	4	6
33050	4	4
33056	1	1
33062	2	2
33063	2	2
33066	1	1
33076	1	3
33126	1	1
33131	2	2
33132	1	1
33133	1	1
33139	1	1
33143	1	5
33157	1	5
33160	1	1
33161	1	1
33165	1	1
33166	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
33172	1	2
33176	2	2
33186	1	1
33196	1	1
33197	1	1
33301	2	2
33304	2	3
33308	2	2
33309	2	2
33311	1	1
33316	1	1
33317	1	1
33319	2	2
33322	3	4
33324	2	2
33330	1	1
33334	1	1
33351	1	2
33401	1	1
33406	1	1
33407	1	1
33410	2	5
33411	3	4
33412	2	2
33418	0	1
33422	1	1
33428	1	2
33434	1	1
33436	1	1
33437	1	1
33444	1	1
33445	1	5
33446	1	1
33449	2	2
33455	1	1
33458	3	3
33467	1	1
33469	1	1
33472	1	6
33473	1	1
33482	1	1
33483	1	1
33487	1	1
33523	2	4
33525	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
33543	2	2
33544	1	1
33545	2	2
33556	2	2
33558	2	2
33559	1	1
33563	0	1
33565	1	1
33569	1	1
33570	1	1
33572	5	7
33573	2	2
33578	2	2
33579	1	1
33584	1	1
33597	1	1
33598	1	2
33606	2	5
33607	1	1
33612	1	1
33613	2	3
33615	1	1
33618	4	4
33624	2	2
33625	2	2
33626	1	1
33635	1	1
33647	4	4
33681	1	1
33701	1	1
33702	1	1
33705	1	1
33706	3	3
33707	1	1
33708	1	1
33710	1	1
33711	1	1
33713	1	1
33714	1	1
33715	1	1
33716	1	2
33755	1	1
33764	1	1
33765	2	2
33773	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
33774	1	1
33778	1	1
33782	1	2
33803	2	4
33809	1	1
33810	1	1
33812	1	1
33813	2	2
33823	1	1
33825	3	4
33836	2	2
33837	2	2
33839	1	1
33843	1	1
33844	1	1
33850	3	3
33855	1	1
33862	1	1
33868	1	1
33870	1	4
33873	1	1
33880	2	2
33884	5	5
33897	1	1
33901	2	3
33903	1	1
33904	1	1
33905	3	3
33908	1	1
33913	2	3
33914	2	2
33916	1	1
33917	3	3
33919	1	1
33928	1	4
33929	1	1
33931	0	2
33936	0	1
33946	2	2
33947	1	1
33948	1	1
33950	4	4
33954	1	1
33956	1	1
33970	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
33971	1	1
33973	1	1
33980	2	2
33981	1	1
33983	3	3
33991	2	2
34104	2	2
34105	2	2
34108	1	1
34110	2	3
34112	1	1
34117	1	2
34119	1	1
34120	1	1
34134	3	4
34202	2	2
34205	2	2
34207	1	2
34208	4	5
34210	2	2
34211	2	2
34219	2	2
34221	1	1
34223	1	1
34224	1	1
34228	2	2
34229	1	1
34231	1	1
34233	1	1
34234	1	1
34235	1	1
34236	1	1
34237	1	1
34238	1	1
34239	1	1
34240	1	1
34242	1	1
34243	1	1
34269	1	1
34275	3	4
34285	1	1
34286	2	2
34287	2	2
34292	4	5
34293	5	7

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
34421	1	1
34428	3	3
34431	1	1
34432	1	1
34433	2	2
34434	1	1
34436	2	2
34446	1	1
34448	1	1
34452	1	1
34465	3	3
34471	1	1
34472	1	1
34473	3	3
34476	4	5
34478	1	1
34481	6	7
34491	3	4
34606	1	1
34607	1	1
34608	3	3
34609	2	2
34610	1	1
34613	1	1
34639	1	1
34653	1	1
34654	1	1
34655	2	2
34667	1	1
34668	3	3
34677	1	1
34681	1	2
34684	1	1
34688	1	1
34695	1	1
34698	1	1
34711	3	3
34715	1	1
34736	2	2
34741	1	2
34743	1	1
34744	1	1
34746	3	3
34748	1	1
34759	3	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
34787	1	1
34788	2	3
34946	1	2
34949	2	2
34951	3	3
34952	4	4
34953	1	2
34954	1	1
34957	3	3
34974	5	5
34982	2	4
34983	1	1
34986	2	2
34990	2	4
34994	1	1
34997	2	2
35004	2	2
35022	2	2
35043	1	1
35064	1	2
35079	2	2
35085	1	1
35120	1	1
35128	1	1
35209	2	2
35211	1	1
35214	2	2
35216	1	2
35222	1	1
35226	2	2
35242	5	5
35244	1	1
35401	4	4
35406	1	1
35469	1	1
35470	1	1
35501	1	1
35578	1	1
35613	3	3
35633	2	2
35634	1	1
35748	1	1
35756	1	2
35759	1	1
35763	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
35803	1	1
35806	1	1
35903	1	3
35952	1	1
35962	1	1
35989	1	1
36066	2	2
36092	1	2
36093	1	5
36207	1	1
36278	1	3
36305	1	1
36323	3	3
36330	1	1
36376	2	2
36460	2	2
36523	1	1
36526	3	3
36527	1	2
36532	1	1
36535	3	3
36549	1	1
36582	1	1
36608	1	1
36613	1	1
36693	1	1
36701	1	1
36744	1	1
36801	1	1
36804	2	2
36830	2	6
36832	1	1
36856	1	1
36870	1	1
37013	1	1
37015	1	1
37027	6	11
37040	3	3
37042	2	2
37064	3	4
37067	1	1
37072	2	4
37075	1	2
37085	1	1
37087	1	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
37090	1	1
37115	1	1
37122	2	2
37127	2	2
37128	1	1
37135	1	1
37148	1	1
37185	1	1
37203	1	1
37204	1	7
37205	1	2
37206	0	1
37210	1	1
37211	1	1
37215	2	2
37221	1	1
37303	1	1
37311	1	1
37312	2	2
37317	4	6
37323	1	3
37326	1	1
37328	1	1
37329	1	1
37330	1	1
37331	1	1
37343	2	2
37363	2	5
37380	1	1
37388	1	1
37391	1	3
37402	1	1
37403	1	1
37405	1	1
37415	1	1
37416	2	2
37419	1	1
37421	3	3
37601	10	14
37602	1	1
37604	13	20
37615	2	2
37617	4	4
37618	1	1
37620	7	10

State Health Plan for Teachers and State Employees
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Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
37640	27	33
37641	2	2
37643	10	10
37650	9	11
37657	3	4
37658	3	6
37659	6	7
37660	4	4
37663	4	7
37664	3	3
37680	1	2
37682	1	1
37683	87	105
37684	1	1
37687	39	50
37688	1	1
37691	31	40
37692	4	4
37713	1	1
37716	1	1
37722	1	1
37725	1	1
37727	2	2
37743	9	10
37744	1	1
37745	3	5
37752	1	1
37763	1	1
37764	2	2
37801	1	1
37803	3	5
37804	1	1
37807	1	2
37813	1	1
37814	4	6
37818	1	2
37821	1	1
37825	3	3
37830	1	1
37843	7	9
37846	1	1
37857	1	1
37862	3	4
37864	1	1
37865	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
37869	1	1
37870	1	1
37876	7	8
37882	2	2
37909	2	3
37914	1	1
37917	2	2
37918	2	2
37919	3	4
37920	3	4
37921	1	1
37922	5	12
37923	1	1
37924	1	1
37931	2	3
37932	3	6
37934	4	5
37938	1	1
38002	1	1
38008	1	1
38012	1	1
38016	1	1
38017	1	1
38053	1	1
38063	1	1
38104	2	2
38112	1	1
38138	1	1
38139	1	1
38201	2	2
38221	1	1
38305	2	2
38315	1	1
38343	0	1
38401	1	2
38501	4	4
38506	2	6
38553	1	1
38556	1	1
38558	3	3
38571	1	1
38583	2	2
38632	1	1
38655	6	15
38668	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
38801	1	1
38828	1	1
38948	0	1
38965	1	1
38967	1	1
39042	1	2
39047	2	2
39074	1	1
39111	1	1
39157	1	4
39168	1	1
39209	2	2
39232	1	1
39288	1	1
39361	1	1
39364	1	1
39403	1	1
39501	1	1
39506	1	1
39531	1	1
39532	3	3
39560	1	1
39564	2	2
39565	1	1
39648	1	1
39702	2	2
39705	1	1
39759	0	5
40203	0	1
40204	1	1
40207	1	1
40222	1	1
40243	1	1
40324	1	2
40330	2	2
40351	1	1
40353	1	1
40361	1	1
40383	1	1
40403	2	3
40422	3	3
40475	2	3
40503	1	1
40508	1	1
40509	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
40513	1	3
40515	4	4
40741	1	1
40843	1	4
41001	1	1
41011	1	1
41094	1	1
41097	1	1
41301	1	1
42031	1	1
42071	1	1
42104	1	1
42303	1	1
42437	1	1
42539	1	1
42564	1	1
42717	1	1
43015	1	1
43016	2	2
43017	1	3
43021	1	1
43028	1	1
43035	1	1
43050	2	4
43054	1	1
43065	1	1
43068	1	1
43081	1	1
43107	1	1
43109	1	1
43123	0	1
43140	1	3
43201	0	1
43209	1	1
43210	0	1
43220	0	1
43229	0	1
43235	1	2
43311	1	1
43402	1	1
43452	1	1
43502	1	1
43558	2	3
43605	1	1
43832	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
43912	1	1
43940	1	1
44001	1	1
44011	1	1
44022	1	1
44035	1	1
44041	0	1
44048	1	1
44065	1	1
44077	1	2
44089	0	1
44094	1	1
44095	1	1
44107	0	1
44122	2	2
44128	1	1
44130	2	2
44139	1	1
44224	2	5
44240	2	2
44272	1	1
44281	1	1
44305	1	1
44333	1	1
44406	1	1
44408	1	1
44614	1	2
44667	1	1
44691	1	1
44721	1	4
44842	1	2
44906	1	1
45011	1	2
45039	0	1
45040	1	1
45044	1	1
45069	3	3
45106	0	1
45140	1	1
45150	1	2
45177	1	2
45204	0	1
45209	0	1
45211	0	1
45215	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
45220	1	1
45226	1	1
45243	1	1
45255	2	3
45324	1	1
45342	1	1
45365	1	1
45385	1	1
45417	1	1
45419	1	1
45426	1	3
45431	1	1
45449	0	1
45458	2	2
45502	1	1
45628	1	1
45634	1	3
45640	2	3
45648	1	1
45701	3	6
45750	1	1
45822	0	1
45840	1	1
45877	1	1
45885	1	1
46033	1	1
46038	1	1
46040	1	1
46062	1	4
46074	1	1
46077	1	5
46123	1	1
46203	1	1
46220	1	1
46221	1	1
46240	2	2
46256	1	2
46311	1	1
46385	1	1
46545	2	5
46702	1	1
46804	0	2
46845	2	2
46902	2	2
47112	1	4

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
47129	1	1
47130	1	1
47374	0	3
47404	1	1
47408	0	1
47433	1	1
47591	1	1
47613	1	1
47807	0	1
47833	1	2
47901	0	1
47906	2	2
48025	1	1
48103	1	1
48104	1	1
48105	0	1
48145	1	1
48154	2	2
48167	0	1
48168	3	3
48170	0	1
48184	1	1
48198	1	1
48309	1	2
48334	1	1
48335	1	1
48362	1	1
48380	1	1
48415	1	1
48433	1	1
48441	1	3
48450	1	1
48602	1	1
48734	1	1
48823	1	1
49006	1	1
49009	1	1
49015	1	1
49032	2	2
49058	1	1
49068	1	1
49085	1	1
49097	1	1
49107	2	2
49247	0	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
49401	1	1
49418	1	1
49441	1	1
49442	1	1
49503	1	1
49504	1	3
49534	1	1
49601	2	2
49630	1	1
49648	1	1
49657	0	1
49686	1	1
49744	1	1
49777	1	1
49913	1	1
49930	1	1
49950	1	1
50010	1	1
50021	1	2
50211	1	1
50263	1	1
50265	0	1
50310	1	1
50311	1	1
50571	1	1
50644	1	1
50701	1	1
51106	1	1
51334	1	1
51502	1	1
51535	1	1
52101	2	4
52246	1	1
52247	1	1
52353	1	1
52601	1	1
52626	1	1
53092	1	1
53207	1	1
53217	3	3
53226	2	2
53511	1	1
53532	1	2
53545	1	1
53703	0	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
53705	0	1
53711	0	1
53714	1	2
54001	1	1
54173	1	1
54494	1	1
54701	1	1
54891	1	1
55033	1	1
55045	1	1
55075	0	1
55090	1	4
55104	1	1
55106	1	1
55113	1	1
55125	1	1
55129	1	1
55369	1	1
55414	1	1
55415	1	2
55419	1	1
55430	1	1
55437	1	1
55441	1	1
55760	1	1
56001	1	2
56201	1	1
57104	1	1
57332	1	1
57701	0	3
57719	1	1
57730	1	1
57790	1	1
58501	1	1
58503	1	1
59047	2	2
59405	0	1
59501	1	1
59635	1	1
59715	4	4
59801	1	1
59802	1	1
59803	1	1
59840	1	1
59871	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
59873	1	1
59875	1	1
59903	1	1
59911	1	1
59912	1	1
60008	1	1
60010	0	1
60016	1	1
60045	1	1
60047	1	1
60060	1	1
60068	1	1
60070	1	1
60074	1	1
60084	1	1
60090	1	1
60124	1	1
60126	1	1
60134	2	4
60137	2	2
60156	1	1
60190	1	1
60201	1	1
60202	1	1
60304	0	2
60430	1	1
60440	1	1
60449	0	2
60461	1	1
60466	1	2
60491	1	1
60516	1	1
60559	0	1
60560	1	1
60601	1	1
60605	0	1
60608	1	1
60614	2	5
60615	0	1
60630	1	1
60641	1	1
60643	1	1
60657	3	3
60901	2	2
61068	1	1

State Health Plan for Teachers and State Employees
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Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
61108	0	1
61276	1	2
61455	1	1
61611	0	1
61802	1	1
61822	2	2
61874	1	1
62025	2	2
62094	1	2
62305	1	1
62321	1	1
62630	1	2
62656	1	1
62839	1	1
62946	1	1
62960	1	1
63051	1	1
63070	0	1
63101	1	1
63109	1	1
63114	1	1
63115	1	1
63116	1	1
63132	1	1
63139	1	1
63141	1	2
63146	2	2
63303	1	1
63376	1	1
63385	1	1
63459	1	1
63755	3	3
64061	1	1
64064	1	1
64082	1	1
64119	1	1
64123	1	1
64505	1	1
64508	1	1
65202	1	1
65203	4	4
65270	1	1
65583	1	1
65608	1	2
65721	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
65738	1	1
66049	0	1
66062	1	1
66206	1	1
66223	1	3
66604	1	1
66732	1	1
67152	0	2
67214	1	2
67235	1	1
67846	1	1
68026	1	1
68114	1	2
68130	2	2
68132	0	1
68133	1	1
68505	1	1
68510	1	1
68526	1	1
68701	1	1
68803	1	1
69101	1	1
70003	1	1
70039	1	1
70065	1	2
70072	1	1
70114	2	2
70118	0	2
70119	1	1
70124	0	1
70125	1	1
70126	1	1
70127	1	1
70394	1	4
70433	3	3
70447	1	1
70506	1	1
70508	1	1
70548	1	1
70601	1	1
70769	2	2
70791	1	1
70810	1	1
71105	1	1
71201	2	3

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
71203	1	1
71225	1	3
71270	2	4
71360	1	1
71457	1	1
71459	1	1
71463	1	1
71909	1	1
71913	2	3
72007	1	1
72114	1	3
72120	1	1
72173	2	2
72211	0	1
72212	1	1
72396	1	1
72401	1	1
72525	1	1
72642	2	2
72701	1	1
72712	1	1
72801	1	1
72846	1	1
72921	1	1
72956	1	1
73025	2	2
73072	1	1
73078	1	1
73106	1	1
73111	1	1
73117	1	1
73118	1	1
73136	1	1
73162	2	2
73460	1	1
73461	1	1
74006	1	5
74011	1	1
74070	1	1
74137	1	1
74347	1	1
74464	1	1
74804	0	1
75007	1	1
75010	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
75013	1	3
75019	1	1
75020	1	3
75023	1	1
75025	1	3
75034	1	1
75048	1	1
75052	1	2
75056	2	4
75060	1	1
75070	1	1
75071	2	2
75081	1	1
75104	0	1
75116	2	2
75156	1	1
75189	2	2
75205	2	3
75206	1	1
75214	1	1
75229	0	2
75254	1	3
75287	1	1
75426	1	1
75432	1	1
75455	4	6
75605	2	2
75686	1	1
75948	1	1
76002	1	4
76011	1	1
76012	0	1
76014	1	2
76021	1	1
76034	2	2
76036	1	1
76051	1	1
76063	1	1
76067	1	1
76078	2	2
76116	1	1
76132	2	2
76155	1	1
76177	1	3
76179	1	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
76205	2	4
76207	1	1
76208	3	3
76210	3	4
76227	2	2
76244	2	3
76310	1	1
76450	0	1
76549	1	3
76689	1	4
76904	3	3
77006	3	3
77007	2	2
77019	1	1
77025	2	5
77041	1	1
77043	1	1
77044	1	3
77062	2	2
77065	1	1
77070	2	3
77082	1	2
77095	1	1
77318	1	1
77340	1	1
77342	1	1
77373	1	1
77377	1	1
77379	1	1
77386	1	2
77389	1	1
77399	3	4
77406	1	1
77433	1	1
77441	1	1
77449	1	3
77479	5	5
77494	2	4
77498	1	1
77511	1	1
77581	1	1
77802	1	1
77808	1	1
77833	2	5
77840	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
77845	0	1
77979	1	1
78003	1	1
78015	1	1
78023	1	1
78043	1	4
78064	1	2
78101	1	1
78212	1	1
78244	1	1
78249	1	1
78253	2	2
78270	1	1
78382	1	1
78414	1	1
78501	2	2
78550	2	2
78596	1	1
78613	2	2
78619	1	1
78628	2	2
78633	2	3
78641	3	5
78653	1	1
78660	1	1
78664	1	2
78665	2	2
78666	2	2
78701	1	1
78703	1	2
78723	2	4
78731	1	2
78736	1	2
78741	0	1
78745	0	1
78746	1	1
78749	1	1
78750	1	1
78758	1	1
78759	1	1
78838	1	1
78873	1	1
79015	1	2
79109	1	1
79121	2	2

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
79413	1	1
79414	1	1
79416	1	1
79423	1	2
79424	1	1
79606	1	1
79703	1	1
79706	1	1
79707	1	1
79902	1	1
79924	1	1
79934	1	1
80011	1	1
80013	1	1
80016	1	1
80023	2	3
80120	1	1
80128	2	2
80129	1	1
80132	1	1
80134	1	1
80203	1	1
80209	1	2
80212	1	2
80214	1	1
80220	1	1
80228	1	1
80233	1	1
80238	1	1
80241	1	4
80247	1	1
80249	1	1
80301	4	4
80302	3	3
80303	1	3
80304	2	3
80401	1	1
80403	1	1
80461	1	1
80488	1	1
80503	1	2
80513	1	1
80521	1	1
80525	5	10
80526	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
80538	1	2
80602	1	1
80902	1	1
80908	1	1
80909	1	1
80910	1	1
80917	1	1
80918	1	1
80919	3	3
80924	1	5
80962	1	1
81101	1	1
81131	1	1
81212	2	2
81224	2	2
81244	1	1
81301	2	2
82009	1	1
82070	0	1
82331	1	1
82414	2	3
82421	1	1
82801	1	1
83001	1	1
83002	1	1
83221	1	1
83263	0	3
83404	1	1
83605	1	2
83634	1	1
83713	1	1
83835	1	1
83854	1	1
84032	3	3
84049	2	2
84058	0	1
84092	1	1
84096	1	1
84098	3	3
84109	1	1
84111	1	1
84310	1	1
84405	1	1
84414	1	1
84651	2	9

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
84663	0	1
84720	1	1
84780	1	1
84790	1	1
85006	1	1
85008	1	1
85009	1	1
85021	1	1
85044	1	1
85054	1	1
85122	1	1
85140	1	1
85143	1	1
85202	1	1
85203	1	1
85204	1	1
85251	1	1
85254	1	1
85260	0	1
85268	1	2
85281	0	1
85284	1	2
85307	0	2
85326	2	2
85339	1	1
85340	1	1
85345	1	1
85351	1	1
85375	1	1
85379	1	1
85388	2	2
85395	1	1
85396	2	2
85603	2	2
85704	2	2
85705	1	1
85713	1	1
85718	1	1
85719	2	3
85726	1	1
85733	1	1
85743	2	2
86046	1	1
86301	2	6
86305	2	2

State Health Plan for Teachers and State Employees
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Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
86315	1	1
86403	0	1
86404	1	1
87001	1	1
87004	1	1
87107	1	1
87109	1	1
87111	1	1
87113	1	1
87114	1	1
87116	1	2
87120	1	1
87144	1	1
87181	1	1
87501	1	1
87502	2	2
87505	3	3
87508	4	4
87574	1	2
87592	1	1
88011	3	3
88061	3	3
88101	1	2
88203	1	1
88240	1	1
89014	2	2
89027	2	2
89031	2	2
89034	1	1
89041	1	1
89052	3	5
89084	1	1
89117	1	1
89118	1	1
89119	1	1
89121	1	1
89129	1	1
89131	3	3
89134	1	1
89135	1	1
89148	1	1
89156	1	1
89170	1	1
89173	1	1
89193	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
89503	2	6
89521	0	1
89801	1	1
90034	2	2
90039	1	1
90043	1	1
90046	0	1
90049	2	2
90065	1	1
90066	1	2
90077	1	1
90230	1	1
90303	0	1
90403	1	1
90712	0	1
90732	1	1
90804	1	1
91017	1	1
91107	1	1
91214	1	1
91387	2	4
91403	1	1
91602	1	2
91709	1	1
91745	1	1
91767	1	1
91775	2	2
91789	1	1
92024	0	1
92037	1	2
92075	1	1
92101	2	2
92107	1	1
92110	1	1
92118	0	1
92126	2	2
92128	1	1
92130	1	1
92131	1	1
92139	1	1
92203	1	1
92252	1	1
92262	1	1
92264	1	1
92284	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
92584	2	2
92586	1	1
92592	2	2
92646	1	1
92651	1	1
92660	1	1
92663	1	1
92675	1	1
92691	3	6
92692	3	4
92705	1	1
92706	1	1
92708	1	2
92823	1	1
92833	1	1
92835	1	1
92880	1	1
93023	1	1
93041	0	1
93101	1	1
93103	1	1
93111	1	4
93405	2	2
93428	1	2
93534	1	2
93535	1	4
93636	1	1
93662	1	1
93950	1	1
94002	2	2
94010	0	2
94024	1	1
94062	1	1
94086	1	1
94114	1	1
94117	2	2
94118	0	1
94158	0	1
94303	1	1
94402	1	1
94404	1	1
94539	1	1
94542	1	1
94582	1	1
94589	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
94608	1	1
94610	1	1
94702	1	2
94928	1	1
94945	1	1
94954	1	1
95037	1	1
95060	2	2
95070	1	3
95076	1	1
95112	1	1
95121	1	4
95136	1	1
95203	1	1
95269	1	2
95334	1	1
95380	2	2
95476	1	1
95608	1	2
95610	1	1
95722	1	1
95742	1	1
95814	1	1
95817	1	1
95826	0	3
95926	0	1
96322	1	1
96707	1	1
96734	1	1
96753	1	1
96754	1	1
96768	1	1
96772	1	1
96816	1	1
96913	1	1
97003	1	2
97034	1	1
97035	1	1
97060	1	1
97124	1	1
97202	2	2
97213	1	1
97219	1	1
97222	1	2
97229	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
97232	1	1
97239	3	3
97290	1	1
97302	1	4
97367	2	2
97376	1	1
97381	1	1
97401	1	1
97405	3	3
97411	1	1
97424	1	1
97439	1	1
97540	1	1
97624	1	1
97701	0	1
98006	0	2
98042	1	1
98045	1	1
98052	1	1
98058	1	1
98072	1	2
98074	1	1
98087	1	1
98103	1	4
98105	1	1
98106	1	1
98109	2	2
98110	1	3
98115	1	1
98116	1	1
98121	1	1
98122	1	2
98177	1	1
98221	1	2
98229	3	3
98249	1	1
98258	1	1
98276	1	1
98296	1	1
98311	1	1
98335	1	1
98365	1	1
98368	1	1
98374	1	1
98387	1	1

State Health Plan for Teachers and State Employees
Membership by 5 Digit ZIPcode

Exhibit 8

Zip5, Member Address	Subscriber Distinct Count	Member Distinct Count
98391	1	1
98407	1	1
98498	1	1
98502	1	1
98604	1	1
98632	1	1
98662	1	1
98664	1	1
98683	2	2
98684	2	2
98685	1	1
99016	1	2
99163	1	1
99205	2	2
99507	1	5
99627	1	1
99654	1	1
TOTALS:	388,964	582,147

Exhibit 9

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 Copay

Selected PCP	$10
PCP/Mental Hlth/Subst Abuse	$25
Specialist	$80
Phy/Occu/Spch Therapy/Chiro	$52
Urgent Care	$70*
ER	$300 + Ded** & 20%*

* same for out-of-network
** Deductible

Blue PPO

Subscriber: JOHN SAMPLE 01

Subscriber ID:
SMPL0001

Your Group

Date Issued: 01/01/2019

Group No: S60114

RXBIN:	RXPCN:	RXGRP:
004336	ADV	RX0274

Primary Care Provider (PCP)

Dr. PCP
123 Anywhere Street
123-456-7890

BlueOptions **80/20 Plan**

Paid for by **YOU** *and other* **NC Taxpayers**

Exhibit 9

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 and does not assume any financial risk for claims.

CVS caremark® Pharmacy Benefits Administrator

Subscriber: JOHN SAMPLE 01

Subscriber ID: **SMPL0001**

Phone

Benefits & Claims	888-234-2416
Eligibility & Enrollment*	855-859-0966
Find Non-NC Providers	800-810-2583
Provider Service	800-214-4844
Prior Review/Certification	800-672-7897
Mental Health/Substance Use	800-367-6143
Pharmacy Help Desk*	800-364-6331
CVS Caremark*	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

Exhibit 10

Group Structure			
Group Number	Sponsor Name	Employing Unit Type	Beacon Agency
S26028	SHP-Alamance Community College	Community Colleges	
S27072	SHP-Alamance-Burlington Schools	Public Schools	
S60106	SHP-Albemarle ABC Board	Municipalities	
S60075	SHP-Albemarle Commission	Municipalities	
S60029	SHP-Albemarle District Jail	Municipalities	
S60026	SHP-Albemarle Regional Health Services	Municipalities	
S27017	SHP-Alexander County Schools	Public Schools	
S27018	SHP-Alleghany County Schools	Public Schools	
S28027	SHP-American Renaissance School	Charter Schools	
S60105	SHP-Angier ABC Board	Municipalities	
S60076	SHP-Anson County	Municipalities	
S27035	SHP-Anson County Schools	Public Schools	
S60077	SHP-Appalachian District Health	Municipalities	
S60043	SHP-Appalachian Regional Library	Municipalities	
S25002	SHP-Appalachian State University	Universities	
S28003	SHP-Arapahoe Charter School	Charter Schools	
S28046	SHP-Art Space Charter Schools	Charter Schools	
S28050	SHP-Arts Based Elementary	Charter Schools	
S27019	SHP-Ashe County Schools	Public Schools	
S27057	SHP-Asheboro City Schools	Public Schools	
S26001	SHP-Asheville Buncombe Community	Community Colleges	
S27002	SHP-Asheville City Schools	Public Schools	
S27020	SHP-Avery County Schools	Public Schools	
S60004	SHP-Bay River Metropolitan Water Sewer District	Municipalities	
S17001	SHP-Beacon	Beacon	Public Safety
S16001	SHP-Beacon	Beacon	Health Human Services
S22001	SHP-Beacon	Beacon	Judicial Branch
S07002	SHP-Beacon	Beacon	Agriculture Consumer Service
S20001	SHP-Beacon	Beacon	Revenue
S15001	SHP-Beacon	Beacon	Wildlife Resources Commission
S11001	SHP-Beacon	Beacon	Transportation
S04001	SHP-Beacon	Beacon	State Treasurer
S19014	SHP-Beacon	Beacon	Department of Information Technology
S06001	SHP-Beacon	Beacon	Justice
S19014	SHP-Beacon	Beacon	Information Technology
S14001	SHP-Beacon	Beacon	Environmental Quality
S21001	SHP-Beacon	Beacon	Natural and Cultural Resources

Exhibit 10

S27091	SHP-Beacon	Beacon	School of Science & Math
S30031	SHP-Beacon	Beacon	Barber Exam
S19001	SHP-Beacon	Beacon	Commerce - DES & DWS
S09001	SHP-Beacon	Beacon	Insurance
S19001	SHP-Beacon	Beacon	Commerce
S10006	SHP-Beacon	Beacon	Military and Veterans Affairs
S05001	SHP-Beacon	Beacon	Public Instruction
S10001	SHP-Beacon	Beacon	Administration
S02001	SHP-Beacon	Beacon	Secretary of State
S10005	SHP-Beacon	Beacon	State Controller
S10002	SHP-Beacon	Beacon	State Budget and Management
S10003	SHP-Beacon	Beacon	Administrative Hearings
S10001	SHP-Beacon	Beacon	State Personnel
S03001	SHP-Beacon	Beacon	State Auditor
S10001	SHP-Beacon	Beacon	Lt Governor's Office
S07002	SHP-Beacon	Beacon	Transportation
S05003	SHP-Beacon	Beacon	Community Colleges
S08001	SHP-Beacon	Beacon	Labor
S10001	SHP-Beacon	Beacon	Elections
S01002	SHP-Beacon	Beacon	Governor's Office
S22001	SHP-Beacon	Beacon	Public Safety
S08001	SHP-Beacon	Beacon	Information Technology
S19001	SHP-Beacon	Beacon	Insurance
S16001	SHP-Beacon	Beacon	State Controller
S07002	SHP-Beacon	Beacon	Public Safety
S19014	SHP-Beacon	Beacon	Transportation
S19001	SHP-Beacon	Beacon	Public Safety
S30026	SHP-Beacon	Beacon	Psychology
S06001	SHP-Beacon	Beacon	State Personnel
S10001	SHP-Beacon	Beacon	Public Safety
S17001	SHP-Beacon	Beacon	Health Human Services
S11001	SHP-Beacon	Beacon	Information Technology
S07002	SHP-Beacon	Beacon	Information Technology
S10001	SHP-Beacon	Beacon	Public Instruction
S16001	SHP-Beacon	Beacon	Public Safety
S03001	SHP-Beacon	Beacon	Labor
S30020	SHP-Beacon	Beacon	Auctioneer Licensing
S11001	SHP-Beacon	Beacon	Justice
S16001	SHP-Beacon	Beacon	Public Instruction

Exhibit 10

S10001	SHP-Beacon	Beacon	State Ethics
S16001	SHP-Beacon	Beacon	State Personnel
S22001	SHP-Beacon	Beacon	Public Instruction
S19014	SHP-Beacon	Beacon	Public Safety
S09001	SHP-Beacon	Beacon	Public Safety
S11001	SHP-Beacon	Beacon	Public Safety
S17001	SHP-Beacon	Beacon	Commerce - DES & DWS
S20001	SHP-Beacon	Beacon	Commerce - DES & DWS
S10001	SHP-Beacon	Beacon	Health Human Services
S11001	SHP-Beacon	Beacon	Revenue
S04001	SHP-Beacon	Beacon	Public Safety
S19001	SHP-Beacon	Beacon	Information Technology
S17001	SHP-Beacon	Beacon	School of Science & Math
S19014	SHP-Beacon	Beacon	Agriculture Consumer Service
S09001	SHP-Beacon	Beacon	Judicial Branch
S19014	SHP-Beacon	Beacon	Judicial Branch
S16001	SHP-Beacon	Beacon	Transportation
S17001	SHP-Beacon	Beacon	Judicial Branch
S10001	SHP-Beacon	Beacon	State Treasurer
S16001	SHP-Beacon	Beacon	Labor
S06001	SHP-Beacon	Beacon	Administration
S09001	SHP-Beacon	Beacon	Justice
S01002	SHP-Beacon	Beacon	Environmental Quality
S06001	SHP-Beacon	Beacon	Information Technology
S01002	SHP-Beacon	Beacon	State Personnel
S06001	SHP-Beacon	Beacon	Judicial Branch
S20001	SHP-Beacon	Beacon	Health Human Services
S17001	SHP-Beacon	Beacon	Justice
S30029	SHP-Beacon	Beacon	Opticians
S11001	SHP-Beacon	Beacon	Health Human Services
S28082	SHP-Bear Grass Charter School	Charter Schools	
S26045	SHP-Beaufort Community College	Community Colleges	
S52001	SHP-Beaufort County	Municipalities	
S27112	SHP-Beaufort County Schools	Public Schools	
S60056	SHP-Bertie County	Municipalities	
S27114	SHP-Bertie County Schools	Public Schools	
S60057	SHP-Bertie Martin Regional Jail	Municipalities	
S28068	SHP-Bethany Community Middle School	Charter Schools	
S60110	SHP-Black Mountain ABC Board	Municipalities	
S26036	SHP-Bladen Community College	Community Colleges	
S27098	SHP-Bladen Public Schools	Public Schools	

Exhibit 10

S26004	SHP-Blue Ridge Community College	Community Colleges	
S28098	SHP-Bradford Prep School	Charter Schools	
S28075	SHP-Brevard Academy	Charter Schools	
S28024	SHP-Bridges School	Charter Schools	
S26044	SHP-Brunswick Community College	Community Colleges	
S27092	SHP-Brunswick County Schools	Public Schools	
S27001	SHP-Buncombe County Board of	Public Schools	
S27021	SHP-Burke County Schools	Public Schools	
S60062	SHP-Burke County Tourism Development Authority	Municipalities	
S27042	SHP-Cabarrus County Schools	Public Schools	
S26007	SHP-Caldwell Community College	Community Colleges	
S60020	SHP-Caldwell County	Municipalities	
S27022	SHP-Caldwell County Schools	Public Schools	
S27115	SHP-Camden County Schools	Public Schools	
S28043	SHP-Cape Fear Center for Inquiry	Charter Schools	
S26042	SHP-Cape Fear Community College	Community Colleges	
S60030	SHP-Cape Fear Public Utility	Municipalities	
S28056	SHP-Carolina International School	Charter Schools	
S26054	SHP-Carteret Community College	Community Colleges	
S27138	SHP-Carteret Public Schools	Public Schools	
S28085	SHP-Casa Esperanza Montessori Charter	Charter Schools	
S27073	SHP-Caswell County Schools	Public Schools	
S27023	SHP-Catawba County Schools	Public Schools	
S26008	SHP-Catawba Valley Community College	Community Colleges	
S60114	SHP-Centennial Authority	Municipalities	
S61002	SHP-Center Pigeon Fire Department	Municipalities	
S26030	SHP-Central Carolina Community College	Community Colleges	
S28051	SHP-Central Park School for Children	Charter Schools	
S26017	SHP-Central Piedmont Community	Community Colleges	
S27081	SHP-Chapel Hill Carrborro City Schools	Public Schools	
S27037	SHP-Charlotte Mecklenburg Schools	Public Schools	
S28063	SHP-Charlotte Secondary School	Charter Schools	
S60103	SHP-Chatham Co ABC Board	Municipalities	
S27074	SHP-Chatham County Schools	Public Schools	
S27003	SHP-Cherokee County Schools	Public Schools	
S60005	SHP-City of Bessemer	Municipalities	
S60006	SHP-City of Conover	Municipalities	
S60069	SHP-City of Dunn	Municipalities	
S60021	SHP-City of Goldsboro	Municipalities	
S60031	SHP-City of Lincolnton	Municipalities	
S60070	SHP-City of Lincolnton ABC	Municipalities	
S60025	SHP-City of Lowell	Municipalities	
S60022	SHP-City of Morganton	Municipalities	
S60044	SHP-City of Mt Airy ABC Board	Municipalities	
S60078	SHP-City of Saluda	Municipalities	
S60023	SHP-City of Whiteville	Municipalities	

Exhibit 10

S27004	SHP-Clay County Schools	Public Schools	
S26009	SHP-Cleveland Community College	Community Colleges	
S27026	SHP-Cleveland County Schools	Public Schools	
S60100	SHP-Clinton ABC Store	Municipalities	
S27111	SHP-Clinton City Schools	Public Schools	
S28053	SHP-Clover Garden School	Charter Schools	
S26043	SHP-Coastal Carolina Community College	Community Colleges	
SCOBRA	SHP-COBRA	COBRA	
S26051	SHP-College of the Albemarle	Community Colleges	
S60073	SHP-Columbus County	Municipalities	
S27099	SHP-Columbus County Schools	Public Schools	
S28055	SHP-Community School of Davidson	Charter Schools	
S28081	SHP-Cornerstone Charter Academy	Charter Schools	
S28094	SHP-Corvian Community School	Charter Schools	
S60058	SHP-County of Ashe	Municipalities	
S45001	SHP-County of Bladen	Municipalities	
S60010	SHP-County of Greene	Municipalities	
S60071	SHP-County of Pamlico	Municipalities	
S26055	SHP-Craven Community College	Community Colleges	
S27139	SHP-Craven County Schools	Public Schools	
S27101	SHP-Cumberland County Schools	Public Schools	
S27117	SHP-Currituck County Schools	Public Schools	
S27118	SHP-Dare County Schools	Public Schools	
S26022	SHP-Davidson County Community College	Community Colleges	
S27050	SHP-Davidson County Schools	Public Schools	
S27062	SHP-Davie County Schools	Public Schools	
S28010	SHP-Dillard Academy	Charter Schools	
SHPDBL	SHP-Direct Bill	Direct Bill	
S28017	SHP-Discovery Charter School	Charter Schools	
S16018	SHP-Div of Services for the Blind	Agencies	
S60045	SHP-Dobson ABC	Municipalities	
S27093	SHP-Duplin County Schools	Public Schools	
S27075	SHP-Durham Public Schools	Public Schools	
S26029	SHP-Durham Technical Community	Community Colleges	
S25016	SHP-East Carolina University	Universities	
S28020	SHP-East Wake Academy	Charter Schools	
S27116	SHP-Edenton Chowan Schools	Public Schools	
S26046	SHP-Edgecombe Community College	Community Colleges	
S27119	SHP-Edgecombe County Schools	Public Schools	
S27131	SHP-Elizabeth City Pasquotank Public	Public Schools	
S25017	SHP-Elizabeth City State University	Universities	
S60046	SHP-Elizabeth City-Pasquotank County Airport Authority	Municipalities	
S27068	SHP-Elkin City Schools	Public Schools	
S28100	SHP-Emereau Foundation	Charter Schools	
S28071	SHP-Endeavor Charter School	Charter Schools	
S28070	SHP-Eno River Academy	Charter Schools	

Exhibit 10

S28033	SHP-Evergreen Community Charter	Charter Schools	
S29008	SHP-Excelsior Classical Academy	Charter Schools	
S28088	SHP-Falls Lake Academy	Charter Schools	
S25014	SHP-Fayetteville State University	Universities	
S26038	SHP-Fayetteville Tech Community College	Community Colleges	
S29013	SHP-FernLeaf Community Charter	Charter Schools	
S60067	SHP-First Craven	Municipalities	
S47002	SHP-Foothills Health District	Municipalities	
S26026	SHP-Forsyth Tech	Community Colleges	
S28001	SHP-Francine Delany New School for	Charter Schools	
S28004	SHP-Franklin Academy	Charter Schools	
S27083	SHP-Franklin County Schools	Public Schools	
S29002	SHP-Franklin School of Innovation	Charter Schools	
S26016	SHP-Gaston College	Community Colleges	
S28047	SHP-Gaston College Prep	Charter Schools	
S27036	SHP-Gaston County Schools	Public Schools	
S27121	SHP-Gates County Schools	Public Schools	
S28076	SHP-Global Scholars Academy	Charter Schools	
S27005	SHP-Graham County Schools	Public Schools	
S28038	SHP-Grandfather Academy	Charter Schools	
S60104	SHP-Granite Falls ABC	Municipalities	
S27077	SHP-Granville County Schools	Public Schools	
S60079	SHP-Granville-Vance Health	Municipalities	
S28048	SHP-Gray Stone Day School	Charter Schools	
S27140	SHP-Greene County Board of Education	Public Schools	
S27053	SHP-Guilford County Schools	Public Schools	
S26023	SHP-Guilford Technical Community	Community Colleges	
S26047	SHP-Halifax Community College	Community Colleges	
S27122	SHP-Halifax County Schools	Public Schools	
S28041	SHP-Haliwa- Saponi Tribal School	Charter Schools	
S27085	SHP-Harnett County Schools	Public Schools	
S26003	SHP-Haywood Community College	Community Colleges	
S27006	SHP-Haywood County Schools	Public Schools	
S28073	SHP-Henderson Collegiate	Charter Schools	
S27007	SHP-Henderson County Board of Public	Public Schools	
S60108	SHP-Hertford Co ABC Board	Municipalities	
S27125	SHP-Hertford County Public Schools	Public Schools	
S27024	SHP-Hickory City Schools	Public Schools	
S60017	SHP-High County Council of Governments	Municipalities	
S28007	SHP-Hobgood Charter School	Charter Schools	
S27103	SHP-Hoke County Board of Education	Public Schools	
S27126	SHP-Hyde County Schools	Public Schools	
S30033	SHP-Innovative School District	Agencies	
S28099	SHP-INVEST Collegiate - Imagine	Charter Schools	
S28091	SHP-INVEST Collegiate Consortium	Charter Schools	
S27045	SHP-Iredell Statesville	Public Schools	
S28092	SHP-Island Montessori Charter	Charter Schools	

Exhibit 10

S26012	SHP-Isothermal Community College	Community Colleges	
S27009	SHP-Jackson County Public Schools	Public Schools	
S26041	SHP-James Sprunt Community College	Community Colleges	
S26033	SHP-Johnston Community College	Community Colleges	
S27086	SHP-Johnston County Schools	Public Schools	
S60013	SHP-Jones County	Municipalities	
S27141	SHP-Jones County Public Schools	Public Schools	
S27044	SHP-Kannapolis City Schools	Public Schools	
S60081	SHP-Kerr Tar Regional Council	Municipalities	
S29007	SHP-KIPP Durham	Charter Schools	
S29001	SHP-KIPP Halifax	Charter Schools	
S28074	SHP-Lake Lure Classical Academy	Charter Schools	
S28002	SHP-Lake Norman Charter School	Charter Schools	
S60009	SHP-Land of Sky Regional Council	Municipalities	
S27078	SHP-Lee County Schools	Public Schools	
S26056	SHP-Lenoir Community College	Community Colleges	
S27142	SHP-Lenoir County Public Schools	Public Schools	
S27051	SHP-Lexington City Schools	Public Schools	
S28013	SHP-Lincoln Charter School	Charter Schools	
S27029	SHP-Lincoln County Schools	Public Schools	
S29011	SHP-Longleaf School of the Arts	Charter Schools	
S27010	SHP-Macon County Schools	Public Schools	
S27011	SHP-Madison County Schools	Public Schools	
S28057	SHP-Magellan Charter School	Charter Schools	
S29012	SHP-Mallards Creek Stem Academy	Charter Schools	
S26049	SHP-Martin Community College	Community Colleges	
S60059	SHP-Martin County	Municipalities	
S60060	SHP-Martin County ABC Board	Municipalities	
S27127	SHP-Martin County Schools	Public Schools	
S60063	SHP-Martin County Tourism Development Authority	Municipalities	
S60082	SHP-Martin Tyrrell Washington Health	Municipalities	
S28022	SHP-Maureen Joy Charter School	Charter Schools	
S26011	SHP-Mayland Tech Community College	Community Colleges	
S27030	SHP-McDowell County Schools	Public Schools	
S26010	SHP-McDowell Tech Community College	Community Colleges	
S28040	SHP-Millennium Charter Academy	Charter Schools	
S26014	SHP-Mitchell Community College	Community Colleges	
S53001	SHP-Mitchell County	Municipalities	
S27031	SHP-Mitchell County Schools	Public Schools	
S26018	SHP-Montgomery Community College	Community Colleges	
S60001	SHP-Montgomery County	Municipalities	
S27038	SHP-Montgomery County Schools	Public Schools	
S27079	SHP-Moore County Schools	Public Schools	
S28102	SHP-Moore Montessori Community	Charter Schools	
S27046	SHP-Mooresville Graded School District	Public Schools	
S27069	SHP-Mount Airy City Schools	Public Schools	

Exhibit 10

S28023	SHP-Mountain Community School	Charter Schools	
S28049	SHP-Mountain Discovery Charter	Charter Schools	
S28072	SHP-Mountain Island Charter School	Charter Schools	
S28104	SHP-Mountain Island Day Community	Charter Schools	
S28078	SHP-N East Carolina Prep School	Charter Schools	
S60066	SHP-Nash Co ABC Board	Municipalities	
S26050	SHP-Nash Community College	Community Colleges	
S60064	SHP-Nash County	Municipalities	
S27128	SHP-Nash-Rocky Mount Schools	Public Schools	
S25007	SHP-NC A and T University	Universities	
S30001	SHP-NC Education Lottery	Agencies	
S23001	SHP-NC General Assembly	Agencies	
S23002	SHP-NC General Assembly Legislative	Agencies	
S30030	SHP-NC Housing Finance Agency	Agencies	
S25011	SHP-NC State University	Universities	
S28064	SHP-Neuse Charter School	Charter Schools	
S27094	SHP-New Hanover County Schools	Public Schools	
S27025	SHP-Newton Conover City Schools	Public Schools	
S25012	SHP-North Carolina Central University	Universities	
S27130	SHP-Northampton County Schools	Public Schools	
S29006	SHP-Northeast Academy	Charter Schools	
S28084	SHP-Northeast Regional School	Charter Schools	
S60083	SHP-Northern Hospital of Surry County	Municipalities	
S60084	SHP-Onslow County ABC Board	Municipalities	
S27095	SHP-Onslow County Schools	Public Schools	
S60085	SHP-Onslow Water and Sewer Authority	Municipalities	
S27080	SHP-Orange County Schools	Public Schools	
S28090	SHP-Oxford Preparatory High School	Charter Schools	
S26057	SHP-Pamlico Community College	Community Colleges	
S27144	SHP-Pamlico County Schools	Public Schools	
S60018	SHP-Pasquotank County	Municipalities	
S60027	SHP-Pender County Government	Municipalities	
S27096	SHP-Pender County Schools	Public Schools	
S60028	SHP-Perquimans County	Municipalities	
S27132	SHP-Perquimans County Schools	Public Schools	
S60113	SHP-Person County ABC	Municipalities	
S27082	SHP-Person County Schools	Public Schools	
S60032	SHP-Pettigrew Regional Library	Municipalities	
S28106	SHP-Piedmont Community Charter School	Charter Schools	
S26032	SHP-Piedmont Community College	Community Colleges	
S60047	SHP-Pilot Mountain ABC Board	Municipalities	
S28066	SHP-Pine Lake Preparatory	Charter Schools	
S28089	SHP-Pinnacle Classical Academy	Charter Schools	
S29009	SHP-Pioneer Springs Comm School	Charter Schools	
S26052	SHP-Pitt Community College	Community Colleges	
S27133	SHP-Pitt County Schools	Public Schools	
S28018	SHP-Pocosin Innovative Charter	Charter Schools	

Exhibit 10

S60048	SHP-Polk County Local Government	Municipalities	
S27012	SHP-Polk County Schools	Public Schools	
S27104	SHP-Public Schools of Robeson County	Public Schools	
S28026	SHP-Raleigh Charter High School	Charter Schools	
S28101	SHP-Raleigh Oak Charter School	Charter Schools	
S26024	SHP-Randolph Community College	Community Colleges	
S27056	SHP-Randolph County School	Public Schools	
S28105	SHP-Reaching All Minds Academy	Charter Schools	
S28077	SHP-Research Triangle School	Charter Schools	
S26019	SHP-Richmond Community College	Community Colleges	
S27039	SHP-Richmond County Schools	Public Schools	
S28052	SHP-River Mill Academy	Charter Schools	
S26048	SHP-Roanoke Chowan Community	Community Colleges	
S27123	SHP-Roanoke Rapids City Schools	Public Schools	
S26039	SHP-Robeson Community College	Community Colleges	
S26025	SHP-Rockingham Community College	Community Colleges	
S27058	SHP-Rockingham County Schools	Public Schools	
S60033	SHP-Rocky Mount Wilson Regional Airport Authority	Municipalities	
S26020	SHP-Rowan Cabarrus Community College	Community Colleges	
S27064	SHP-Rowan Salisbury Schools	Public Schools	
S28062	SHP-Roxboro Community School	Charter Schools	
S47001	SHP-Rutherford County Employees	Municipalities	
S27032	SHP-Rutherford County Schools	Public Schools	
S28009	SHP-Sallie B Howard School	Charter Schools	
S26040	SHP-Sampson Community College	Community Colleges	
S27110	SHP-Sampson County Schools	Public Schools	
S26031	SHP-Sandhills Community College	Community Colleges	
S27097	SHP-Scotland County Schools	Public Schools	
S29005	SHP-Shining Rock Classical Academy	Charter Schools	
S60101	SHP-Siler City ABC Board	Municipalities	
S28060	SHP-Socrates Academy	Charter Schools	
S26015	SHP-South Piedmont Community College	Community Colleges	
S28096	SHP-SOUTHEASTERN ACADEMY	Charter Schools	
S26037	SHP-Southeastern Community College	Community Colleges	
S28045	SHP-Southern Wake Academy	Charter Schools	
S26005	SHP-Southwestern Community College	Community Colleges	
SR1014	SHP-Sponsored Dependents	Direct Bill	
SC0RIF	SHP-Sponsored Dependents	Direct Bill	
S40001	SHP-Sponsored Dependents	Direct Bill	
S26021	SHP-Stanly Community College	Community Colleges	
S27048	SHP-Stanly County Board of Education	Public Schools	
S28025	SHP-Stars Charter	Charter Schools	
SR1009	SHP-State Retirement System	Retirees	
SR1004	SHP-State Retirement System	Retirees	
SR1012	SHP-State Retirement System	Retirees	
S28079	SHP-Sterling Montessori Academy	Charter Schools	

Exhibit 10

S27066	SHP-Stokes County Schools	Public Schools	
S28042	SHP-Success Institute	Charter Schools	
S28006	SHP-Summit Charter School	Charter Schools	
S26027	SHP-Surry Community College	Community Colleges	
S60003	SHP-Surry County	Municipalities	
S27067	SHP-Surry County Schools	Public Schools	
S27013	SHP-Swain County Schools	Public Schools	
S28014	SHP-The Academy of Moore County	Charter Schools	
S28030	SHP-The Childrens Village Academy	Charter Schools	
S28097	SHP-The Expedition School	Charter Schools	
S28058	SHP-The Hawbridge School	Charter Schools	
S28011	SHP-The Learning Center Inc	Charter Schools	
S28028	SHP-Thomas Jefferson Classical Academy -	Charter Schools	
S27052	SHP-Thomasville City Schools	Public Schools	
S28069	SHP-Tiller School	Charter Schools	
S60086	SHP-Toe River Health Department	Municipalities	
S60049	SHP-Town of Archer Lodge	Municipalities	
S60012	SHP-Town of Beaufort	Municipalities	
S60008	SHP-Town of Benson	Municipalities	
S58001	SHP-Town of Biltmore Forest	Municipalities	
S50001	SHP-Town of Black Creek	Municipalities	
S55001	SHP-Town of Black Mountain	Municipalities	
S59001	SHP-Town of Blowing Rock	Municipalities	
S60007	SHP-Town of Broadway	Municipalities	
S60050	SHP-Town of Brunswick	Municipalities	
S60034	SHP-Town of Burnsville	Municipalities	
S60087	SHP-Town of Caswell Beach	Municipalities	
S60035	SHP-Town of China Grove	Municipalities	
S60036	SHP-Town of Clayton	Municipalities	
S60037	SHP-Town of Cove City	Municipalities	
S60002	SHP-Town of Elizabethtown	Municipalities	
S60038	SHP-Town of Fairbluff	Municipalities	
S48001	SHP-Town of Forest City	Municipalities	
S60065	SHP-Town of Fremont	Municipalities	
S60088	SHP-Town of Holly Ridge	Municipalities	
S60019	SHP-Town of Indian Beach	Municipalities	
S57001	SHP-Town of Kure Beach	Municipalities	
S49001	SHP-Town of Lake Lure	Municipalities	
S60051	SHP-Town of Laurel Park	Municipalities	
S60112	SHP-Town of Leland	Municipalities	
S60074	SHP-Town of Lilesville	Municipalities	
S60061	SHP-Town of Maggie Valley	Municipalities	
S60039	SHP-Town of Mars Hill	Municipalities	
S60111	SHP-Town Of Marshall	Municipalities	
S61001	SHP-Town of Matthews	Municipalities	
S60089	SHP-Town of Mayodan	Municipalities	
S60072	SHP-Town of Maysville	Municipalities	

Exhibit 10

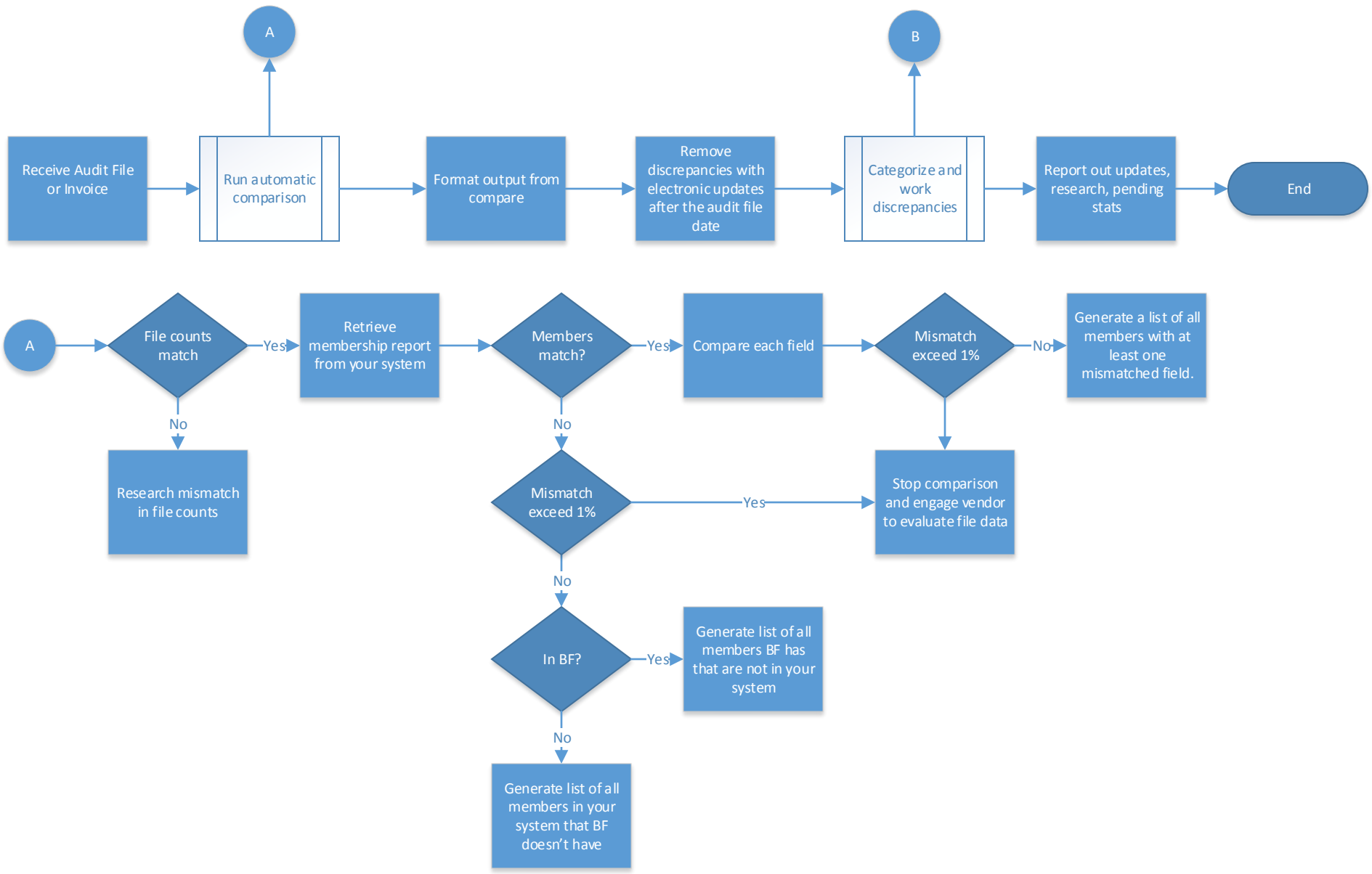
S60052	SHP-Town of Momeyer	Municipalities	
S60090	SHP-Town of Mount Gilead	Municipalities	
S60107	SHP-Town Of Mount Pleasant	Municipalities	
S60091	SHP-Town of Nashville	Municipalities	
S60016	SHP-Town of Oak Island	Municipalities	
S56001	SHP-Town of Ocean Isle Beach	Municipalities	
S60092	SHP-Town of Pilot Mountain	Municipalities	
S60109	SHP-Town Of Pittsboro ABC Board	Municipalities	
S60040	SHP-Town of Princeville	Municipalities	
S60041	SHP-Town of Robersonville	Municipalities	
S60094	SHP-Town of Rural Hall	Municipalities	
S60014	SHP-Town of Rutherfordton	Municipalities	
S60054	SHP-Town of Selma	Municipalities	
S60011	SHP-Town of Seven Devils	Municipalities	
S60068	SHP-Town of Shallotte	Municipalities	
S60053	SHP-Town of Sparta	Municipalities	
S60015	SHP-Town of Spindale	Municipalities	
S60095	SHP-Town of St. James	Municipalities	
S51001	SHP-Town of Sunset Beach	Municipalities	
S54001	SHP-Town of Tabor City	Municipalities	
S60096	SHP-Town of Taylortown	Municipalities	
S60055	SHP-Town of Wallace	Municipalities	
S27015	SHP-Transylvania County Schools	Public Schools	
S26002	SHP-Tri County Community College	Community Colleges	
S28061	SHP-Two Rivers Community School	Charter Schools	
S27135	SHP-Tyrrell County Public Schools	Public Schools	
S25001	SHP-UNC Asheville	Universities	
S25010	SHP-UNC Chapel Hill	Universities	
S25004	SHP-UNC Charlotte	Universities	
S25005	SHP-UNC Greensboro	Universities	
S16031	SHP-UNC Health Care	Universities	
S25015	SHP-UNC Pembroke	Universities	
S25013	SHP-UNC Wilmington	Universities	
S27041	SHP-Union County Public Schools	Public Schools	
S30009	SHP-University of NC Press	Universities	
S25009	SHP-University of NC School of Arts	Universities	
S60042	SHP-Upper Coastal Plain Council of Governments	Municipalities	
S28093	SHP-Uwharrie Charter Academy	Charter Schools	
S28032	SHP-Vance Charter School	Charter Schools	
S27087	SHP-Vance County Schools	Public Schools	
S26034	SHP-Vance Granville Community College	Community Colleges	
S29010	SHP-VERITAS Community School	Charter Schools	
S60098	SHP-Village of Tobaccoville	Municipalities	
S28067	SHP-Voyager Academy	Charter Schools	
S27089	SHP-Wake County Public School System	Public Schools	
S26035	SHP-Wake Tech Community College	Community Colleges	

Exhibit 10

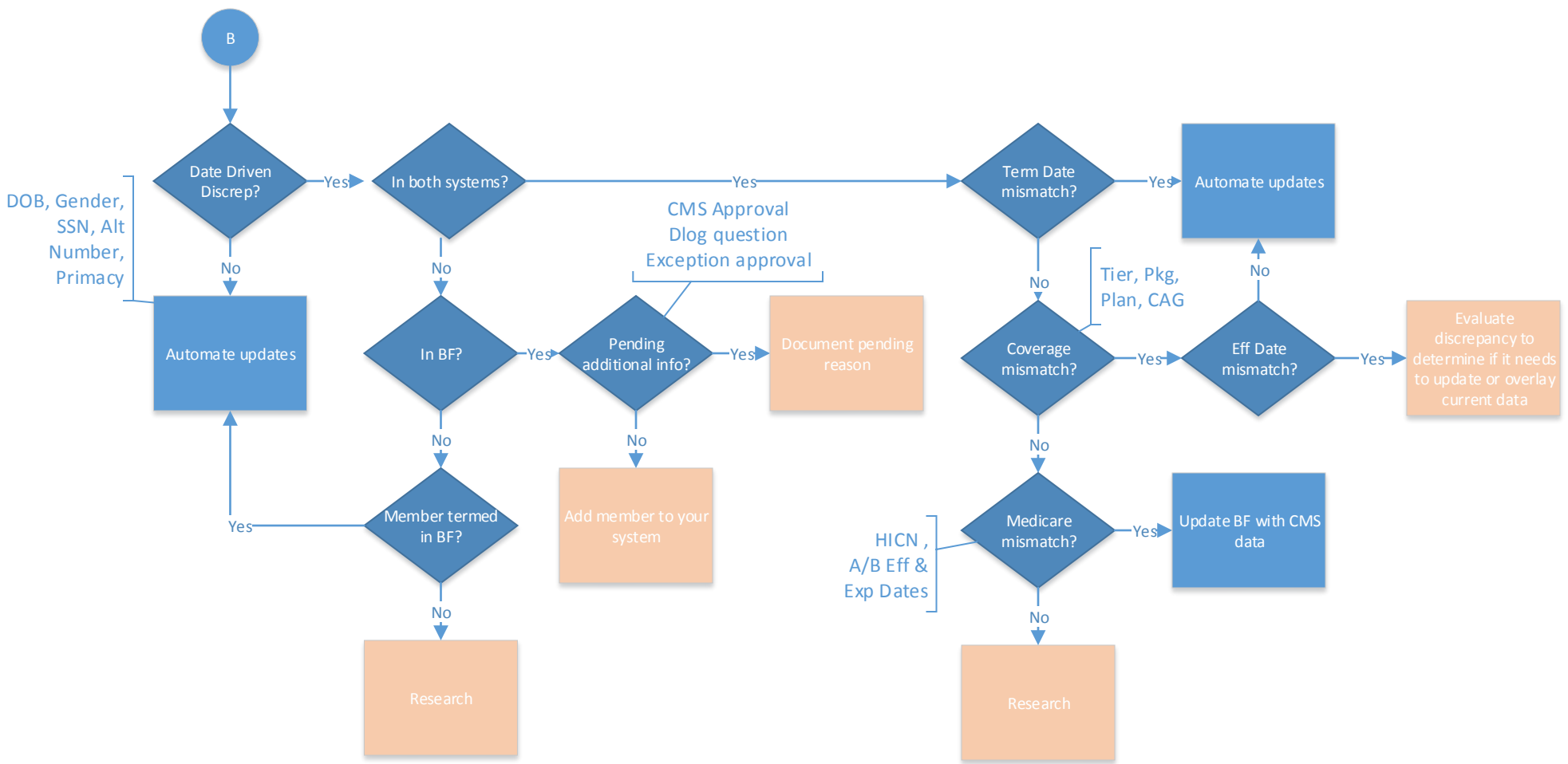
S60102	SHP-Walnut Cove ABC Board	Municipalities	
S27088	SHP-Warren County Schools	Public Schools	
S46001	SHP-Washington County	Municipalities	
S27136	SHP-Washington County Schools	Public Schools	
S27033	SHP-Watauga County Board of Education	Public Schools	
S28080	SHP-Waters Edge Village School	Charter Schools	
S26058	SHP-Wayne Community College	Community Colleges	
S27145	SHP-Wayne County Public Schools	Public Schools	
S27124	SHP-Weldon City Schools	Public Schools	
S25003	SHP-Western Carolina University	Universities	
S26006	SHP-Western Piedmont Community	Community Colleges	
S60024	SHP-Western Piedmont Regional Transit Authority	Municipalities	
S27100	SHP-Whiteville City Schools	Public Schools	
S26013	SHP-Wilkes Community College	Community Colleges	
S27034	SHP-Wilkes County Schools	Public Schools	
S28086	SHP-Willow Oak Montessori Charter	Charter Schools	
S28065	SHP-Wilmington Preparatory Academy	Charter Schools	
S26053	SHP-Wilson Community College	Community Colleges	
S27137	SHP-Wilson County Schools	Public Schools	
S27063	SHP-Winston Salem Forsyth County	Public Schools	
S25008	SHP-Winston Salem State University	Universities	
S27070	SHP-Yadkin County Schools	Public Schools	
S60099	SHP-Yancey County	Municipalities	
S27016	SHP-Yancey County Schools	Public Schools	
S28095	SHP-ZECA INC	Charter Schools	

Exhibit 11

Vendor Audit Process

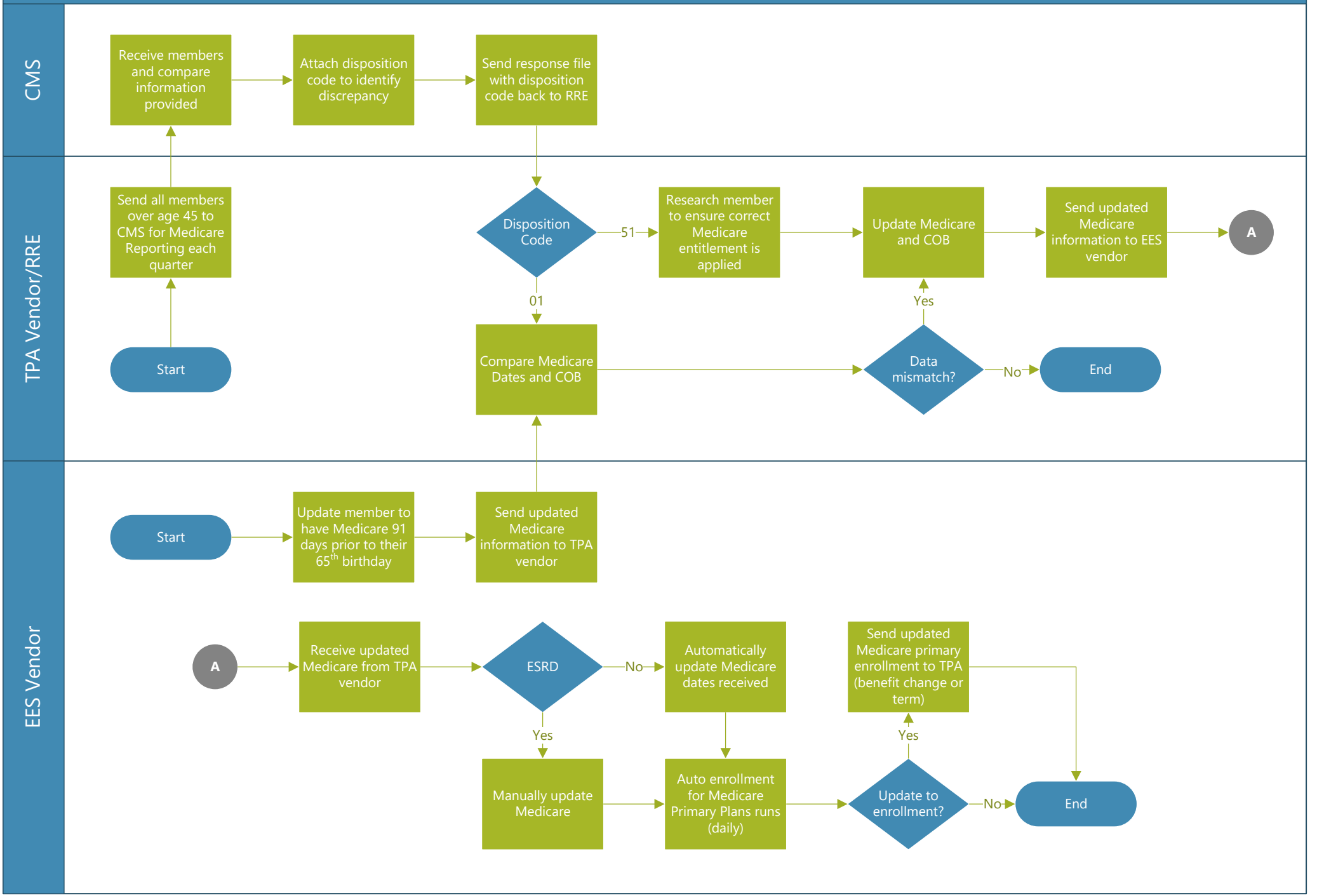


Vendor Audit Process



CMS Responsible Reporting Entity (RRE) Process

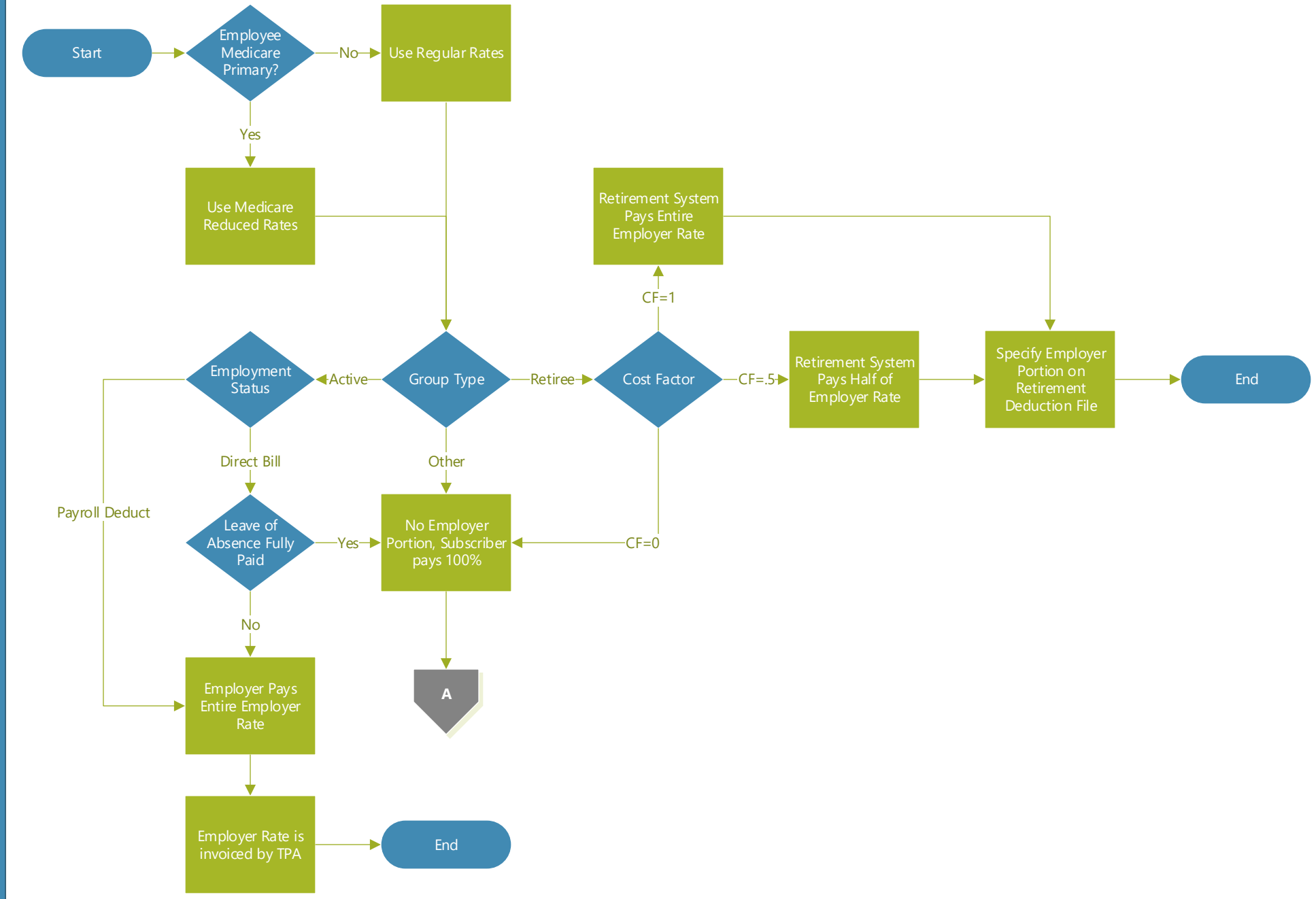
Exhibit 12



Group Billing Rate Structure

Exhibit 13

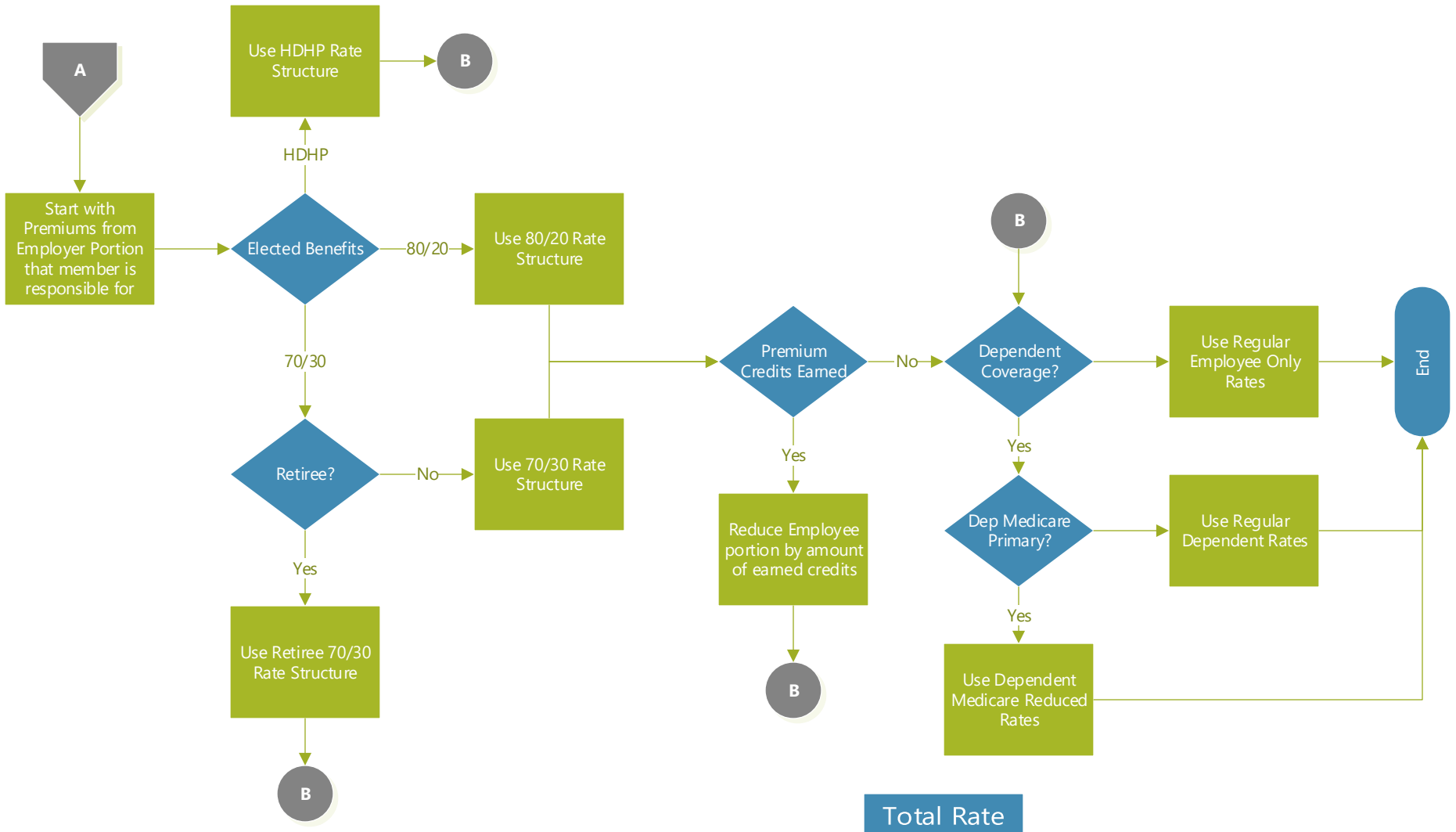
Employer Portion



Group Billing Rate Structure

Exhibit 13

Employee Portion



Total Rate

- PPO or HDHP
- Employment Status
- Medicare Primacy
- Retiree Cost Factor

Employer Portion

+

Employee Portion

- Elected Benefits
- Elected Coverage
- Dependent Medicare Primacy
- Premium Credits

Exhibit 14

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
Treasurer Dale R. Folwell, CPA

BlueCross BlueShield of North Carolina

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***

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/????***

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:		**$2,844.00**	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:	**–**	**$1,044.00**	You saved **$969.00** by using in-network providers. The State Health Plan paid **$75.00** towards the claims in this summary. **Overall, being a State Health Plan member saved you 37% off the total amount charged.**
What Provider(s) May Bill You:	**=**	**$1,800.00**	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.) **Your provider(s) may bill you directly for this amount.**

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.***

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.

HELPFUL TERMS

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.

Alert Code	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.
Allowed Amount	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.
Amount Not Covered / Other Liability	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.
Appeal	A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).
Coinsurance	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.
Copayment (Copay)	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.
Covered Services	Refer to your benefit booklet for details on which health care services are covered by your plan.
Date of Care	This is the date you received the services listed on the claim.
Deductible	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.
Family Deductible	Once the sum of all family member payments meets the family deductible, each member begins to pay the copay or coinsurance amount.
Family Out-of-Pocket Limit	Once this limit is reached, the plan pays 100% of covered services for each family member.
In-Network	Doctors, hospitals, clinics and other providers that contract with your plan to provide services at a lower rate.
In-Network Discount	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.
Out-of-Network	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.
Out-of-Pocket Limit	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.
Plan's Limit	This is the specific deductible, coinsurance or out-of-pocket limit for your plan.
Service	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.
State Health Plan Member Savings	The total amount you saved from in-network discounts and plan payments.
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.
Total Provider May Bill You	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.

Exhibit 14

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
Treasurer Dale R. Folwell, CPA

BlueCross BlueShield of North Carolina

CLAIM DETAILS

THIS IS NOT A BILL

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	E51, SC1
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	
Total Amount Provider Charged: $740.00		**State Health Plan Member Savings: $130.00**			**Total Provider May Bill You: $610.00** (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	
Total Amount Provider Charged: $99.00		**State Health Plan Member Savings: $49.00**			**Total Provider May Bill You: $50.00** (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	
Total Amount Provider Charged: $330.00		**State Health Plan Member Savings: $190.00**			**Total Provider May Bill You: $140.00** (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	
Total Amount Provider Charged: $95.00		**State Health Plan Member Savings: $95.00**			**Total Provider May Bill You: $0.00** (You do not need to pay anything on this claim.)			

Exhibit 14

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
Treasurer Dale R. Folwell, CPA

BlueCross BlueShield of North Carolina

CLAIM DETAILS

THIS IS NOT A BILL

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	! E2U
Total Amount Provider Charged: $1,580.00		**State Health Plan Member Savings: $580.00**			**Total Provider May Bill You: $1,000.00** (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***.

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℠, visit *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®[1]

Exhibit 14

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
Treasurer Dale R. Folwell, CPA

BlueCross BlueShield of North Carolina

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)
90% met	**60% met**	**7% met**	**5% met**
$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)
2% met	**1% met**	**0% met**	**0% met**
$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)
91% met	**61% met**	**7% met**	**5% met**
$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

Exhibit 14

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.

Have a question about your claims or benefits?

Please contact Customer Service at **888-234-2416**.

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.***

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*** 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*** 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***.

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.

VENDOR DATA FEEDS for 2019

Revised: 02/25/2019

Exhibit 15

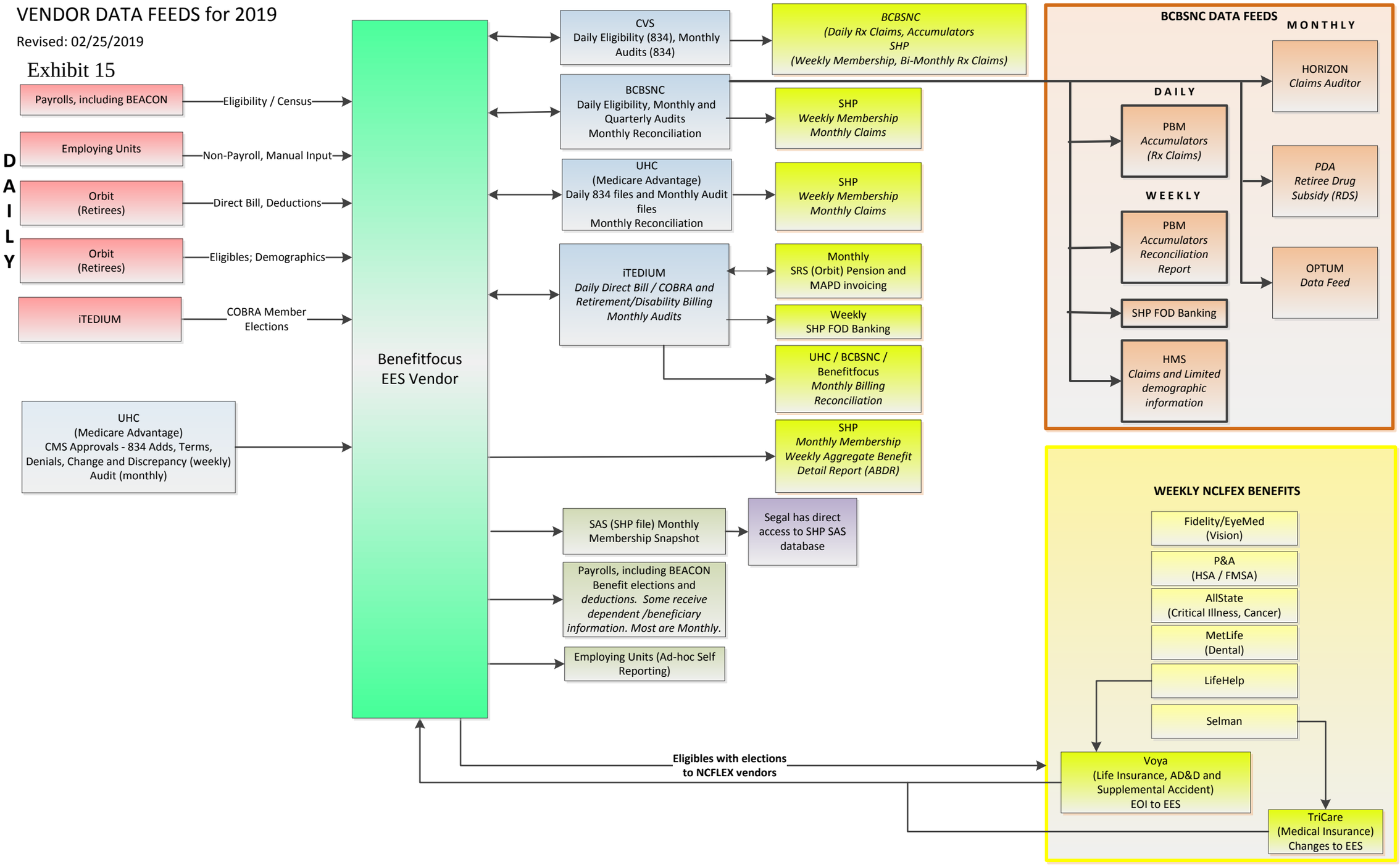
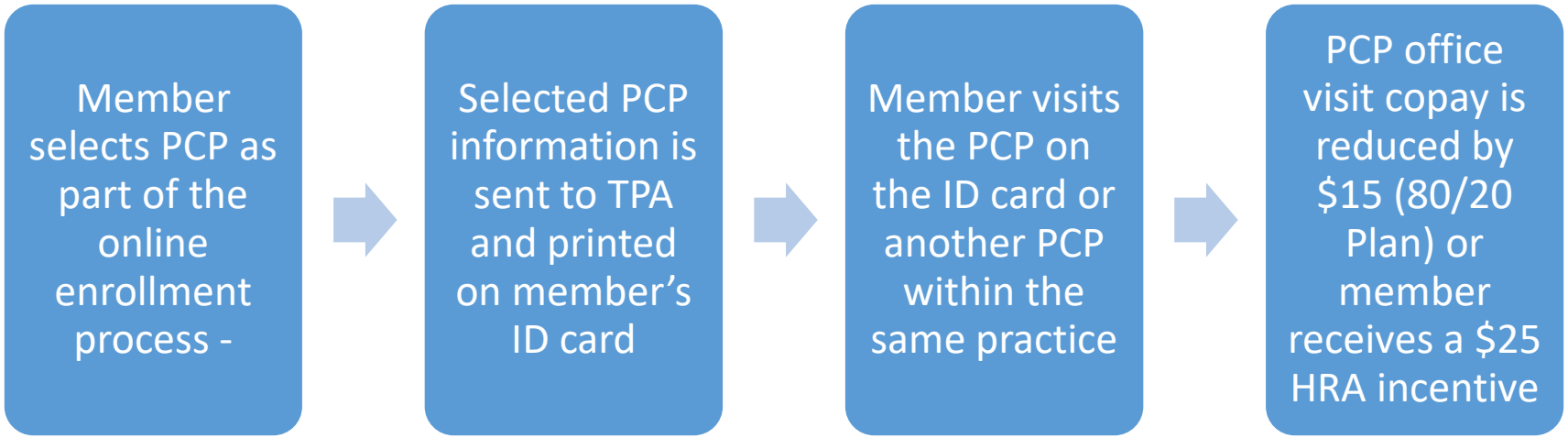


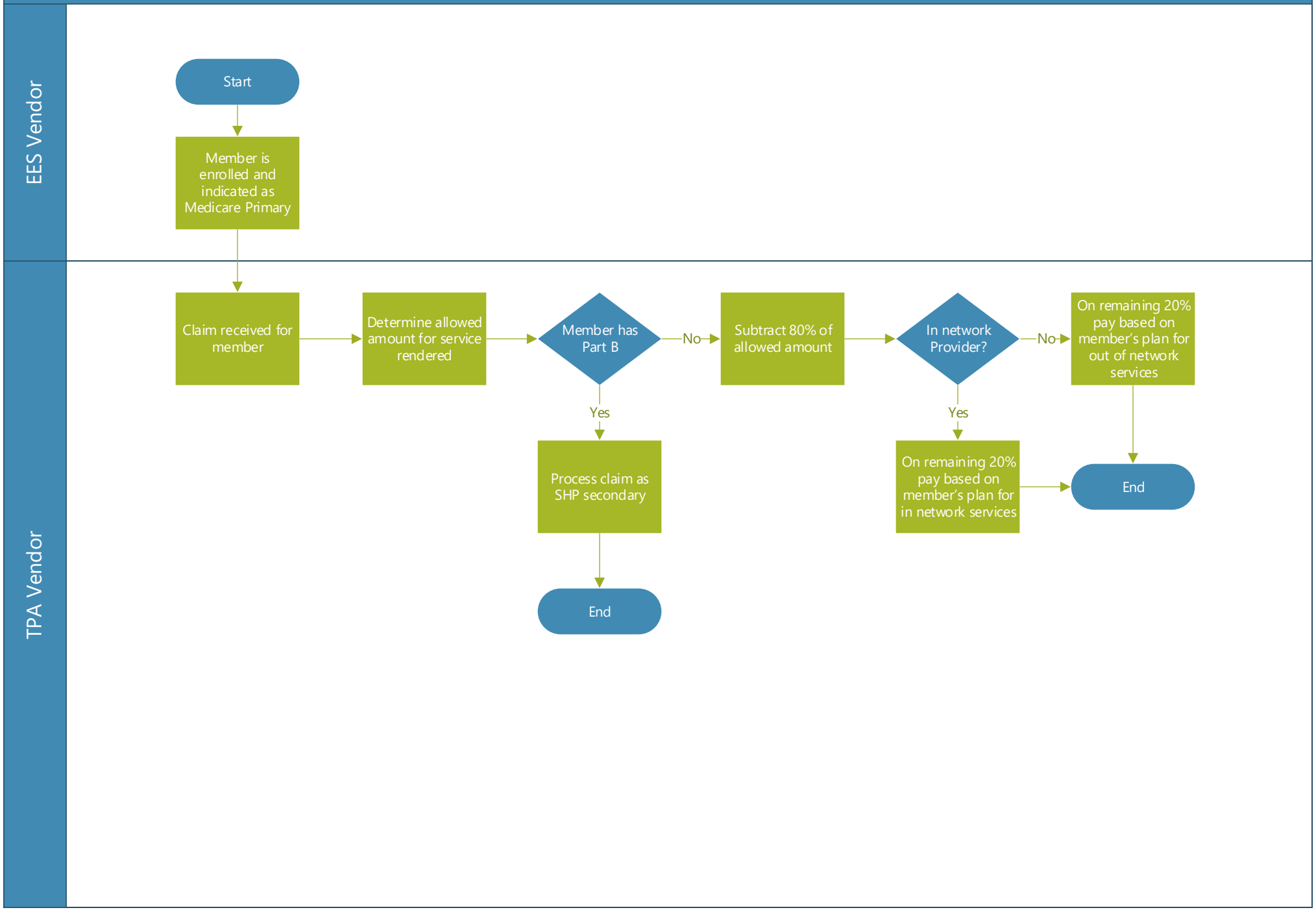
Exhibit 16

Primary Care Provider (PCP) Incentive Program



Claims Processing Phantom Plan – Medicare Part B

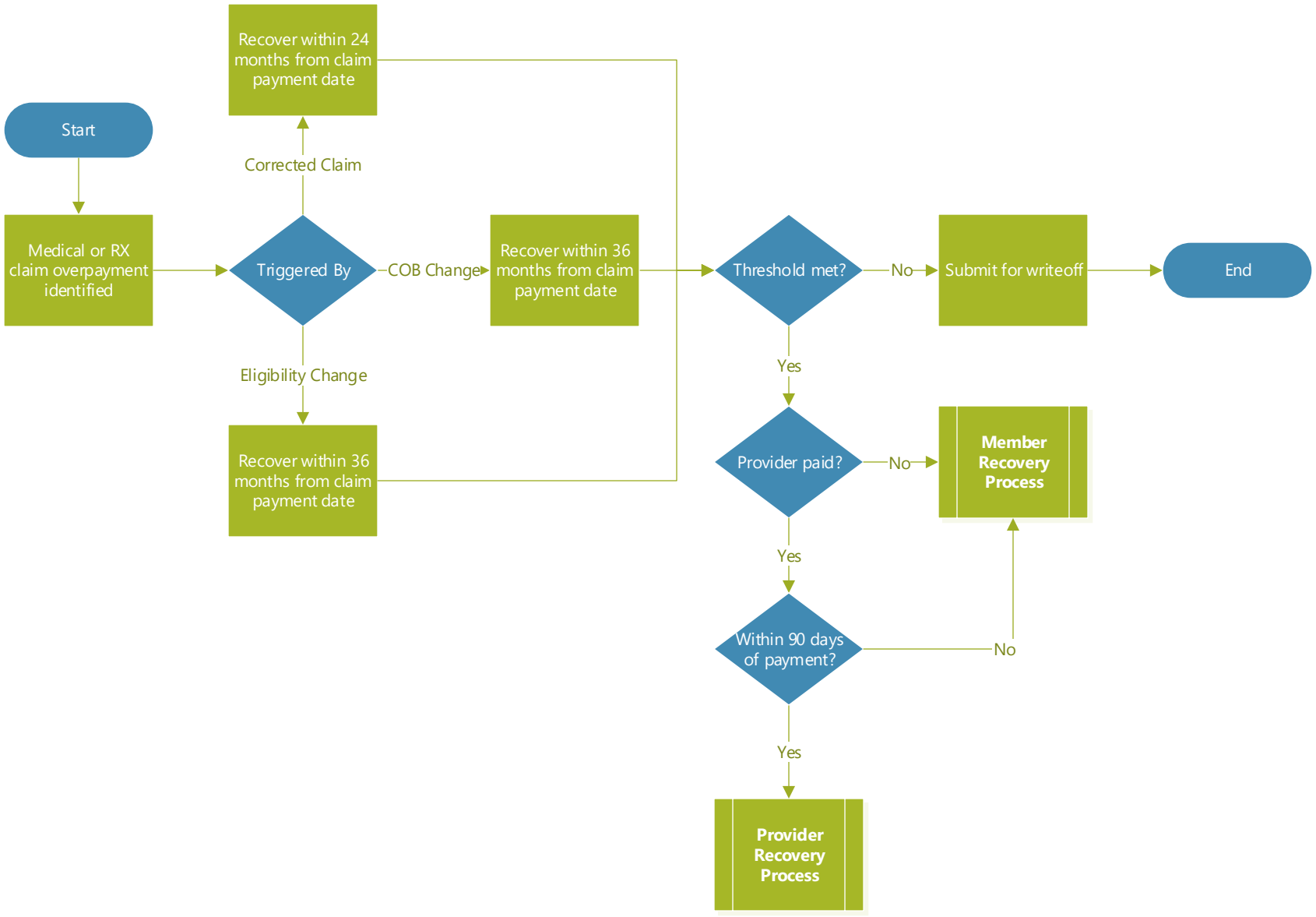
Exhibit 17



Overall Recovery Flow

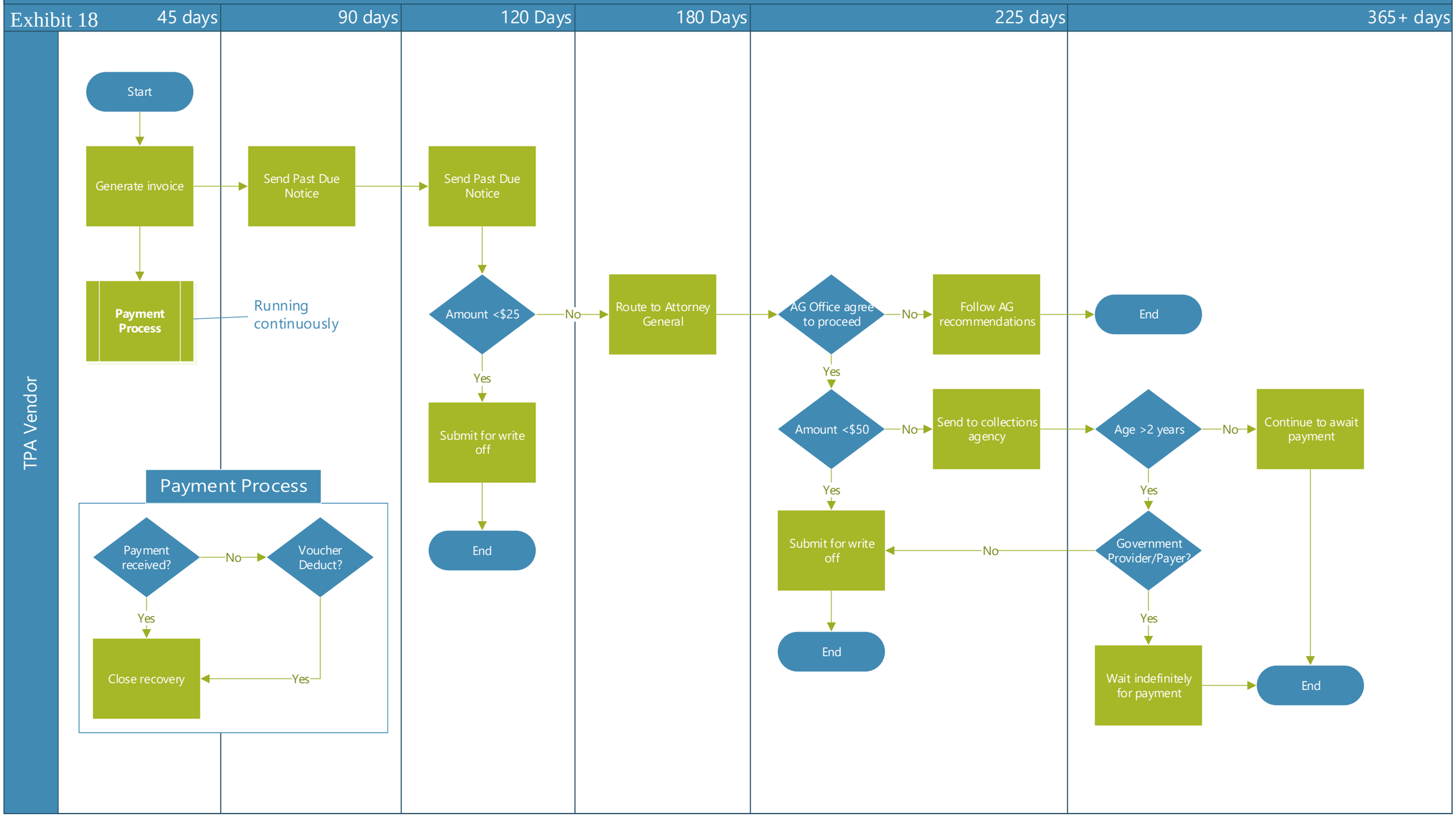
Exhibit 18

TPA Vendor



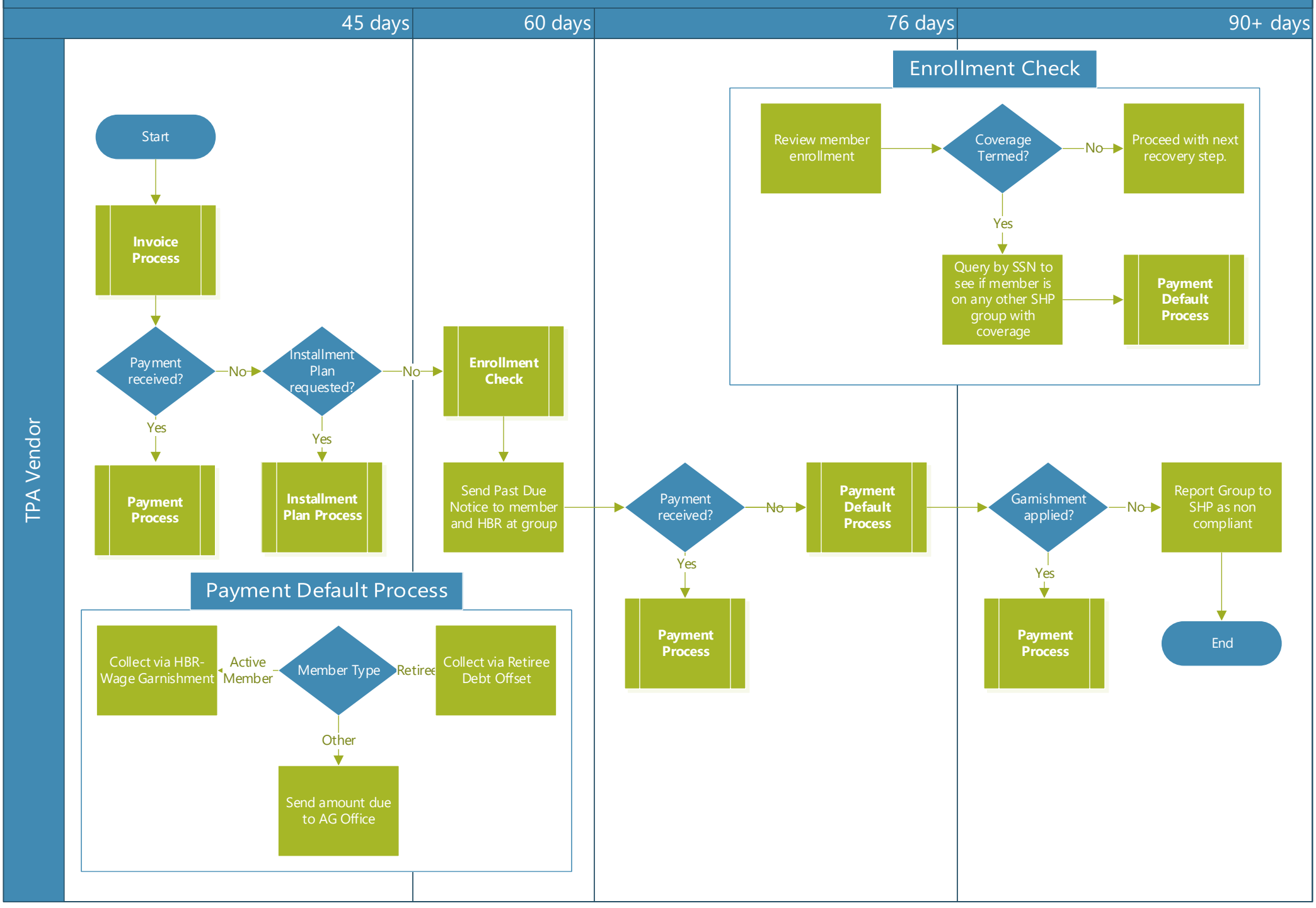
Provider Recovery Process

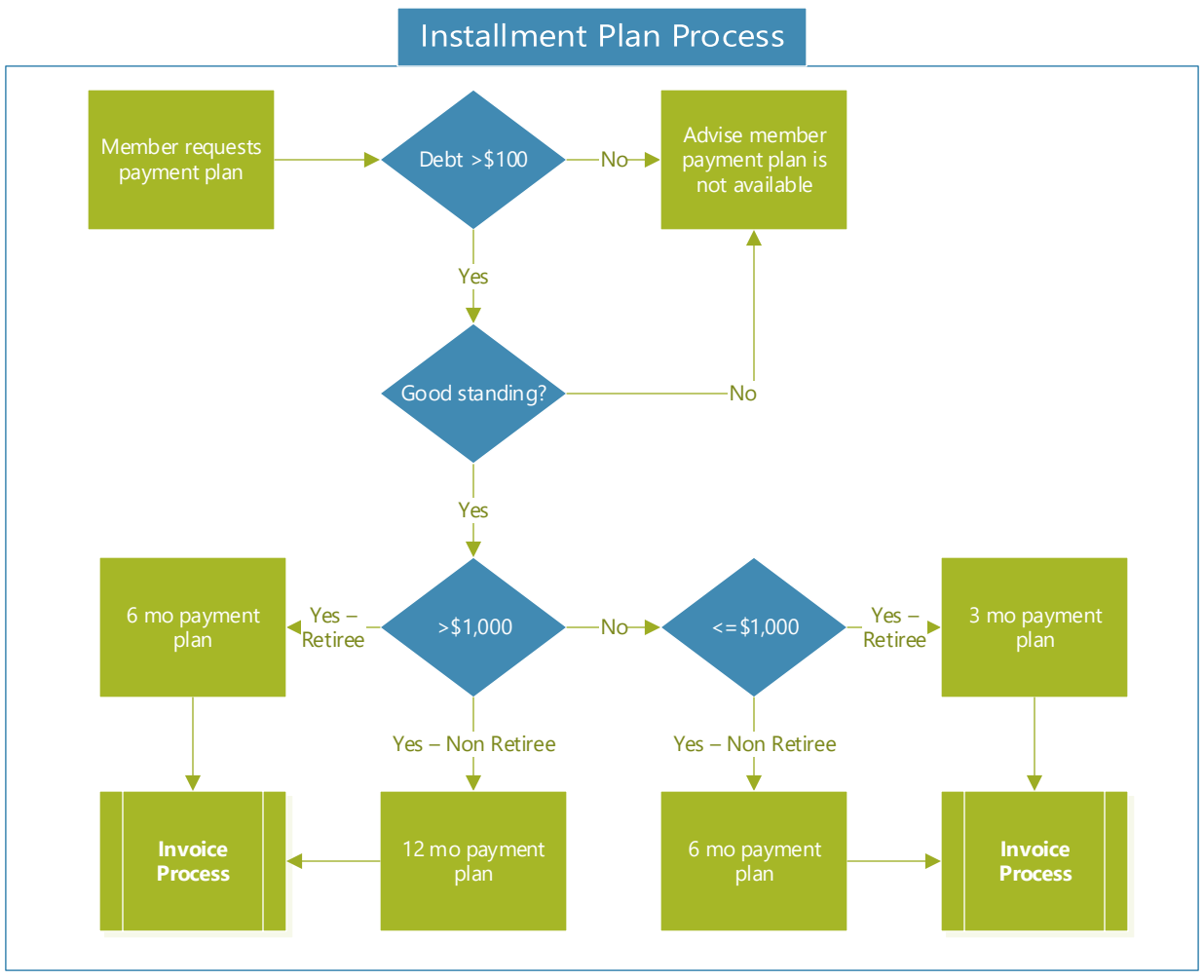
Exhibit 18



Member Recovery Process

Exhibit 18





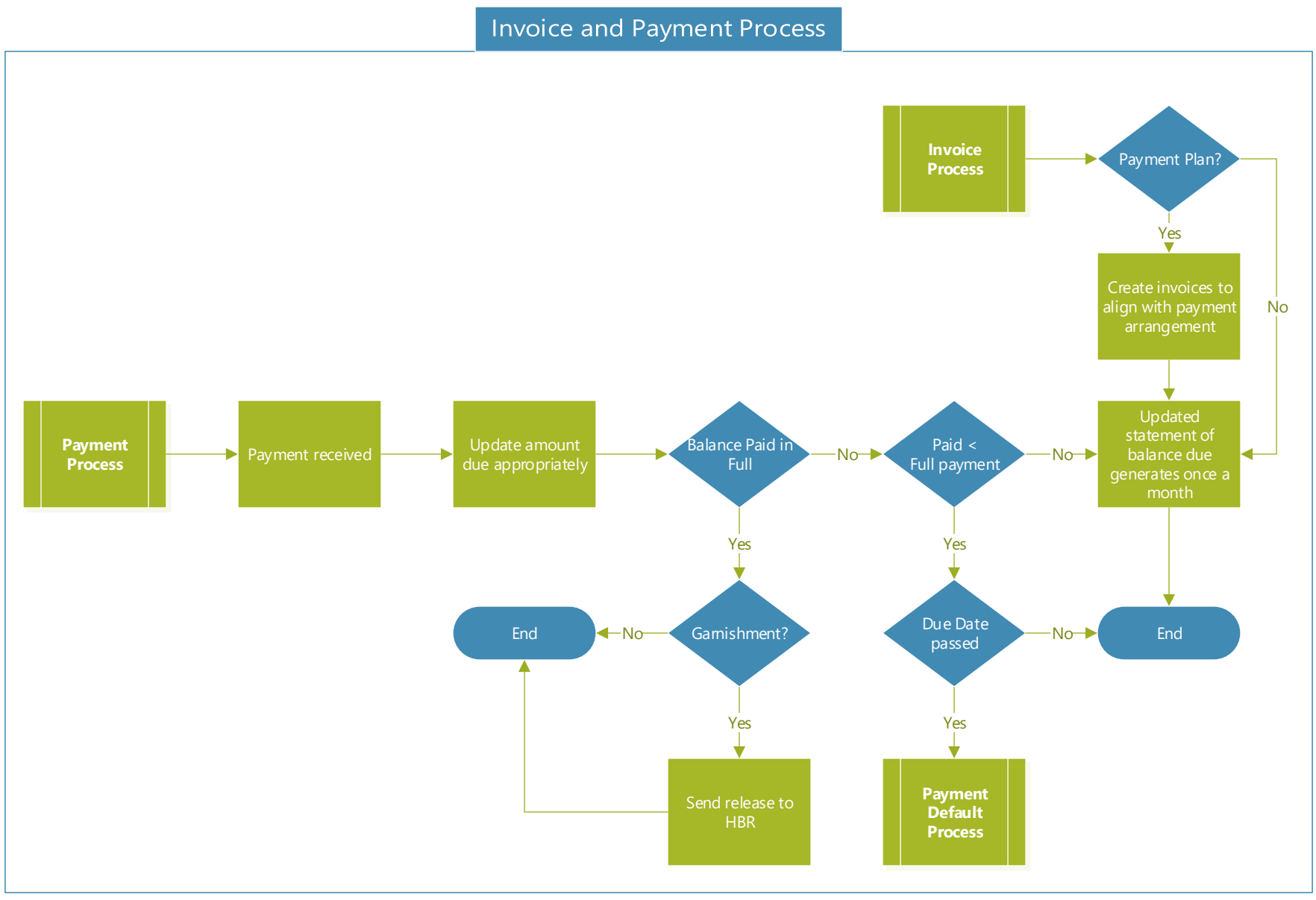


Exhibit 19

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 Paid April 1 through June 30, 2016			CYTD Paid January 1 through June 30, 2016			
	Employees	**Dependents**	**Totals**	**Employees**	**Dependents**	**Totals**	***Percent**
1. Billed Charges	$0	$0	$0	$0	$0	$0	NA
2. Non Covered	$0	$0	$0	$0	$0	$0	NA
3. Allowed Charges	$0	$0	$0	$0	$0	$0	NA
4. Member Liability							
A. Member Deductible	$0	$0	$0	$0	$0	$0	NA
B. Member Coinsurance	$0	$0	$0	$0	$0	$0	NA
C. Member Copay	$0	$0	$0	$0	$0	$0	NA
Total Member Liability	$0	$0	$0	$0	$0	$0	NA
5. Coordination of Benefits	$0	$0	$0	$0	$0	$0	NA
6. Financial Adjustments	$0	$0	$0	$0	$0	$0	NA
7. Payments	$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.

Exhibit 19

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 Incurred April 1 through June 30, 2016			CYTD Incurred January 1 through June 30, 2016			
	Employees	**Dependents**	**Totals**	**Employees**	**Dependents**	**Totals**	***Percent**
1. Billed Charges	$0	$0	$0	$0	$0	$0	NA
2. Non Covered	$0	$0	$0	$0	$0	$0	NA
3. Allowed Charges	$0	$0	$0	$0	$0	$0	NA
4. Member Liability							
A. Member Deductible	$0	$0	$0	$0	$0	$0	NA
B. Member Coinsurance	$0	$0	$0	$0	$0	$0	NA
C. Member Copay	$0	$0	$0	$0	$0	$0	NA
Total Member Liability	$0	$0	$0	$0	$0	$0	NA
5. Coordination of Benefits	$0	$0	$0	$0	$0	$0	NA
6. Financial Adjustments	$0	$0	$0	$0	$0	$0	NA
7. Payments	$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.

Exhibit 19

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
Totals	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
QTD Totals	$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.

Exhibit 19

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
Totals	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
QTD Totals	$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.

Exhibit 19

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%
$.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%
TOTAL	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.00%**

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.

Exhibit 19

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

Allowed Band	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**

Exhibit 19

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%
$.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%
TOTAL	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.00%**

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.

Exhibit 19

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

Allowed Band	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**

Exhibit 19

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%
$.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%
TOTAL	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.00%**

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.

Exhibit 19

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

Allowed Band	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**

Exhibit 19

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%
$.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%
TOTAL	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.00%**

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.

Exhibit 19

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

Allowed Band	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**

Exhibit 19

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 Claimants	Number of Visits	Billed Charges	Non Covered	Allowed Charges	Member Deductible	Member Coinsurance	Member Copay	COB	Financial Adjustments	Payments
EMPLOYEE - 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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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.

Exhibit 19

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
EMPLOYEE - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
DEPENDENT - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
TOTAL - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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 #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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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 #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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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.

Exhibit 19

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
EMPLOYEE - 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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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.

Exhibit 19

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
EMPLOYEE - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
DEPENDENT - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
TOTAL - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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 #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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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 #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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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.

Exhibit 19

MATRIX #12

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

	Employees		Dependents		Total		
Age Band	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
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
TOTAL	**$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.

Exhibit 19

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

	Employees		Dependents		Total		
Age Band	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
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			
TOTAL	**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.

Exhibit 19

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

	Employees		Dependents		Total		
Age Band	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
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							
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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.

Exhibit 19
MATRIX #13

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.

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.

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.

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.

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.

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.

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.

Exhibit 19

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**
Traditional								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
Enhanced								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
CDHP								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
All Products								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

* 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.

Exhibit 19

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**
Traditional								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
Enhanced								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
CDHP								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

	Employees	**Dependents**	**QTD Totals**		**Employees**	**Dependents**	**YTD Totals**	***Percent**
All Products								
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
Total Claims (A+B-C+D)	**$0**	**$0**	**$0**	**#**	**$0**	**$0**	**$0**	**0.0%**

* 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.

Exhibit 19

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	B	C	D	E=A+B-C+D	A	B	C	D	E=A+B-C+D
	Claims Subject to Copay	**Claims Subject to Coinsurance and Deductible**	**Overlap**	**Claims Not Subject to Member Liability**	**Total**	**Claims Subject to Copay**	**Claims Subject to Coinsurance and Deductible**	**Overlap**	**Claims Not Subject to Member Liability**	**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.

Exhibit 19

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	B	C	D	E=A+B-C+D	A	B	C	D	E=A+B-C+D
	Claims Subject to Copay	**Claims Subject to Coinsurance and Deductible**	**Overlap**	**Claims Not Subject to Member Liability**	**Total**	**Claims Subject to Copay**	**Claims Subject to Coinsurance and Deductible**	**Overlap**	**Claims Not Subject to Member Liability**	**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.

Exhibit 19

State Health Plan for Teachers and State Employees MATRIX #18
Premium Billing by Type of Coverage Report
Earned Months = July 2015 - June 2016 Financial Reporting Months = June 2015 - June 2016
Traditional - Actives - No One Eligible for Medicare (See Note Below)

EMPLOYEE - NO ONE WITH MEDICARE

			Financial Reporting Month Runout														
Earned Month	**Employees**	**Dependents**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12+**	**Grand Total**	**PEPM**
201507	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201508	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201509	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201510	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201511	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201512	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201601	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201602	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201603	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201604	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201605	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201606	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
Grand Total	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

EMPLOYEE SPOUSE - NO ONE WITH MEDICARE

			Financial Reporting Month Runout														
Earned Month	**Employees**	**Dependents**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12+**	**Grand Total**	**PEPM**
201507	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201508	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201509	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201510	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201511	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201512	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201601	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201602	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201603	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201604	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201605	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201606	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
Grand Total	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Identical report must be provided for each plan option, employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee), and for number of Medicare members (none, one, and two or more), and then aggregated for each plan option, employee group, and by number of Medicare members, including an overall total for the population.

Exhibit 19

State Health Plan for Teachers and State Employees MATRIX #18
Premium Billing by Type of Coverage Report continued
Earned Months = July 2015 - June 2016 Financial Reporting Months = June 2015 - June 2016
Traditional - Actives - No One Eligible for Medicare (See Note Below)

EMPLOYEE DEPENDENT(S) - NO ONE WITH MEDICARE

			Financial Reporting Month Runout														
Earned Month	**Employees**	**Dependents**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12+**	**Grand Total**	**PEPM**
201507	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201508	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201509	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201510	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201511	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201512	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201601	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201602	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201603	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201604	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201605	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201606	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
Grand Total	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

FAMILY - NO ONE WITH MEDICARE

			Financial Reporting Month Runout														
Earned Month	**Employees**	**Dependents**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12+**	**Grand Total**	**PEPM**
201507	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201508	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201509	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201510	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201511	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201512	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201601	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201602	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201603	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201604	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201605	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
201606	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
Grand Total	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Identical report must be provided for each plan option, employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee), and for number of Medicare members (none, one, and two or more), and then aggregated for each plan option, employee group, and by number of Medicare members, including an overall total for the population.

Exhibit 19

State Health Plan for Teachers and State Employees MATRIX #18
Premium Billing by Type of Coverage Report continued
Earned Months = July 2015 - June 2016 Financial Reporting Months = June 2015 - June 2016
Traditional - Actives - No One Eligible for Medicare (See Note Below)

COMBINED TOTAL - NO ONE WITH MEDICARE

			Financial Reporting Month Runout														
Earned Month	**Employees**	**Dependents**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12+**	**Grand Total**	**PEPM**
201507	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201508	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201509	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201510	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201511	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201512	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201601	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201602	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201603	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201604	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201605	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
201606	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Grand Total	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Identical report must be provided for each plan option, employee status (active employee; COBRA member; non-Medicare retiree; Medicare retiree; local government employee; or National Guard, Fire, and Rescue employee), and for number of Medicare members (none, one, and two or more), and then aggregated for each plan option, employee group, and by number of Medicare members, including an overall total for the population.

Exhibit 19

MATRIX #19

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 Copay	COB	Financial Adjustments	Payments
EMPLOYEE - 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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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 #19 (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 Copay	COB	Financial Adjustments	Payments
EMPLOYEE - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
DEPENDENT - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Type of Service:											
TOTAL - CYTD											
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
TOTAL	**0**	**0**	**$0**	**$0**	**$0**	**$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 #19 (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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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 #19 (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
EMPLOYEE - 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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
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
TOTAL	**0.00**	**$0**	**$0**	**$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.

Date: October 7, 2019

RFP Number: 270-20191001TPAS

RFP Description: Third Party Administrative Services

Addendum Number: 1

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Sharon L. Smith

Opening Date / Time: January 3, 2019 @ 2:00 p.m. ET

INSTRUCTIONS:

Vendors shall abide by the updated RFP Schedule that clarifies the due dates and times.

****

2.3 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	October 1, 2019
Vendor Deadline for Submission of Written Minimum Requirements Questions	Vendor	October 8, 2019, 11:59 p.m. ET
Plan Responds to Minimum Requirements Questions (Posted on IPS)	Plan	October 14, 2019
Deadline to Submit Minimum Requirements Proposals including executed Attachment I	Vendor	October 21, 2019, 2:00 p.m. ET
Notify Vendors if Minimum Requirements Met		October 29, 2019
Issue Vendor's designated recipient, a link to Secure File Transfer Protocol (SFTP) system for attachments and Data Files	Plan	October 29-31, 2019
Vendor Deadline for Submission of All Written Questions	Vendor	November 7, 2019, 11:59 p.m. ET
Plan Responds to Questions (Posted on IPS)	Plan	November 15, 2019
Opening of Proposals by Plan (Bid Closes)	Vendor	January 3, 2020, 2:00 p.m. ET
Evaluation Period (Review of Proposals and Finalist Presentations)	Plan	January 15-28, 2020
Proposed Finalist Presentations	Vendor	February 6-10, 2020
Best and Final Offer (BAFO)	Plan	February 11-14, 2020
Plan Seeks Approval from the Attorney General's Office	Plan	February 17-26, 2020
Present award recommendation to the Board	Plan	February 27-28, 2020
Award of the Contract	Plan & Vendor	February 28, 2020
Implementation Period	Plan & Vendor	March 1, 2020 through December 31, 2021
Services Begin	Vendor	January 1, 2022

Date:	October 14, 2019
RFP Number:	270-20191001TPAS
RFP Description:	Third Party Administrative Services
Addendum Number:	2
Using Agency:	The North Carolina State Health Plan for Teachers and State Employees
Purchaser:	Sharon L. Smith
Opening Date / Time:	January 3, 2020 @ 2:00 p.m. ET

INSTRUCTIONS:

1. This Addendum is issued in response to questions submitted.
2. Return two properly executed originals of this Addendum Number 2 with your Minimum Requirements Proposal. Failure to sign and return this Addendum Number 2 may result in the rejection of your proposal.

****

Execute Addendum Number 2, RFP Number 270-20191001TPAS:

Vendor: _____

Authorized Signature: _____

Name and Title (Print): _____

_____

Date: _____

No.	Reference	Vendor Question	Answer
1.	2.6 Proposal Submittal Page 11	Minimum Requirement General Question: Is it acceptable for us to hand-deliver our Minimum Requirements response and our response to the Technical Requirements to the Plan's office, or is it mandatory for the responses to be mailed or shipped by some other means?	Hand delivery is acceptable per RFP Section 2.6.1 d) that states the following: **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 the Vendor. It is the sole responsibility of the 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.**
2.	2.6.2 Minimum Requirements Proposal Submission Page 12	Minimum Requirement General Question: We understand that the files contained on the flash drives are not to be password protected. Is it acceptable for the flash drives themselves to be password protected?	No, it is not acceptable for Vendors to password protect flash drives or files.
3.	2.6.2 Minimum Requirements Proposal Submission Page 12	Minimum Requirement General Question: Is it acceptable for us to provide certain attachments for the Minimum Requirement response on flash drives (one flash drive with each binder) as opposed to in print? Specifically, if the attachment is lengthy, is it acceptable to provide the attachment on a flash drive only?	No, it is not acceptable for Vendors to provide attachments on flash drives only. Vendors are required to submit the Minimum Requirement response as specified in RFP Section 2.6.2 Minimum Requirements Proposal Submission.

4.	RFP Section 5.1 Page 30	Instructions indicate to "provide page number reference to the location within the Vendor's proposal where the minimum requirements has been satisfied." 1. Please clarify instructions regarding listing page number reference, since page numbers within the RFP response/questionnaire will change with the final technical response. Does the page number requested refer to the page number in the RFP section or the response within the technical response? 2. Is it the intent of the State for bidder's to reference (within our supporting documentation) the RFP minimum requirement and page number where we outlined how bidder has met the requirement (in an additional clarification document)?	1. Vendors shall respond to all questions and confirmation/certification/ description requests that are described herein in their Minimum Requirements Proposal using the same RFP numbering sequence. The Plan is requesting Vendors to provide the section and page number(s) within the Vendor's Minimum Requirements Proposal where the response can be found. 2. Yes, Vendors should label supporting documentation to indicate which TPA Minimum Requirement is being addressed.
5.	RFP Section 5.1 Page 30	Vendors are cautioned to provide sufficient detail for the Plan to validate their responses. In order to respond to the minimum requirements table found on 5.1, is a "confirmed" response sufficient where no documentation is requested? Or is supporting documentation required for all responses?	Yes, a confirmed response is sufficient where no documentation is requested.
6.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 1: Please clarify in as much detail as possible the Plan's intent when requiring that the Vendor "assume and exercise the same fiduciary responsibility established in N.C.G.S. 135-48.2 for the State Treasurer, Executive Administrator, and Board of Trustees".	The Plan expects the Vendor to act in the best interest of the Plan in relation to the Services under this Contract. The Vendor shall not act in any manner adverse or contrary to the interests of the Plan or for the Vendor's own benefit in performing these Services. The Vendor shall utilize its best efforts on behalf of the Plan and must exercise all of the skill, care, and diligence at its disposal in performing these Services. The Vendor shall be held to a high standard of honesty and full disclosure in regard to the Plan.
7.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 2: Please provide specific examples of how the fiduciary responsibility might apply to the Vendor.	The Plan is unable to speculate regarding hypothetical scenarios that could implicate the Vendor's fiduciary duty to the Plan. In general, the Vendor's fiduciary responsibility to the Plan applies to the Services under this Contract and any activities or actions undertaken by the Vendor that impact the Services under this Contract.

8.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 3: Please describe any limitations on the fiduciary responsibility.	The Vendor's fiduciary responsibility to the Plan applies to the Services under this Contract and any activities or actions undertaken by the Vendor that impact the Services under this Contract. The Vendor's fiduciary duty to the Plan does not extend to ministerial duties.
9.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 4: What actions or activities would the fiduciary responsibility require a Vendor to engage in that the Vendor would not otherwise be required to undertake?	The Plan cannot comment specifically on the actions or activities that the Vendor might undertake to perform the Services under this Contract in the absence of a fiduciary duty. However, the Plan expects the Vendor through its actions and activities to uphold its fiduciary duty to the Plan. Similarly, the Plan expects the Vendor to refrain from undertaking any actions or activities that would breach its fiduciary duty to the Plan.
10.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 5: What actions or activities would the fiduciary responsibility require a Vendor to refrain from engaging in that would be permissible in the absence of the fiduciary responsibility?	The Plan cannot comment specifically on the actions or activities that the Vendor might undertake to perform the Services under this Contract in the absence of a fiduciary duty. However, the Plan expects the Vendor through its actions and activities to uphold its fiduciary duty to the Plan. Similarly, the Plan expects the Vendor to refrain from undertaking any actions or activities that would breach its fiduciary duty to the Plan.
11.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 6: If a Vendor agrees to assume the fiduciary responsibility, does the Plan intend for Plan members to be able to sue the Vendor for breach of that fiduciary responsibility? If not, what does the Plan believe would prevent a Plan member from pursuing such litigation against the Vendor?	The Plan cannot provide legal advice to Vendors regarding the likelihood or viability of any potential litigation. However, the Plan's intent is to create a fiduciary duty owed to the Plan by the Vendor, which can be enforced by the Plan through its Contract with the Vendor.
12.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 7: This requirement states that the Vendor must exercise loyalty and a duty of care to the Plan, and must assume a fiduciary responsibility. Are the loyalty and duty of care cited in this requirement parts of the fiduciary responsibility or something different? If they are different from the fiduciary responsibility, please explain the differences.	The Vendor's loyalty and duty of care to the Plan are part of this fiduciary responsibility.
13.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 8: The fiduciary responsibility created by the General Assembly in N.C.G.S. 135-48.2	The Vendor's fiduciary duty to the Plan does not extend to ministerial duties.

		broadly applies to all the duties and responsibilities that the State Treasurer, Executive Administrator, and the Board of Trustees carry out for the Plan. Does the Plan intend for the fiduciary responsibility cited in Minimum Requirement #4 to broadly apply to all duties and responsibilities of the Vendor, including ministerial duties where the Vendor has not been delegated discretion by the Plan?	
14.	5.1 Minimum Requirements Page 30	Minimum Requirement #4 – Question 9: If the fiduciary responsibility that a Vendor owes to the Plan were to conflict with either a legal or regulatory requirement or a fiduciary responsibility that the Vendor owed to a third-party, what methodology would the Plan want the Vendor to use to resolve that conflict?	If the Vendor's fiduciary duty to the Plan conflicts with an applicable legal or regulatory requirement then the legal or regulatory requirement will control. However, the Vendor shall notify the Plan of any such conflicts as soon as they arise. Aside from this, the Vendor shall not take any action or inaction that would breach its fiduciary duty to the Plan. Further, the Vendor shall not accept any new fiduciary responsibilities after execution of the Contract that conflict with its fiduciary duty to the Plan.
15.	5.1 Minimum Requirements Page 31	Minimum Requirement #8 – Question 1: The Vendor must agree to manage the part of the network that is "owned" by the Plan. Please define "owned".	The part of the network that is owned by the Plan refers to the North Carolina State Health Plan Network providers who were contracted through the Clear Pricing Project. See Section 5.2.4 Network Management for more background regarding the Plan's reimbursement strategy.
16.	5.1 Minimum Requirements Page 31	Minimum Requirement #8 – Question 2: Does the Plan intend to contract the network on Plan paper, with the Vendor not being a party to the provider contracts? Or, does the Plan intend for the provider contracts be on Vendor paper, between the Vendor and the provider, but reflective of the Plan's reimbursement strategy?	The Plan intends for the contracts to be directly between the Plan and the providers – the Vendor will not be a party to these contracts.
17.	5.1 Minimum Requirements Page 31	Minimum Requirement #8 – Question 3: If the "owned" network will be on Plan paper, what functions will the Plan perform relative to the network? For example, will the Plan manage contract communication, negotiation, etc. directly with providers? In addition to the examples provided, please provide the specific functions that you will expect the Vendor to assume?	See Section 5.2.4 Network Management for details regarding the functions that the Plan will perform and the expectations for the Vendor.
18.	5.1 Minimum Requirements Page 31	Minimum Requirement #8 – Question 4: Does the Plan intend to negotiate and execute its own provider contracts independent of the Vendor? In other words, does the Plan intend to deliver contracts to	Yes, the Plan intends to negotiate and execute contracts with providers, independent of the Vendor, that the Vendor will be expected to administer. See Section 5.2.4 Network Management

		the Vendor that the Vendor has had no involvement in and expect the Vendor to administer those contracts?	for details regarding the functions that the Plan will perform and the expectations for the Vendor.
19.	RFP Section 5.1 page 30	Are bidders required to meet all five items listed within requirement #11, or is HITRUST certification sufficient as stated in #11- section iii? If yes, what type of documentation is needed at this time to satisfy the minimum requirements?	Pursuant to subsection iv. a HITRUST certification will be considered as a substitute for a SOC 2, Type 2 as long as the security controls can be cross-walked to the appropriate NIST-800-53 security control requirements. The Vendor shall include the full version of any substitute third party assessment report(s) as part of its submission. The Vendor shall supply a third-party security assertion for all service components used/involved in the proposed services (i.e. IaaS, PaaS, and SaaS). The report shall clearly define the service type(s) included in the assertion. If the Vendor supplies a substitute third party assessment report(s), subsections i., ii, and v. are still relevant and must be met to satisfy the Minimum Requirements.
20.	5.1 Minimum Requirements Page 32	Minimum Requirement #13 – Question 1: If an applicant plans to list a subcontractor on the RFP submission, but is also considering replacing that subcontractor before the contract effective date, how should the applicant respond to Attachment D? Should they list the current subcontractor, the new subcontractor, or both? What should they do if they plan to replace a subcontractor, but have not yet selected a replacement subcontractor?	Attachment D: Location of Workers Utilized by Vendor, Question a) 1. requires Vendors to list the location(s) outside the United States where work under this Contract will be performed by the Vendor, any sub-Contractors, employees, or other persons performing work under the Contract. In cases where Vendors are in transition from one sub-Contractor to another sub-Contractor, Vendors should list both the current sub-Contractor and the replacement sub-Contractor. In cases where Vendors intend to replace a sub-Contractor, but have not identified a replacement sub-Contractor, Vendors should list the current sub-Contractor with a note that the Vendor has plans to replace the sub-Contractor and provide the timeframe for which this will be done. Vendors will be required to provide an updated Attachment D if awarded the TPA Contract.
21.	5.1 Minimum Requirements Page 32	Minimum Requirement #13 – Question 2: Does the Plan want the list of worker locations to include locations used by subcontractors as well as direct employees of the Vendor? If the Plan wants an applicant to list the locations of the workers of subcontractors, how does the Plan want an applicant to address a situation where	Attachment D: Location of Workers Utilized by Vendor, Question a) 2. requires Vendors to describe the corporate structure and location of corporate employees and activities of the Vendor, its affiliates or any other sub-Contractors that will perform work outside the U.S.

		they anticipate using a subcontractor to support a given function, but have not yet identified or engaged the subcontractor and don't know the locations of its workers?	Vendors are required to list the location of sub-Contractors' workers. In cases where Vendors anticipate using a sub-Contractor to support a given function, but have not yet identified or engaged the sub-Contractor and do not know the locations of its workers, Vendors shall list the function to be performed by a sub-Contractor and explain why the sub-Contractor and location of worker information is not available, and include the timeframe for when the information will become available. Vendors will be required to provide an updated Attachment D if awarded the TPA Contract.
22.	5.1- MINIMUM REQUIREMENTS, page 30-32	Should we put our initial explanation in the rightmost column of the minimum requirements grid and provider the supplemental information requested (i.e. additional documentation for items 2, 3, 5, 6, 9, 10, 11 and completion of the requested forms for items 13, 14, 15, 16, 17, 18) following the document?	Vendors are required to submit a Minimum Requirements Proposal in accordance with RFP Sections 2.7 Proposal Contents, 2.7.1 Minimum Requirements Proposal Contents, and RFP Section 5.1 Minimum Requirements. Vendors shall reference in the column labeled "RFP Section Number and Page Number of Response", the page number to the location within the Vendor's Minimum Requirements Proposal where the minimum requirement has been satisfied. Vendors shall respond to all questions and confirmation/certification/description requests that are described herein in their Minimum Requirements Proposal using the same RFP numbering sequence. Vendors are cautioned to provide sufficient detail for the Plan to validate their responses.
23.	5.1- MINIMUM REQUIREMENTS, page 30-32	Can we refer to separate tabs with documents for each item, rather than page numbers?	Vendors cannot refer to tabs rather than page numbers. However, Vendors can reference tabs in addition to page numbers.
24.	5.1- MINIMUM REQUIREMENTS, page 30-32	For minimum requirements items that don't requirement documentation, is stating that we are in agreement with the requirement sufficient? (i.e. items 1, 4, 7, 8, 12)	Yes. Vendor's confirmation in the Minimum Requirements Proposal of Minimum Requirements that do not require documentation is sufficient.
25.	5.1- MINIMUM REQUIREMENTS, page 31-32	Does the State require vendors to include the SOC reports and/or applicable alternates asked for in #11	Vendors are required to include the SOC reports and/or applicable alternates with the Minimum Requirements Proposal.

		with the actual minimum requirements response, or just certify that we will provide upon award?	
26.	5.1- MINIMUM REQUIREMENTS, page 31-32	If the State does want actual reports for #11, will the State sign a confidentiality agreement for the release of the reports?	No. The Plan will not sign a confidentiality agreement for the release of reports. Vendors may redact reports in accordance with Minimum Requirement # 11. iii. and iv.
27.	5.1- MINIMUM REQUIREMENTS, page 30-32	Will the State allow vendors to put larger files only on the USB drive, if they describe the contents in the actual response? For example, our financial statement for minimum requirements #10 would be 320 pages.	No, it is not acceptable for Vendors to provide attachments on flash drives only. Vendors are required to submit the Minimum Requirement Proposal as specified in RFP Section 2.6.2 Minimum Requirements Proposal Submission.

Date: November 15, 2019

RFP Number: 270-20191001TPAS

RFP Description: Third Party Administrative Services

Addendum Number: 3

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Sharon L. Smith

Opening Date / Time: January 3, 2020 @ 2:00 p.m. ET

INSTRUCTIONS:

1. This Addendum is issued in response to questions submitted.

2. The nomenclature for sections 5.2.2.2 “Experience”, and 5.2.2.3 “Resources” is incorrect. Corrected pages with tracked changes are attached. Vendors should use the correct nomenclature in proposal responses.

3. Section 5.2.16.6 a. iv. is amended to replace “Quarterly high claimant reports” with “Quarterly reports of denied claims” in accordance to the response in Question # 95; and is restated in its entirety below:

   iv. Quarterly reports of denied claims that include, but are not limited to:

   1) Denial reason
   2) Number of claims for each denial reason
   3) Total charges for each denial reason

4. Return two properly executed originals of this Addendum Number 3 with your Minimum Requirements Proposal. Failure to sign and return this Addendum Number 3 may result in the rejection of your proposal.

****

Execute Addendum Number 3, RFP Number 270-20191001TPAS:

Vendor: _____

Authorized Signature: _____

Name and Title (Print): _____

_____

Date: _____

NO.	Reference	Vendor Question	Answer
1.	General question, no page number	Can the RFP be provided in Microsoft Word format?	No, the Plan cannot provide the RFP in Microsoft Word format.
2.	General question, no page number	Will there be any changes to the SPDs for 2020?	The new 2020 benefits booklets have been posted on the Plan's web site. The 2020 benefit and network changes are included.
3.	Section 1.2 (Page 8)	Would the Plan consider a multi-tier plan option in place of their current two-tier broad arrangement or are carriers required to quote their full National Network as the broad arrangement?	In section 5.2.11.2.b., Vendors are asked to confirm their capabilities to administer a multi-tier plan design; however, Vendors should use their full national network for the pricing exercise. The Plan's current 2020 network is not tiered.
4.	Section 1.2 (Page 8)	Will the SHP be releasing the current TPA (BCSBNC) administrative costs, as well as those proposed for 2020 with (line item detail)?	No. The Plan will not be releasing the current TPA administrative costs or those proposed for 2020 with line item detail.
5.	1.2 Plan Vendors, Page 9	In regard to the list downloaded from the State site, the list of vendors does not indicate what services each vendor provides for the state. Can the list be updated to reflect what services each vendor provides (i.e., behavioral health, population health, etc.)?	Refer to page 9 of the RFP for a list of the Plan's major vendors and the services provided by each.
6.	1.2 Plan Vendors, Page 9	Will the State provide the contract period and vendor for the existing population health and disease management programs?	The Plan does not have a separate population health management contract. BCNC provides these services as part of the current TPA Contract.
7.	Section 2.4 (Page 10)	Will the Plan definitely be asking bidders for a Best and Final Offer, or is this an optional step?	The issuance of a BAFO(s) is at the Plan's discretion.
8.	**2.4 RFP Schedule - Page 10**	Please clarify the dates for finalist presentations. The schedule indicates that finalist presentations will be held from January 15-28, 2020 but also indicates that finalist presentations will be held from February 6-10, 2020.	The Plan intends to hold finalist presentations during February 6-10, 2020.
9.	Section 2.5 (Page 10-11)	Will bidders have the opportunity to ask additional proposal questions around the responses to these proposal questions?	No. The Vendor Deadline for Submission of All Written Questions ended November 7, 2019.
10.	Section 2.6.3 (d) and (e) (Page 12)	Do you require separate Flash Drives for each of the Cost and Technical, or should they both go on one Flash Drive? If the later, should they go with the cost or technical proposal?	No, the Plan does not require Technical Proposals and Cost Proposals to be on separate flash drives. If space allows, Vendors may include the Technical Proposal and the Cost Proposal as separate files on the same flash drive; and submit

			with the Technical Proposal. Flash drives shall be labeled as specified in Section 2.6.3.
11.	**2.6.3.a - Page 12** 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 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 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 General Statutes, the Public Records Act. All redactions shall be made in black so that the redactions are easily identifiable by the Plan.	Is it acceptable for us to provide lengthy attachments for the Technical response on flash drives (one flash drive with each binder) as opposed to hard copy?	No, it is not acceptable for Vendors to provide attachments on flash drives only. Vendors are required to submit the Technical and Cost Proposal response as specified in RFP Section 2.6.3 Technical and Cost Proposal Submission.
12.	**2.6.3.c - Page 13** 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.	Please confirm that Vendor should not password protect flash drives. If so, please describe how the Plan will ensure Vendor's data will be secured and protected.	It is not acceptable for Vendors to password protect flash drives or files. The flash drives will be stored in secured storage at the Plan's offices.
13.	Section 2.7 (Page 13)	Can vendor put large samples/response files requested in Section 5 on flash drive, rather than printing? If printing is required, could there be a page size limit? (i.e. only print the first 10 pages, then refer to the rest of the item on Flash? (Examples of sections of the RFP that would require large files/page counts: 5.2.9.2, 5.2.9.3, 5.2.16)	No, it is not acceptable for Vendors to provide attachments on flash drives only. No, it is not acceptable for Vendors to print partial documents.
14.	Section 2.7.1, (Page 13)	Can you confirm items including the in the minimum requirements items need not be re-submitted in the full proposal (cf 4.5. 3.5)	Vendors shall submit Technical and Cost Proposal contents as specified in section 2.7.2.
15.	Section 2.7.2, (Page 13)	Can you confirm that letters a, b, d and e would go in the technical response, and that only letter c (Attachment A: Pricing) would going in the cost response?	Confirmed.

16.	Section 2.7.2,a (Page 13)	Do vendors need to include a copy of the complete original RFP document RFP with their response, appending their name to the top? If so, would this just be the first 170 pages?	Yes. Vendors are required in section 2.7.2 a) to include a copy of the entire RFP as posted on the IPS.
17.	Section 2.8, Item yyy (Page 17)	Can vendors include additional direct contracts as part of their offer, or should all services be part of the medical contract (for example, if we have a division that provides some reporting services, would the Plan be willing to sign a contract directly with that division, or would the Plan prefer to only sign one contract with the primary vendor, to include all the quoted services?	No. The Plan will enter into one contract with the Vendor that includes all services described in this RFP. The Plan will not enter into separate contracts with separate divisions of the Vendor.
18.	**3.1 Method of Award - Page 18**	This section states that the intent is to award the contract to a single Vendor, but that the State reserves the right to make separate awards to different Vendors for one or more line items. Please define "line item".	It is the Plan's intent to enter into one contract with a single Vendor that includes all services described in this RFP.
19.	**3.1 Method of Award - Page 18**	If separate awards could be made to different Vendors for one or more line items, how should the cost proposal be structured to account for the potential for each line item to stand on its own?	It is the Plan's intent to enter into one contract with a single Vendor that includes all services described in this RFP.
20.	**3.4.b - Page 21** Technical Requirements & Specifications: Scoring points for the Technical Proposal will be allocated as follows: TECHNICAL AREAS POINTS Section 5.2.2 Account Management 1,000 Section 5.2.3 Finance and Banking 1,100 Section 5.2.4 Network Management 1,200 Section 5.2.5 Medical Management & Health Care Support 600 Section 5.2.6 Pharmacy Management 400 Section 5.2.7 Enrollment & Group Set-Up 900 Section 5.2.8 Group Billing & Collection 900 Section 5.2.9 Data & Technology 900 Section 5.2.10 Customer Experience 700	In the table of possible points awardable by section, sections 5.2.16 and 5.2.17 are not included. Please confirm that there are no points awardable for those sections as a part of the Plan's evaluation.	Confirmed. There will be no points awarded for sections 5.2.16 and 5.2.17.

	Section 5.2.11 Product Management 400 Section 5.2.12 Claims Processing & Appeals 300 Section 5.2.13 Audit 500 Section 5.2.14 Recovery and Investigations 600 Section 5.2.15 Initial and Ongoing Implementations 500 Total for Technical Areas 10,000		
21.	Section 3.4 c) Cost Proposal- (Page 21)	Will there be consideration given to potentially scoring the Claims Repricing results of the TPA's narrow network(s), as with Broad?	No, the TPA's narrow network will not be considered when scoring the pricing section. The Cost Proposals will be scored based upon the assumption that the Vendor's broad network described in Section 5.2.4.3 and priced in Attachment A will be used as a wrap-around to supplement the Plan's custom network.
22.	**4.3.1.h - Page 23** 4.3.1 Administrative Fees 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.	Please provide the criteria for measuring "satisfactorily completed." How will the Plan determine if the services represented by the administrative fee invoice have been satisfactorily completed?	Most administrative fees are based on a per member or per subscriber per month fee. The Plan will evaluate the Contract, the appropriate membership report(s), and whatever other supporting documentation may be required to validate the invoice. If there is a discrepancy, the Plan will reach out to the Vendor for clarification.
23.	**4.3.1.h - Page 23** 4.3.1 Administrative Fees 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.	Is it the Plan's intent to withhold payment of administrative fees in addition to assessing performance guarantee penalties if certain deliverables do not meet agreed upon performance standards?	The payment of invoices and the assessment of performance guarantees are separate and it is not the Plan's intent to withhold payment and assess a performance guarantee on the same deliverable.
24.	4.12 Administrative Decision Memos (ADM), Page 28	Please provide a sample of the Administrative Decision Memo used today.	See attached Sample Administrative Decision Memo.
25.	Services a., v, Page 38, d., i, ii, Page 40	There are a few instances where statements have referred to the possible use of a vendor bank account. Is this an option that may also be discussed?	Vendors are required to meet all of North Carolina's financial processing, banking, and reporting requirements as outlined in 5.2.3.2.a.
26.	Section 5.2.3 (page 37)	Will the SHP consider an alternative Banking model if we feel it can save the Plan money or only one that replicates the current SHP Banking model as described in the RFP? If you would accept this alternative, how should we message this	Vendors are required to meet all of North Carolina's financial processing, banking, and reporting requirements as outlined in 5.2.3.2.a. Only models that meet these requirements will be considered. Failure to meet all of North Carolina's financial processing, banking, and reporting requirements

		option in the technical and cost proposals?	will result in disqualification of a Vendor's proposal.
27.	Section 5.2.4, Network Management (page 41)	Related to transparency requirement language: Will confidential contracts be subject to public access at any point during or after the RFP/process?	Vendors may designate information supplied to the Plan in their RFP response or during the life of the Contract as confidential in accordance with the applicable portions of 2.6.3 Technical and Cost Proposal Submission and Attachment B, Item 14.
28.	Section 5.2.4, Network Management (page 41)	What party currently holds the contract b/w the 28,000 providers participating in the SHP Clear Pricing initiative? SHP or BCBST or other? How if at all, will that change effective 1/1/22?	Blue Cross Blue Shield of North Carolina is the current signatory to the provider contracts for the North Carolina State Health Plan Network. The plan is for these contracts to novate to the Plan on 1/1/22 at which time the Plan will be directly contracted with these providers.
29.	Section 5.2.4, Network Management (page 41)	Are there any existing or proposed Alternative Payment Models with the incumbent carrier as part of the SHP for plan year 2020 or 2021?	There are currently several bundled payment arrangements in place for orthopedics. The Plan is also reviewing other alternative payment models for implementation with Clear Pricing Project providers.
30.	Section 5.2.4, Network Management (page 41)	Please provide a complete listing of the providers that are currently in the Clear Pricing Project network, including the following detail that's needed at the provider-level: provider name, TIN #, NPI #, and the discounts by place of service (Inpatient, Outpatient and Professional).	Vendors can access the complete listing of providers who have committed to the Clear Pricing Project at the following link: https://www.shpnc.org/cpp-provider-lookup-tool The Plan will not be providing TINs or NPIs at this time. See Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy for all reimbursement information.
31.	**5.2.4.1 Overview and Expectations - Page 41-42** The Plan seeks a Vendor that will support its provider reimbursement strategy which is the focal point of the Clear Pricing Project. This project has been designed to provide affordable, quality care and increase transparency,	This section states that, during the initial phase of the Clear Pricing Project, providers outside of North Carolina will not be required to accept the Medicare-based reimbursement methodology. When does the Plan intend to extend the Medicare-based reimbursement	The Plan does not have a schedule in place to implement Medicare-based reimbursements for out-of-state providers. The current focus is on North Carolina providers.

	predictability, and value for Plan Members. To accomplish these goals, the Plan has begun to build its own network of North Carolina providers, the North Carolina State Health Plan Network ("custom network"), with reimbursement rates that are referenced to Medicare rates. The Vendor must load the Plan's custom network in the Vendor's system(s), and process claims based on the reimbursement methodology developed by the Plan. See Exhibits 4, North Carolina State Health Plan Network Master Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy. While the Plan will contract directly with some providers, the Vendor must be able to supplement the Plan's custom network with other providers to ensure access to care standards are met throughout the state and provide supplemental contracts for services such as reference labs, durable medical equipment, and other commodity services. The Vendor must be flexible in this regard, including being able to accommodate the transition of more providers to the custom network in the future. The Vendor also must be able to supplement the Plan's custom network with a national wra17.p-around network of providers located outside of North Carolina, as the Plan has Members in every state. During the initial phase of the Clear Pricing Project, providers outside of North Carolina will not be required to accept the Medicare-based reimbursement methodology. The Plan shall partner with a Vendor that will work with the Plan during the implementation of the custom network to develop processes, payment policies, and ongoing network maintenance, to ensure that the integrity and ongoing viability of the custom network is maintained. While phase one of the Clear Pricing Project is the establishment of a provider	methodology to providers outside of North Carolina?	

	network whose reimbursement rate is referenced to Traditional Medicare, it is the Plan's intent in the next phase to strategically layer alternative payment arrangements such as, but not limited to, bundled/episodic payments, shared risk/savings, and global payment/capitation, into the provider contracts where appropriate. The Plan shall partner with a Vendor with a shared vision to customize and implement these strategies, as needed, to meet the Plan's goals. A 'one size fits all' methodology will not meet the needs of a state so geographically diverse as North Carolina. Finally, the Plan recognizes that the health care landscape is constantly changing; therefore, the Plan also seeks to partner with a Vendor that has the flexibility to meet changing needs which may include a full-service network offered by the Vendor or a narrow network offered by the Vendor or designed specifically for the Plan. The Plan intends to evaluate the full breadth of provider services offered by the Vendor.		
32.	**5.2.4.2.a.i - Page 42** a. The Plan requires a Vendor that will provide claims processing and related services utilizing a custom network that includes providers contracted by the Plan. While the Plan intends to contract directly with service providers in North Carolina, the Vendor will need to supplement the network with a national wrap- around network of providers located outside of North Carolina. The Vendor will also be asked to supplement the network with contracts for services such as reference labs, durable medical equipment, or other commodity services and other North Carolina providers, as needed, to ensure access to care standards are met. i. Vendor acknowledges that the Plan is a governmental payor.	Please elaborate on the reasons the Plan is requiring the Vendor to acknowledge that the Plan is a governmental payor. What significance / impact does the Plan view such acknowledgment as having in the context of the TPA services?	The Plan is a government payor of health care because 82% of the Plan's expenses are funded by the North Carolina General Assembly, and the remaining 18% comes from public workers whose salaries are paid by tax dollars. As a government payor, the Plan has a fiduciary responsibility to provide quality, affordable health care to its Members and to ensure in a transparent manner that what it spends on health care is aligned with what it costs to provide health care. The Plan, as a government payor and as a fiduciary, cannot pay inflated health care bills and subsidize other customers at the expense of Plan Members and taxpayers. As a partner in administering the Plan, it is important that the TPA has an understanding of these facts.
33.	**5.2.4.2.a.i - Page 42** a. The Plan requires a Vendor that will provide claims processing and related services utilizing a custom network that includes providers contracted by the Plan. While the Plan intends to contract	Please define what the Plan means by "governmental payor" in the context of this question.	The Plan is a government payor of health care because 82% of the Plan's expenses are funded by the North Carolina General Assembly, and the remaining 18% comes from public workers whose salaries are

	directly with service providers in North Carolina, the Vendor will need to supplement the network with a national wrap- around network of providers located outside of North Carolina. The Vendor will also be asked to supplement the network with contracts for services such as reference labs, durable medical equipment, or other commodity services and other North Carolina providers, as needed, to ensure access to care standards are met. i. Vendor acknowledges that the Plan is a governmental payor.		paid by tax dollars. As a government payor, the Plan has a fiduciary responsibility to provide quality, affordable health care to its Members and to ensure in a transparent manner that what it spends on health care is aligned with what it costs to provide health care. The Plan, as a government payor and as a fiduciary, cannot pay inflated health care bills and subsidize other customers at the expense of Plan Members and taxpayers.
34.	**5.2.4.2.c.ii - Page 43** c. The Plan requires a Vendor that will administer the Plan's Medicare-based reimbursement methodology for out-of-network providers as follows: ii. Vendor will reimburse Members, not providers, when services are rendered by an out-of-network provider. **5.2.12.2.b.i - Page 95** b. The Plan prefers a Vendor that can perform the following claims services. i. Upon request, Vendor will pay all claims, including non-network claims based on assignment of benefits.	Please confirm the Plan's intention regarding assignment of benefits. The two referenced sections seem to contradict each other. Section 5.2.4.2 states that the "Vendor will reimburse Members, not providers, when services are rendered by an out-of-network provider." Section 5.2.12.2 states that "Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits."	The Plan prefers a Vendor that has the flexibility to pay providers as requested by the Plan. But based on the current strategy, the Plan requires that non-network reimbursements be made to Members.
35.	**5.2.4.2.d.ii - Page 43 - 44** d. While the Plan may contract directly with North Carolina providers in the custom network, the Plan requires a Vendor that will be responsible for the development, maintenance, and administration of medical and payment policies. In addition, the Vendor must be able to administer any Medicare medical and payment policies adopted by the Plan. Because the Plan's reimbursement methodology is indexed to Medicare, some policies may need to be adjusted to better align with Medicare guidelines. In the future, the Plan may require the administration of medical or payment policies developed by other Plan vendors. The Vendor shall confirm and describe: ii. Vendor will administer any Medicare medical and payment policies adopted by the Plan.	What would be the basis and source for any custom medical or payment policies that the Plan would request the Vendor to adopt? At what point in the policy adoption would the Plan consult with the Vendor to confirm ability to administer said policy(ies).	The Plan would consult with the Vendor prior to implementing any custom medical or payment policy. A Vendor, for example, that does not currently use a Medicare reimbursement methodology may be required to implement custom payment policies. Additionally, the Plan may have benefits, such as ABA therapy, that require a vendor to implement custom medical policies.

36.	5.2.4.2 Custom Network Services h. Page 44	What is the State's tolerance of balance billing of members for non-network services which are paid at the in-network level of benefit?	Plan Members are currently held harmless in hidden provider situations, but the Plan may consider making changes to that policy in the future.
37.	**5.2.4.2.j - Page 45** j. The Plan requires a Vendor with a provider call center to have hours of operation from at least 8:00 a.m. ET to 5:00 p.m. ET, each State Business Day, to respond to all provider inquiries, whether for the custom network or Vendor's supplemental network. The call center should be dedicated to the Plan with Plan- specific phone number and greeting.	Is it the Plan's intent that the dedicated provider call center would serve only those providers that participate in the Plan's owned network?	The Plan is requesting a dedicated provider call center. This can be a dedicated group within a larger call center.
38.	**5.2.4.2.j - Page 45** j. The Plan requires a Vendor with a provider call center to have hours of operation from at least 8:00 a.m. ET to 5:00 p.m. ET, each State Business Day, to respond to all provider inquiries, whether for the custom network or Vendor's supplemental network. The call center should be dedicated to the Plan with Plan- specific phone number and greeting.	Is it acceptable for the provider call center to have a dedicated toll-free number that is routed to designated resources within a larger call center of the Vendor's? To ensure providers receive the best service for all of their patients, please confirm that it is acceptable for the dedicated provider call center (toll-free number) can to be routed to designated resources within the Vendor's larger call center.	The Plan is requesting a dedicated provider call center. This can be a dedicated group within a larger call center.
39.	**5.2.4.2.c.iv - Page 48** The Plan requires a Vendor that maintains high quality networks. The Vendor shall complete: The Vendor shall provide each of the following: iv. A GeoAccess report for Vendor's proposed network using the zip code census data for Plan membership. See Exhibit 8 for the State Health Plan for Teachers and State Employees 5 Digit ZIP code report.	Should the GeoAccess report be completed based on the membership by zip code from Exhibit 8 or based on census information that the Plan will release after Minimum Requirements are met?	Vendors may use either the membership by zip or the census information to create the GeoAccess report.
40.	**5.2.4.3.d.ii - Page 49** d. The Plan requires a Vendor that, upon request, will offer a "narrow" network of lower cost, high quality providers for the Plan's Members located in all 100 counties in North Carolina. The Vendor shall confirm and describe how it will:	Please describe the "custom narrow network". How would the network be customized to the Plan? For example, would the customization be based on quality metrics, provider reimbursement, provider participation as defined by the Plan, or other?	Developing a custom narrow network is an option the Plan continues to consider but the parameters cannot be determined until the Contract is awarded. The Plan must have a network solution(s) that ensures access to care for all Plan Members, but quality, transparency, and cost will all be part of the equation.

	ii. Build a custom narrow network at the regional or state level for the Plan. Include in the description the timeline to develop and deploy a custom network.		
41.	**5.2.4.3.d.vi - Page 49** d. The Plan requires a Vendor that, upon request, will offer a "narrow" network of lower cost, high quality providers for the Plan's Members located in all 100 counties in North Carolina. The Vendor shall confirm and describe how it will: iv. Support transparency by allowing the Plan, at its request, to view any contracts associated with this network.	The Plan asks for a description of custom network reimbursement options for Members who live and/or seek care outside of North Carolina. Is it the Plan's intent that any custom reimbursement would be referenced to Medicare, or would the Plan consider other reimbursement approaches?	The Plan does not have a schedule in place to implement Medicare-based reimbursements for out-of-state providers. The current focus is on North Carolina providers, but the Plan may consider other reimbursement options in the future.
42.	5.2.4.3 Traditional Network Services d., Page 49	Is the State's current network utilized as a narrow network today?	No it is not.
43.	5.2.4.3 Traditional Network Services d., Page 49	How will the state evaluate a vendor's response to a narrow network in 100 counties of North Carolina if the Narrow Network is not available in all counties? Please clarify the State's definition of "Narrow"?	The Plan defines a Narrow Network as a network that limits the number of providers covered in an area to a select group of high-quality, low cost providers. The Plan also understands that in areas of the state where there is limited provider access, a competitive, narrow network may not be possible. Therefore, a successful Narrow Network in North Carolina may be a combination of more competitively bid provider contracts in the more populated areas with the standard network in other parts of the state. The Plan will evaluate each Vendor's response based on their ability to meet the Plan's financial and quality goals while also meeting access to care standards.
44.	Section 5.2.5 Medical Management (Page 50)	Please outline the current medical management programs in place with BCBS today.	In addition to utilization management and prior authorizations, the Plan offers Members case and disease management and disease management services to Members taking high cost medical specialty drugs; pre and post-operative phone calls for total knee replacements, hip replacements and coronary artery bypass surgery; management of transplants; transition of care for inpatient and extended length of stay; management of ESRD; and outreach via mail, email, or one case manager to high emergency room users. There are other health and wellness

			resources found on the Plan's website.
45.	Section 5.2.5 Medical Management (Page 50)	Please provide additional clarity around substance abuse support for members.	The Plan's mental health and substance abuse benefit are outlined in the booklets which are on the Plan's web site: shpnc.org
46.	Section 5.2.5 Medical Management (Page 50)	Does the Plan foresee using annual gate keeper activities such as Health Risk Assessment (HRA) completions, biometric screenings or other incentivized activities?	The Plan has used these types of activities in the past and may again in the future.
47.	**5.2.5 Medical Management & Health Care Support Programs - Page 50**	The Plan has used the terms "Care Management" and "Medical Management" within the RFP. The Plan defines "Medical Management" but does not define "Care Management". Are the terms interchangeable? If not, please define the term "Care Management".	In the context of this RFP, Care Management is similar to Population Health Management.
48.	5.2.5.1 (Medical Management & Health Care Support Programs) Overview and Expectations, Page 50	Who is the vendor providing Behavioral Health/Substance Use Disorder services for the State's membership? What are the services currently being provided?	These services are covered under the current TPA contract. BCBSNC uses a subcontractor, Beacon Health.
49.	5.2.5.1 (Medical Management & Health Care Support Programs) Overview and Expectations, Page 50	The statement "The Vendor must provide Medical Management services for physical and behavioral health diagnoses, including substance abuse diagnoses…." Is the State planning to use a carve-out behavioral health vendor in the future?	The Plan has no current plans to carve out behavioral health. These services are included in this Contract.
50.	5.2.5.1 (Medical Management & Health Care Support Programs) Overview and Expectations, Page 50	The definition of Health Care Support Programs includes "managing all aspects of health, across the spectrum of wellness to chronic disease and end of life support." Do the current population health vendor's services overlap with current TPA services to promote wellness and chronic disease management?	Population Health Management services are included in the current TPA Contract with BCBSNC.
51.	**5.2.5.2.b.iv - Page 51** The Vendor will provide solutions to address significant and unfavorable medical diagnoses and care gap closure trends specific to Plan Members.	Please clarify if "specific to Plan members" refers to trends in the Plan's overall population (e.g., the Plan has a higher than average rate of	The Plan expects the Vendor to identify trends and to identify specific Members with health situations.

		a certain surgical procedure) or to specific members' health situations (e.g., a specific individual has a condition that we identify and target that individual for outreach).	
52.	5.2.5.2 Services e., Page 52-53	Are we to include any disease management and health coaching services with our offering, or will these services be administered by the current vendor?	The Plan does not have a separate Population Health Management contract. Disease and case management are included in this Contract.
53.	**5.2.5.2.e.vii - Page 53** The vendor shall confirm that it will stratify and perform targeted outreach based on the following: § Enrollment in special programs (eg lower or waived co-pays…) that requirement engagement with a nurse or health coach.	Please clarify if this means that stratification and outreach will be done based on a member's current enrollment in special programs requiring nurse engagement (stratification will take into account whether the member is already enrolled in the copay waiver program), or based on the member's eligibility to be enrolled in a special program requiring nurse engagement (e.g., members who could have their copay waived by participating with a nurse will be specially targeted and outreached to inform them of the copay waiver available to them)?	The Plan would anticipate there would be some transition of care for patients at risk, but the Plan would also expect the Vendor to identify and engage Members in new programs based on their own methodology.
54.	**5.2.5.2.e.xxiv - Page 54** e. The Plan requires a Vendor that will conduct risk stratification for identifying and targeting Plan Members who could benefit from disease management, case management, and health coaching services. The Vendor shall provide the approach, process, and tools used to: xxiv. Members for outreach	This requirement appears to be incomplete. Please confirm the Plan would like Vendors to identity members for outreach.	This is correct. The Plan would like Vendors to identify Members for outreach.
55.	**5.2.5.2.i. - Page 55** i. The Plan requires a Vendor that can support the Plan in its estimation of ROI for Medical Management programs provided and can provide the ROI methodology of Medical Management programs for the current book of business. The Vendor shall confirm and describe that it will provide the following:	Please specify whether this refers only to ROI for utilization management programs or also to ROI for disease management, case management, and health coaching services?	This is not specific to utilization management. The Plan may seek to determine ROI disease management, case management, or any programs for which the Plan pays an additional administrative fee.

	i. Necessary data and participate fully in the calculation of ROI by the Plan and its actuary in consultation with the TPA. ii. The ROI calculation methodology used by the Vendor for its current BOB for the overall Medical Management program, as well as for each component of service described above. iii. Any tools that the Vendor has access to that will assist the Plan in assessing financial impact and/or return on investment of the Plan's current plan designs. iv. Any strategies to assess financial impact and/or return on investment for proposed plan design changes. v. The Vendor shall describe any limitations and/or issues with meeting requirements i.i. – iv., above.		
56.	5.2.5.2 Services h. i, ii, Page 55	Which mHealth Products are currently being used and in the future? How would you like the vendor to use the data? Does the State envision including this on the member portal? What is the expectation of integration, and what is the expectation of the data once collected?	The Plan has not seen wide adoption of mHealth for health surveillance and there has been minimal adoption of other apps and tools to track health status or even to enroll in benefits. The Plan is open to discussions about increasing adoption but does not have a current roadmap for mHealth.
57.	5.2.6 Pharmacy Management, Page 55	The questions in this section address the Vendor's specialty pharmacy Medical Management Clinical program and later suggest Specialty medications covered under the medical plan would be transitioned to the Plan's PBM. What are the State's plans regarding the future of specialty medications? Will they be covered under the medical plan or the PBM partnership?	This requirement is intended to ensure the Plan has the flexibility to remove a medication from coverage under the medical benefit and to the pharmacy benefit, if appropriate. Currently there is no intention of moving all specialty drugs to the pharmacy benefit.
58.	5.2.7.1 (Enrollment and Group Set-up) Overview and Expectations i., Page 58	This indicates that the vendor must produce accurate letters and notices. What letters and notices are included in this expectation? Please provide information required and/or sample.	The Vendor would be required to produce notices such as a Certificate of Credible Coverage when a Member terminates. As the Plan's Responsible Reporting Entity under Section 111, the Vendor may have to communicate with Members about their Medicare status. The Vendor will also have to respond to Member inquiries. All communications will be

			reviewed and finalized as part of the implementation.
59.	5.2.7.2 Services a., vii, Page 58	As it relates to supporting Reduction in Force Employees who stay enrolled for 12 months paying the employee share of premium; how are these employees represented on the file?	The file indicators cannot be finalized until the implementation because all the data elements required by the Vendor along with the configuration options of the Plan's EES vendor must be taken into consideration.
60.	5.2.7.2 Services c., Page 59	Is the unique Member ID number that will be provided to other Plan vendors and listed on the ID card a unique number for each family member (subscriber and each dependent) or is it produced at a family level (one ID for the entire family)? Please provide some examples including the composition of the ID (number of positions and if all numeric or alpha numeric).	Yes, this will be unique for each family member. The Plan's EES vendor is implementing the solution later this year so it is not currently in production. It will be an alphanumeric ID with up to 13 characters. Examples could be: 4321B0231BYC8, 1234561290135.
61.	5.2.7.2 Services j. i, ii, Page 62	For this question, does this mean each family member can choose a different plan of benefits (i.e., different copay, deductible or out of pocket)? Can each member of the family choose a different plan of benefits (i.e., different copay, deductible or out of pocket)? Please provide any examples of families and each member with their plan design and Medicare indicator.	Different plan design options are available based on Medicare status. If, for example, a family in the Retirement System Group has four members in the family and two are Medicare Primary and two are not, there will be a split contract. The two non-Medicare primary family members will have to be enrolled in the same non-Medicare primary plan. The Medicare primary family members should be enrolled in the same option, but because of Medicare Advantage rules, sometimes they are not. Initial enrollment: Subscriber – Medicare Advantage Base Spouse – Medicare Advantage Base 2 Dependent children - 80/20 PPO The initial Medicare Primary enrollment is submitted to the Medicare Advantage carrier, but the spouse does not have Part B and cannot be enrolled. Therefore, the spouse is enrolled in the only available Medicare primary option – the 70/30 PPO.

			Final enrollment: Subscriber – Medicare Advantage Base Spouse – 70/30 PPO 2 Dependent children - 80/20 PPO
62.	5.2.7.2 Services l.vi., Page 63	Would this be applicable for maintenance outside of open enrollment? What is the normal ID card volume that is expected on a routine basis? How many can we expect to see on a daily basis?	This would be the expectation for maintenance outside of open enrollment. The Plan does not track ID card volume as it is handled by the TPA but there are approximately 900 new Members each month.
63.	5.2.7.2 Services n., vii, viii, Page 64	In relationship to the 1095 reporting, what was the total eligible population and what was the turnover that the state endured in 2018?	The Plan does not the track turnover rate, but the population is approximately 75,000 Members.
64.	5.2.8.1 (Group Billing and Collection) Overview and Expectations, State Banking Handbook link, Page 65	Is the vendor allowed to send void/stop payment/stale dated warrant transactions on the check issuance file to remove from the positive pay system, or must they be removed manually or via a "delete only" file?	In the Positive Pay file, Vendor can include Positive Pay additions and Positive pay deletes. Stop Payments must come in a separate file as the formats are different.
65.	**5.2.8.2.a.ii - Page 65** a. The Plan prefers a Vendor with a premium billing system that is fully integrated with the Vendor's enrollment and claims administration systems. The Vendor shall describe each of the following: ii. The integration between the premium billing system, enrollment system, claim system, and, if offered, the employer portal.	Please confirm the Plan is inquiring about the integration of these abilities within our application for the purpose of the Plan's access via employer portal or is the Plan trying to understand if all of these are part of one system and how these might be integrated with the employer portal?	This question is not specific to the employer portal. The Plan wants to know if the billing system is separate from the enrollment system (two separate databases).
66.	5.2.8.2 Services b., ii, 4, Page 66	Provide a description of the wellness credit. How is it earned and is it static for the year, or variable?	The Premium Wellness Credit is described in detail on page 6 of the 80/20 and 70/30 benefit booklet.
67.	5.2.8.2 Services b., ii, 5, Page 66	How are 12 month RIF employees invoiced?	12-month RIF employees receive an invoice for their share of the premium from the Plan's billing vendor. The employer share is included in the Group's invoice.
68.	5.2.8.2 Services c., v, Page 67	How is interest to be calculated?	Interest is calculated as 1.5% of the billed amount for a month for charter school and local governments whose

			premiums are postmarked after the 15th of the month.
69.	5.2.8.2 Services c., vi, Page 67	Define invoicing frequency on a monthly basis. Is invoicing required more than once monthly? For all Employing Units?	Groups are invoiced on a monthly basis, but the specific invoice date varies by Group and may vary by month.
70.	5.2.8.2 Services c., vii, Page 67	What is the retro adjustment period?	There is no limit on retroactivity. Although, the Plan does require the Groups to make any corrections within a billing cycle.
71.	5.2.8.2 Services c., xiii, Page 67	What is the premium billing system?	The premium billing system is whatever system the Vendor uses to track premium receipts.
72.	5.2.8.2 Services e., i, Page 68	What entity is referred to here as the Plan's billing vendor?	The Plan's billing vendor is iTEDIUM.
73.	5.2.8.2 Services f., ii, Page 68	What entity is referred to here as the Plan's billing vendor?	The Plan's billing vendor is iTEDIUM.
74.	Section 5.2.9.1 (Page 69)	Would the plan have additional data sources that they would want included in a data aggregator/analytics solution (above medical, rx, eligibility)? Disability, Absence, Wellness, Financial (401k) etc.?	No, the Plan does not expect other data sources to be integrated into the data.
75.	Section 5.2.9.3 Technology Services, a-ii. (Page 70)	Please provide additional details on the Plan's needs around the Data Center (data warehouse). Specifically, is the Plan requesting a separate, dedicated data warehouse or a partition of the Plan's data within an existing Data Center (data warehouse)? Specifically, what services does the Plan desire around the management of the Plan's data (e.g., infrastructure, vendor feeds, additional support needs)? How does this request fit with the Plan's current warehouse solution and is it is the Plan's intention to replace the current solution?	The Plan's preference is that the Plan's data is partitioned from other Vendor data, but the Plan will allow the Vendor to prevent "co-mingling" Plan data through application of access controls in operational and analytic systems.
76.	**5.2.9.3.a.ii - Page 70** a. The Plan requires a Vendor that will provide state-of-the-art Data Centers that will be secure 24/7/365 with an uptime of 99.9%. This includes having the tools, technology, and protocols to ensure the confidentiality, integrity, and availability of the Plan's data, to prevent	Please confirm that the Plan will allow the Vendor to prevent "co-mingling" by logically segregating Plan data through the application of access controls in operational and analytic systems	The Plan's preference is that the Plan's data is partitioned from other Vendor data, but the Plan will allow the Vendor to prevent "co-mingling" Plan data through application of access controls in operational and analytic systems.

	unauthorized access, and to prevent data corruption. ii. Plan data will not be "co-mingled" with data from the rest of Vendor's book of business.		
77.	**5.9.9.9.d.iv - Page 78** The Plan requires a Vendor that will release data to the Plan as described in N.C.G.S. § 135-48.32(b). Any limitations on the Plan's use of data shall be no more restrictive than as described in N.C.G.S. § 135-48.32. The Vendor shall confirm each of the following: iv. Any limitations that may be placed on the Plan, Plan vendors, and Partners or Employing Units, as far as access to systems or data.	Under what circumstances does the Plan contemplate a Plan Partner or Employing Unit having need to access Blue Cross NC's systems?	This is outlined in a section 5.2.9.10. The Plan prefers access to Vendor's system to manage the day-to-day operations of the Plan.
78.	**5.2.9.11.a.iii - Page 79** a. To ensure the accuracy of the enrollment data in the Vendor's system, the Plan requires a Vendor that can accept and process Full Files, or Audit Files, from the Plan's EES vendor for the purposes of both auditing and reconciling enrollment and financial data. The Vendor shall confirm and describe each of the following: iii Vendor will use automated processes to ensure the appropriate amounts are reconciled.	In the data elements listed in the table, there are no elements that would be an "amount". Please clarify what the Plan is asking for.	Many of the data elements in the table are used to determine the appropriate premium to be charged.
79.	**5.2.10.e.xv - Page 85** e. The Plan requires a Vendor that offers a robust, secure Member portal for Plan Members which can be customized to meet the Plan's needs. Members should have access to view and print their claims and benefit information, order ID cards and print temporary ID cards, search for providers, and shop for services. The portal should also include wellness tools and other health care support tools. If the Plan chooses to offer applicable plan designs, Members should also be able to view their Health Reimbursement Account (HRA) and/or Health Savings Account (HSA) information and engage in other activities that increase their health literacy.	Please define Electronic Medical and Health Records. Are there specific measures that the Plan is interested in?	The Plan is interested to know what capabilities the Vendor has to display this data.

	xv. Member portal will accept and display Member-specific information from other systems and Vendor's health team, including: 1) Electronic medical and health records. 2) Disease Management Nurse notes. 3) Case Management notes.		
80.	Section 5.2.10, (Page 112) Editor's Note: This is in Section **5.2.13.2 Services** page 99 rather than Section 5.2.10, page 112.	Is the Electronic Document Processing (EDP) equivalent to the claim data file?	This is the documentation required to understand how the claims have been electronically processed.
81.	Section 5.2.10.2 "i" (ix) (page 87)	Please provide a rough estimate for the percentage of employees that currently participate in onsite biometric screenings.	The Plan does not offer biometric screening on a routine basis. This is primarily offered at health fairs with less than 100 people participating. It is possible that the Plan could sponsor larger events in the future.
82.	**5.2.11.2.b.xxii - Page 91** b. The Plan prefers a Vendor that can configure up to four benefit (coinsurance) levels per PPO Plan as follows: The Vendor shall describe each of the following: xxii Current value-based plan design elements available in Vendor's current product suite with projected or actual cost/savings on a PMPY basis. Include in the description willingness to put performance guarantees around these elements.	Please provide an example of a value-based plan design element and an example of how that the Plan would place a performance guarantee on that plan design element.	The Plan is asking the Vendor for an example of a current value-based plan design element that it offers and how it would propose a performance guarantee on this element.
83.	**5.2.11.d.ii - Page 91** d. The Plan prefers a Vendor that offers a full-service health reimbursement account (HRA). The Vendor shall confirm and describe that, upon request, it will implement an HRA for Plan Members with the following features: ii. Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.3 Include in the description a copy of the integration workflow between the medical claims processing systems and the HRA processing system.	Please confirm that the financial reporting requirements referenced in 5.2.11.d.ii are outlined in section 5.2.16 verses 5.2.3.	The 5.2.3. reference is correct. The requirement is that funding of HRA claims meet all of the State of North Carolina's financial processing, banking, and reporting requirements
84.	5.2.11.2 Product Services d., ix, xvi, Page 92	What customization is anticipated for the HSA and HRA accounts in the member	The types of customizations that may be required include such items as co-branding the site, customer service

		portal and the reporting requested? As there are system limitations that may prevent customization.	information housed in the site, and references to employer funded.
85.	5.2.11.2 Product Services g., i., Page 93	Are we confirming our capabilities in reference to this section and if a claims repricing file is requested, to exclude these claims and members?	There is no pricing exercise associated with this requirement. This is simply a confirmation of the Vendor's ability to provide a self-funded Medicare Supplement Plan to the Plan, if requested.
86.	**5.2.12.2.a.iii - Page 94** The Plan requires a Vendor that can provide the following claims services. The Vendor shall confirm and describe each of the following: As required by N.C.G.S. § 90-414.4, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. Vendor must deny any claims received from providers that are not in compliance on the date of service.	Please confirm if it is the Plan's intent to withhold payment from non-compliant providers based on the date of claim receipt or based on the date of service.	Based on current information, it will be based on the date of the receipt of the claims. The process could change in the future.
87.	**5.2.12.2.b.iii - Page 95** b. The Plan prefers a Vendor that can perform the following claims services. The Vendor shall confirm and describe each of the following: iii Vendor will attempt to negotiate a lower rate for any out-of-network claims ≥ $5,000, even in scenarios where the Plan allows for the payment of billed charges for emergent, medically necessary care.	Is it the Plan's intent that the Vendor negotiates out-of-network claims that are greater than $5,000 after the Vendor has receive the claim, or is it the Plan's intent that the Vendor also negotiate in instances where we have reviewed and authorized a request for services to be performed by an out-of-network provider? Does the Plan intend to give the Vendor any discretion to forego negotiation if certain circumstances are present or does the Plan want the Vendor to negotiate every out-of-network claim greater than $5,000 without exception? If the Plan does intend to give the Vendor discretion, in what circumstances would the Plan view such negotiation as futile and allow the discretion to be exercised? If the Vendor has negotiated a case-specific rate with an out-of-network provider before a service is provided, would the	It is the Plan's intent for the Vendor to negotiate out-of-network reimbursement rates for claims that are greater than $5,000 as early as possible. If the Vendor has negotiated a case-specific rate with an out-of-network provider before the service is provided, the Vendor does not need to negotiate a lower rate after the claim is received unless there is new information associated with the claim when it is filed. The specific parameters for negotiating with non-network providers will be established with the Vendor during the implementation.

		Plan still expect the Vendor to try and negotiate a lower rate after the claim for that service is received?	
88.	**5.2.12.2.b.ii - Page 95** The Plan prefers a Vendor that can perform the following claims services. The Vendor shall confirm and describe each of the following: ii. Vendor will provide a weekly summary of any claims totaling ≥ $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.	The Plan asks that the Vendor provide a weekly summary of any claims totaling $100,000 or greater. Please confirm that the $100,000 threshold is based on claim paid amount.	The $100,000 is based on billed amount.
89.	**5.2.13.2.d.iii - Page 102** The Plan seeks a Vendor that places a high value on the accuracy of all its deliverables, demonstrates a dedication to quality in all aspects of its operation, and is willing to share internal and external accuracy and audit results. The Vendor shall confirm and describe each of the following: iii. Vendor will provide benchmark and book of business results in addition to Plan specific results when reporting accuracy.	Does the Plan require Vendors to provide benchmark and book of business results on an ongoing basis or just for reference for RFP response?	The Plan requires the Vendor to provide benchmark results in reports on an ongoing basis.
90.	**Section 5.2.12.2.b.xxii - Page 105** b. The Plan requires a Vendor that can provide strong overpayment identification and recovery programs and meet the accounts receivable requirements of the North Carolina Office of State Controller. The Vendor must be willing to follow all statutes and state policies governing debts and accounts receivable. The Vendor will also be required to support the Plan's participation in the North Carolina Debt Setoff Program (N.C.G.S. 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). This requirement also applies to any claims	Please clarify the requirement that "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). Is it the Plan's intent that the Vendor will negotiate before payment is made, even in those cases where we have authorized the service and have signed a pre-service letter of agreement with the provider? Under what circumstances does the Plan believe that a provider that receives payment for a	Once an overpayment has been uncovered, the provider will be notified and given the opportunity to refund the Plan the full amount owed. There should be no negotiation for an overpayment. If the provider does not respond in the designated timeframe, the amount owed should be off-set from future payments for other claims. This offset should take place regardless of the timeframe of the initial payment. If the provider does not receive payments electronically, a demand should be sent. Prior approval is not confirmation of payment. Even with a confirmation, overpayments can occur if the claim is not processed correctly or if the provider submits a corrected claim.

	or reimbursements made by a Subcontractor, such as, but not limited to, a Subcontractor that processes HRA reimbursements. Finally, the Vendor must support Plan vendors that seek recoveries on the Plan's behalf. The Vendor shall confirm and describe: xxii. 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).	service from the Plan would also be "receiving payment for the same service from a government payor" for purposes of an overpayment recovery under N.C.G.S. § 58-3-225(h)?	Additionally, if a Member is retroactively terminated, any claims with dates of service after the termination date should be recovered. The Plan is a government payor so a provider would be receiving payment for a service from a government payor every time it receives payment from the Plan.
91.	5.2.14.2 Services b., xvi, Page 105	How many members are currently enrolled in COBRA, direct billing, sponsored dependents, or retiree services?	This information can be found on page 8 of the RFP. Sponsored Dependents are included in the direct bill count.
92.	5.2.14.2 Services b., xvi, Page 105	What is the definition of a sponsored dependent?	The Sponsored Dependent Group contains surviving Dependents. See section 5.2.7.2.a. for the statutory reference.
93.	5.2.16 Reporting Services, Page 111-114	Are the statements in this section specific to medical claim reporting only, or is a response from all functional reporting departments required? (i.e., banking, care management, customer reporting, etc.)	This section applies to any reporting the Vendor may provide to the Plan.
94.	5.2.16.4 Banking and Finance Reports a., 1f, Page 116	What is the definition of "Payee Status" relative to overpayment and reporting? What required information would be viewable on uncollectible account reporting?	Active, terminated, retired, disabled, COBRA, etc.
95.	**5.2.16.6.a.iv - Page 119** The Plan requires a Vendor that can provide claims reports that meet the Plan's needs. The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements. iv. Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to: 1) Denial reason. 2) Number of claims for each denial reason. 3) Total charges for each denial reason.	Please confirm the Plan is seeking a quarterly denial report that is not limited to high cost claimants.	Quarterly reports of denied claims that include, but are not limited to: • Denial reason • Number of claims for each denial reason • Total charges for each denial reason

96.	**5.2.16.6.a.viii - Page 120** a. The Plan requires a Vendor that can provide claims reports that meet the Plan's needs. The Vendor shall confirm that it will provide each of the following reports or reporting packages. Include copies of any standard reports Vendor believes may meet or may be modified to meet the Plan's requirements. viii A monthly pharmacy appeals resolved detail report that includes, but is not limited to, the following: (10) Appeal Origin	Please specify how "appeal origin" is being defined by the Plan.	The appeal origin can be either the Member or the provider.
97.	**Section 5.2.16.11.a - Page 122** a. The Plan requires a Vendor that can provide recovery and special investigations reports that meet the Plan's needs. The Vendor shall confirm that it will provide: i. Book of business data.	Please define "book of business data". What book of business data elements is the Plan requesting?	The Vendor shall provide information about its book of business results when reporting on recoveries and special investigations.
98.	1.1.1 Access Reports, Page 132	Do members with zip "00000" represent all membership residing outside of the United States?	The Members with "00000" are not necessarily out-of-country Members. They are just Members who did not provide a zip code. Only 15 Members with $37K in total claims have this zip code. There is no material impact.
99.	Attachment A: Repricing, Section 1.2.1 (Page 133)	Will the Plan sign a Non-Disclosure agreement to prevent public release of the completed Repricing File? If not, can the information in the Repricing file be claimed as "Confidential" per Attachment B, Item 14	No, the Plan will not sign a Non-Disclosure agreement. Vendors may designate information as confidential in accordance with 2.6.3 Technical and Cost Proposal Submission and Attachment B, Item 14.
100.	Attachment A: Repricing, Section 1.2.1 (Page 133)	Provide the following information that's missing from the repricing file: Column with provider names; Values for all the TIN # and NPI # entries (as many of these are currently blank).	Provider Name is not required. . Every record on the extract has a TIN and/or NPI populated. No records have both blank.
101.	Attachment A: Repricing, Section 1.2.1 (Page 133)	Section 1.2.1 of the RFP asks that we mark the Network Status column with either a Y, L or N for the repricing results. How should we be marking those records that we exclude from a re-pricing exercise? Those could	No data should be excluded from repricing. If they are not in Vendor's network, mark as "N" per the instructions.

		be dental, Rx, vision, holistic, etc.	
102.	Attachment A: Repricing, Section 1.2.1 (Page 133)	Please confirm that there should be no consideration of the Clear Pricing Project network in the Repricing Exercise- i.e. vendors should reprice on their full national network for the broad option, regardless of provider status in the CPP?	Confirmed – Vendors should reprice on their full national network for the broad option, regardless of the provider status in the Clear Pricing Project.
103.	Attachment A: Repricing, Section 1.2.1 (Page 133)	We've been instructed by Segal to upload the completed 1.3 GB Detailed claims file, for repricing, to their Workspace (upon their official release of this to us). Can you confirm these files only need to be included there, and not with our hard copy and/or electronic submission?	Confirmed. These files should only be given to Segal.
104.	Attachment A-3 - Repricing Layout (Page 133)	Given the definitions in Attachment A-3, why isn't the total value for the ELIGIBLE_AMOUNT field lower than the one for the CHARGED_AMOUNT field?	There are very few instances where this anomaly occurs and there is no material impact.
105.	Attachment A-3 - Repricing Layout Attachment A-4 - Repricing Summary - Service Category Attachment A-5 - Repricing Summary - By Provider (Page 133-134)	The query instructions from A-4 and A-5 refer to column names (in yellow below) that are not included in the A-3 Repricing Layout attachment on the "Repricing File" tab. We would need these columns included in the claim file in order to complete the attachments. Some of the columns may be in the file under different column headers but we would need clarification on how these columns all sync up between the different attachments, in order to proper complete the exercises. **Attachment A-4** **Select/Calculate Fields:** ProviderCounty, StateStatus,ServiceCategory, ClaimsNumber, NetStatus, MajorServiceCategory, ServiceCategoryName, Sum(ServiceUnit), Days = Max(1,Max(ServiceToDate)-Min(ServiceFromDate)), Sum(BilledAmount), Sum(ContAmt)	There have been some logical modifications to column names. See appropriate mapping, below. **Attachment A-4** **StateStatus** is based on In/Out of State mapping as provided in A9; If the provider region code is equal to "OOS" then "Out-of-State," otherwise "In-State." **ServiceCategory** is ServiceCategoryCode. **MajorServiceCategory** and **ServiceCategoryName** are based on the mapping provided in A3 (Service Codes tab). **ServiceUnit** is SERVICE_UNIT_COUNT. **ServiceFromDate** and **ServiceToDate** are SERVICE_START_DATE and SERVICE_END_DATE respectively. **BilledAmount** is CHARGED_AMOUNT.

		Attachment A-5 **Select/Calculate Fields:** ProviderName, ProviderTaxID, ProviderID, ProviderAddress, ProviderCounty, ClaimsNumber, NetStatus, Sum(BilledAmount), Sum(ContAmt)	**Attachment A-5** Ignore **ProviderName.** **ProviderID** is ProviderNPI. **BilledAmount** is CHARGED_AMOUNT.
106.	1.2.1 Repricing File, Page 133-134	In the repricing section, the State is asking for the vendor to include network alternatives; please define "Narrow Network"? How will the State evaluate the vendor's broad statewide network, as well as the clear pricing project network? Will the repricing analysis be done on a static state and those results projected out for three years?	"Narrow Network" is self-explanatory and references a network the Vendor has that would exclude certain providers for enhanced pricing. The Broad Network analysis will exclude providers currently contracted under the CPP. Any Vendor supplied contractual changes will be considered. See Section 3.4 c) for more information on Cost Proposal scoring.
107.	1.3 Administrative Fees, Page 134	Will the Administrative Fees only be based on the State's custom network and the wrap of a national network? Will any Narrow Network costs be evaluated?	Cost Proposals will be scored based upon the assumption that the Vendor's broad network described in Section 5.2.4.3 and priced in Attachment A will be used as a wrap-around to supplement the Plan's custom network. Table A-7.1 requests per member per month (PMPM) pricing for additional, optional services. The total PSPM fee should include all administrative fees for all services proposed and for all covered Subscribers; therefore, if there are additional fees for a narrow network, they should be included in Attachment A.
108.	**Attachment A; 1.4 - Page 134** The 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 the 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.	Network Pricing Guarantees requires that Vendors provide network discount guarantees, guarantees not to exceed a percentage of Medicare fees, and a trend guarantee. Since the Plan intends to own the provider network and to establish the provider reimbursement rates, please confirm Vendors should provide network related guarantees on only the portion of the network that is not owned by the Plan?	Yes, the Vendor should quote pricing guarantees of the portion of the network that is not owned by the Plan.
109.	Attachment A-7: Administrative Services Fees (Page 134)	Please outline any current allowances (wellness, implementation, communication)	The Plan's current TPA did not provide allowances for wellness,

		in place with the incumbent carrier today	implementation, and/or communication.
110.	Attachment A-8 - Network Pricing Performance Guarantees (Page 134)	Can the Plan provide the following information that's needed to assess this group's historical claim trend, for use in responding to the request for a trend guarantee: ~Monthly number of subscribers and members for most recent 4 years ~Monthly billed, allowed and paid medical claims for most recent 4 years ~Value and timing for all plan changes for all of the most recent 4 years ~Individual large claim amounts for all of the most recent 4 years ~Annual distribution of members or subscribers by plan options offered ~Annual age / gender distribution of members or subscribers	Sufficient enrollment and claims data has been provided. Attached is the CY 2018 Components of Trend report, performed for the Plan's Non-Medicare population. .
111.	Attachment A-8 - Network Pricing Performance Guarantees (Page 134)	Can bidders propose and aggregate trend for Trend Guarantee, rather than year by year, if we think this would provide better value to the Plan?	Yes, the Vendor may propose that as an option
112.	Attachment B: Instructions, Item 14 (Page 139)	The Plan notes that cost information may not be held as Confidential. Can you confirm this would only include Pricing Attachment A-7 (Administrative Fees), but that vendors would claim as confidential/trade secret the data in the other Pricing Attachments?	Vendors may designate information as confidential in accordance with 2.6.3 Technical and Cost Proposal Submission and Attachment B, Item 14. Historically, the term "cost information" has been treated as referring to the total cost of the Contract.
113.	Exhibit 4, Section 2, a, ii, (Page 204) and Exhibit 4, Section 2, b, iii. (Page 205)	The BCBS Pricing NC Policy is referred to throughout the exhibit. Is the BCBS Pricing NC Policy the same policy described in Exhibit 7? If not, Can vendor substitute its own NC Pricing Policy?	The "Blue Cross NC Pricing Policy" referenced in Exhibit 4 is the same policy linked in Exhibit 7. Per Exhibit 7, the Plan expects the Vendor to supply a substitute policy containing pricing principles for professional services that are substantially the same and/or achieve the same results for the Plan, unless otherwise agreed to by the Plan.
114.	Exhibit 4, Section 2, b, iii. (Page 205)	Can vendor use a different pricing guideline rather than the outlined Pricing Hierarchy (iii.)?	No. Vendors must use what has been provided.
115.	Exhibit 4, Section 2, b, iii. (Page 205)	How is "Individual Consideration" defined?	See Exhibit 7 for a link to the "Blue Cross NC Pricing Policy" in which the fee determination process for

			"individual consideration" is explained.
116.	Exhibit 4, Section 2, c, (Page 205)	What is the source used to build the BCBSNC Specialty Pharmacy Drug fee schedule? If unavailable, can vendor utilize another source for pricing pharmacy other than BCBS North Carolina Specialty Pharmacy Drugs	Exhibit 7 contains a link to the "Blue Cross NC Pricing Policy." This policy includes more information on how specialty pharmacy drugs are priced. The Plan expects the Vendor to replicate this pricing approach as closely as possible, understanding that some information will need to be substituted in place of what Blue Cross NC is using today. The final approach will be agreed upon during implementation.
117.	Exhibit 4, Section 3 , c, ix, Exhibit 4, Section 3,c, ix (Page 205-6)	Can bidders utilize CMS rules for lessor of logic?	The Plan expects lesser of logic to be applied as written in Exhibit 4, Section 3, c., ix.
118.	Exhibit 5 (Page 213)	Is the Plan willing to modify certain methodologies if financially neutral to Plan? Example: Page 3 Drug Services BETOS/CCS Categories 228 and 240; #2, modify BC NC Specialty Pharmacy Drug to another source	The Plan expects the Vendor to replicate this pricing approach as closely as possible, understanding that some information will need to be substituted in place of what Blue Cross NC is using today. The final approach will be agreed upon during implementation.
119.	Exhibit 8, (Page 273) and Exhibit 10, (Page 365)	Can the Plan provide Exhibit 8 and Exhibit 10 in excel?	No. Exhibit 8 and Exhibit 10 are not available in Excel format.

5.2.2.2 “Experience”, and 5.2.2.3 “Resources”

5.2.2.2 Experience

a. The Plan requires a Vendor with a history of providing third party administrative (TPA) services for claims processing and related services and custom client networks.

The Vendor shall provide each of the following:

i. Description of the company, its operations and ownership.

ii. Description of any specific expertise in TPA services and how long the company has been providing TPA services.

iii. Description of the types of custom networks the Vendor has built for other clients.

iv. Description of the Vendor's experience administering plans which utilize networks built by an entity other than the Vendor (e.g., a custom network built by an employer).

v. Description of all processes and protocols involved with loading/building the custom network in the Vendor's claims system.

~~a.~~b. The Plan requires a Vendor with a proven track record of providing TPA services to clients of similar size and complexity to the Plan.

The Vendor shall confirm and describe each of the following:

i. The existence of one or more current or former administrative services only (ASO) clients with more than 100,000 members.

ii. The existence of one or more current or former ASO clients with more than 25,000 Medicare Primary members.

iii. The existence of one or more current or former ASO clients with more than 100,000 lives for which Vendor has managed the client's custom network.

iv. The Vendor shall describe any limitations and/or issues with meeting requirements b.i. - iii., above.

c. The Plan prefers a Vendor with a proven track record of supporting at least two (2) clients with more than 500,000 members.

i. The Vendor shall provide the number of ASO clients in each size category and the name of the two (2) largest clients in each category in the table provided below:

Table 1 ASO/TPA Clients

Number of Members	Number of Clients	Largest clients for this Size Category (complete box with names of at least two (2) clients and number of current members for these clients).
100,000 – 250,000		
250,001 – 500,000		
> 500,000		

5.2.2.3 Resources

a. The Plan requires a Vendor that is willing to dedicate resources to the Plan during implementation and on an ongoing basis.

The Vendor shall provide each of the following:

i. Organizational chart of key executives, operational leaders, and technical leaders who will support the Plan during implementation and on an on-going basis.

ii. Short biography for each of the staff listed in the chart; clearly note the frequency the Plan will interact with each staff member.

b. The Plan requires certain resources be dedicated to the Plan and available to support the Plan on an ongoing basis.

The Vendor shall confirm it will provide a dedicated resource for each of the following roles. If the staff member assigned to fill the role is already known, Vendor shall include a brief biography of the specific resource:

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. **Member Services Manager –** Responsible for all customer service functions and reporting.

iii. **Claims Services Manager –** Responsible for claims payments and recoveries.

iv. **Enrollment, Group Set-Up, and Premium Billing Manager –** Responsible for all enrollment, enrollment files, premium billing, and reconciliation services.

v. **Operations Director –** Provides oversight of Members Services, Claims Services, Enrollment, Group Set-Up, and Premium Billing Manager.

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. If a different resource is needed to manage data exchanges than is needed to manage data analytics, modeling, and data requests, the Vendor shall provide information on both resources.

vii. **Network Operations Manager –** Provides oversight and leadership of the implementation and maintenance of the Plan's custom network, the North Carolina State Health Plan Network. This includes implementing and updating the tools required to maintain the reimbursement rates and methodologies outlined in Exhibit 1, North Carolina State Health Plan Network Participation Agreement: Exhibits 4, North Carolina State Health Plan Network Reimbursement Exhibit; 5, North Carolina State Health Plan Pricing Policy; 6, North Carolina State Health Plan Professional Non-Facility Fee Schedule; and 7, Pricing Development and Maintenance Policy, and any current or future alternative payment arrangements.

viii. **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.

c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed.

The 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 objectives.

ii. **Actuary -** Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating 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.

iii. **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 ERISA. Responsible for maintaining internal controls to protect PHI and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.

iv. **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 the 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 the extent to which North Carolina Department of Insurance ("DOI") regulations apply to the Plan.

~~b.~~d. The Vendor shall describe any limitations and/or issues with meeting requirements b.- c. above.

~~c.~~e. The Plan prefers a Vendor with the resources named in 5.2.2.3.b. located in North Carolina.

The Vendor shall provide the following:

i. City and state for each office where resources named in 5.2.2.3.b. will be primarily located.

ii. City and state for each location that will provide support for the services included in this RFP (i.e., claims processing, customer services, medical management, data management, and implementation).

iii. Approximate number and type of staff for each location**.**

~~d.~~f. The Plan requires a Vendor that is both responsive and transparent.

The Vendor shall confirm and describe 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 forty-eight (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 twenty-four (24) hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.

v. 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.

vi. Vendor will provide the Plan detailed information, including direct access to contracts, relating to current and proposed provider payment arrangements. 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.

vii. Upon request, Vendor will provide detailed cost information on any program offered under this RFP or proposed in the future to the Plan.

viii. The Vendor shall describe any limitations and/or issues with meeting requirements f.i. - vii., above.

5.2.3 Finance and Banking

5.2.3.1 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 the processing, handling, tracking and reporting of group premium billing and collections, and claims processing and provider payments and recoveries. The Vendor must be able to accept electronic fund transfers and checks from multiple Employing Units and process and deposit receipts each day as well as batch claims and other disbursements on a weekly basis as required by the Plan. The 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.

It is important to understand the billing and payment hierarchy of the Plan.

- **Premium billing** – Billed to and paid by the Employing Units with oversight from the Plan
- **Claims funding** – Billed to and funded by the Plan
- **Administrative Services Fees** – Billed to and paid by the Plan

Objectives

a. Promote efficiency, accuracy, and a superior Customer Experience for the Plan and its Employing Units by selecting a Vendor with state-of-the-art business tools, processes and services.

b. Ensure accurate and timely processing and reporting of premium collections and deposits and related transactions.

c. Ensure accurate and timely processing and reporting of disbursements, including claims payments and related transactions.

d. Ensure all applicable policies and regulations of the Office of State Controller and the Department of State Treasurer, including State banking requirements, are supported and followed.

5.2.3.2 Services

a. The Plan requires a Vendor that can support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:

- State banking: https://www.nctreasurer.com/fod/Resources/BankingHandbook.pdf
- Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
- Escheats: https://www.nccash.com/holder-information-and-reporting
- High level daily deposits and disbursements of state funds workflows: Exhibit 2

CY 2018 Components of Trend report (See response to Question #110)

North Carolina State Health Plan
Components of Trend
Calendar Year 2017 vs. Calendar Year 2018
Claims Incurred and Paid through March 2019

	Member	Allowed PMPM	Allowed Total		Paid* PMPM	Paid* Total
CY 2017	553,702	541.63	3,598,840,893		454.20	3,017,878,863
CY 2018	555,154	563.21	3,752,033,943		473.96	3,157,421,951
% Change	0.3%	4.0%	4.3%		4.4%	4.6%

		Breakdown of Components				
		PMPM	Line Item % Change	Trend Impact % Change	Total Allowed	Overall % Change
CY 2017 allowed		**541.63**			**3,598,840,893**	
Membership Change					**9,814,538**	0.3%
Utilization Change						
Hospital Inpatient		(2.28)	-2.6%	-0.4%	(15,129,818)	-0.4%
Hospital Outpatient		(3.63)	-2.3%	-0.7%	(24,120,640)	-0.7%
Physician		(0.41)	-0.3%	-0.1%	(2,748,025)	-0.1%
Pharmacy		4.65	3.6%	0.9%	30,866,383	0.9%
Ancillary		0.03	0.4%	0.0%	187,891	0.0%
Subtotal		**(1.65)**		**-0.3%**	**(10,944,209)**	**-0.3%**
Price Change						
Hospital Inpatient		4.66	5.6%	0.9%	30,948,978	0.9%
Hospital Outpatient		4.35	2.9%	0.8%	28,920,682	0.8%
Physician		5.24	3.2%	1.0%	34,793,882	1.0%
Pharmacy		8.78	6.5%	1.6%	58,310,511	1.6%
Ancillary		0.20	2.8%	0.0%	1,348,668	0.0%
Subtotal		**23.23**		**4.3%**	**154,322,721**	**4.3%**
Total Change		**21.58**		**4.0%**	**153,193,050**	**4.3%**
	Member Share	**3.48**			**24,730,003**	
	Employer	**18.10**			**128,463,047**	
CY 2018 Period Allowed		**563.21**			**3,752,033,943**	

CY 2017 Cost Share**		87.44			580,962,031	
CY 2017 Cost Share with Trend		90.92			605,692,034	
CY 2018 Cost Share**		89.26			594,611,992	
Net Employer Cost Share Impact		**1.66**		**0.4%**	**11,080,042**	**0.4%**
Net Employer Trend		**19.76**		**4.4%**	**139,543,089**	**4.6%**

* Including HRA payments in 2017

** Cost share includes deductible, ccopay/coinsurance, cob, etc.

North Carolina State Health Plan
Trend Analysis

		CY 2017					
		Utilization	Price			PMPY	
Cost Component	Unit	per 1000	(Allowed)	%	Paid	(Allowed)	Paid
Hospital Inpatient							
Medical	Admits	19	14,115	91%	12,799	262	237
Surgical	Admits	15	37,650	96%	36,011	548	524
Maternity	Admits	22	7,092	84%	5,968	158	133
MHSA	Admits	5	5,625	81%	4,544	30	24
Transplant	Admits	0	240,512	101%	242,060	34	35
Unknown	Admits	0	4,145	54%	2,233	0	0
Total		61	16,962	92%	15,666	1,031	953
Hospital Outpatient							
Emergency Room	Claims	187	2,061	58%	1,188	386	223
Surgery	Claims	163	4,047	84%	3,392	661	554
Dialysis	Claims	72	881	98%	863	63	62
Pathology/Laboratory	Claims	384	635	93%	590	244	227
Radiology	Claims	346	914	80%	728	317	252
Cardiology	Claims	66	1,124	79%	883	74	58
Maternity	Claims	21	592	66%	391	13	8
PT/OT/ST	Claims	164	185	76%	140	30	23
MHSA	Claims	29	435	78%	340	12	10
Anesthesia	Claims	9	1,317	87%	1,150	12	11
Other Service	Claims	82	566	84%	475	46	39
Total		1,524	1,220	79%	962	1,860	1,467
Physician							
PCP Office Visit	Services	2,529	127	72%	92	322	233
Specialist Office Visit	Services	1,182	143	65%	92	169	109
Inpatient Visit	Services	203	162	83%	135	33	27
Preventive Medicine	Services	624	166	93%	154	104	96
Emergency Room Visit	Services	203	248	61%	151	50	31
Immunization	Claims	1,235	48	101%	49	60	60
Consultant	Services	174	268	72%	191	47	33
PT/OT/ST	Claims	1,436	36	49%	18	52	25
MHSA	Services	745	103	70%	73	77	54
Surgery	Services	842	415	84%	348	350	293
Anesthesia	Claims	165	740	84%	624	122	103
Obstetrics	Services	224	293	79%	233	66	52
Pathology/Laboratory	Services	6,305	22	94%	21	142	133
Radiology	Services	1,496	178	84%	149	267	223
Other Service	Claims	627	176	95%	167	111	105
Total		17,988	109	80%	88	1,970	1,577
Pharmacy							
Generic	Scripts	11,433	29	76%	22	332	251
Brand Name	Scripts	1,527	429	90%	385	655	588
Specialty	Scripts	103	5,506	97%	5,361	566	551
Total		13,063	119	89%	106	1,553	1,390
Ancillary							
SNF	Claims	0	139	47%	65	0	0
DME	Claims	255	254	72%	184	65	47
Ambulance	Claims	25	740	80%	594	18	15
Hospice	Claims	22	116	94%	110	3	2
Total		301	284	75%	212	85	64
Grand Total						**6,500**	**5,450**
							84%

North Carolina State Health Plan
Trend Analysis

		CY 2018					
		Utilization	Price			PMPY	
Cost Component	Unit	per 1000	(Allowed)	%	Paid	(Allowed)	Paid
Hospital Inpatient							
Medical	Admits	17	15,294	90%	13,758	266	239
Surgical	Admits	14	39,533	95%	37,620	561	534
Maternity	Admits	22	7,202	82%	5,935	159	131
MHSA	Admits	6	5,320	81%	4,302	33	27
Transplant	Admits	0	300,891	100%	300,649	41	41
Unknown	Admits	0	3,090	53%	1,649	0	0
Total		60	17,659	92%	16,190	1,060	972
Hospital Outpatient							
Emergency Room	Claims	185	2,168	57%	1,240	400	229
Surgery	Claims	157	4,242	83%	3,536	665	554
Dialysis	Claims	71	809	98%	794	57	56
Pathology/Laboratory	Claims	394	631	93%	587	249	232
Radiology	Claims	336	920	78%	721	309	242
Cardiology	Claims	65	1,167	77%	903	75	58
Maternity	Claims	20	622	67%	414	12	8
PT/OT/ST	Claims	133	200	73%	145	27	19
MHSA	Claims	32	419	79%	333	13	11
Anesthesia	Claims	10	1,245	83%	1,036	13	11
Other Service	Claims	80	600	83%	498	48	40
Total		1,481	1,261	78%	986	1,868	1,460
Physician							
PCP Office Visit	Services	2,522	131	76%	99	330	251
Specialist Office Visit	Services	1,162	147	66%	97	171	113
Inpatient Visit	Services	203	169	83%	141	34	29
Preventive Medicine	Services	616	172	92%	158	106	97
Emergency Room Visit	Services	200	256	61%	156	51	31
Immunization	Claims	1,258	49	100%	49	62	62
Consultant	Services	168	274	74%	202	46	34
PT/OT/ST	Claims	1,504	36	49%	18	54	27
MHSA	Services	763	104	73%	76	79	58
Surgery	Services	816	428	84%	361	349	294
Anesthesia	Claims	155	795	85%	677	123	105
Obstetrics	Services	247	285	79%	225	70	56
Pathology/Laboratory	Services	6,109	23	97%	23	142	138
Radiology	Services	1,520	183	84%	154	279	235
Other Service	Claims	673	192	94%	182	129	122
Total		17,915	113	81%	92	2,027	1,651
Pharmacy							
Generic	Scripts	11,115	31	74%	23	339	250
Brand Name	Scripts	1,552	474	91%	430	735	668
Specialty	Scripts	113	5,678	97%	5,503	640	620
Total		12,780	134	90%	120	1,714	1,538
Ancillary							
SNF	Claims	0	534	100%	534	0	0
DME	Claims	248	253	72%	182	63	45
Ambulance	Claims	24	825	82%	673	19	16
Hospice	Claims	46	128	94%	121	6	6
Total		318	277	76%	209	88	67
Grand Total						**6,759**	**5,687**
							84%

North Carolina State Health Plan
Trend Analysis

		Annual Trends			
Cost Component	**Unit**	**Utilization**	**Price**	**Cost Share**	**Paid**
Hospital Inpatient					
Medical	Admits	-6.1%	8.4%	-0.8%	0.9%
Surgical	Admits	-2.4%	5.0%	-0.5%	2.0%
Maternity	Admits	-1.2%	1.5%	-2.1%	-1.8%
MHSA	Admits	18.4%	-5.4%	0.1%	12.1%
Transplant	Admits	-5.3%	25.1%	-0.9%	17.6%
Unknown	Admits	299.0%	-25.5%	-2.9%	194.5%
Total		-1.3%	4.1%	-0.8%	2.0%
Hospital Outpatient					
Emergency Room	Claims	-1.4%	5.2%	-0.8%	2.9%
Surgery	Claims	-4.1%	4.8%	-0.5%	0.0%
Dialysis	Claims	-1.7%	-8.2%	0.2%	-9.5%
Pathology/Laboratory	Claims	2.5%	-0.7%	0.1%	2.0%
Radiology	Claims	-2.9%	0.6%	-1.5%	-3.8%
Cardiology	Claims	-2.1%	3.8%	-1.6%	0.1%
Maternity	Claims	-5.6%	5.0%	0.9%	0.1%
PT/OT/ST	Claims	-19.1%	8.2%	-3.4%	-15.9%
MHSA	Claims	10.9%	-3.6%	1.5%	8.4%
Anesthesia	Claims	6.9%	-5.4%	-4.8%	-3.7%
Other Service	Claims	-2.4%	6.0%	-1.2%	2.2%
Total		-2.8%	3.4%	-0.9%	-0.5%
Physician					
PCP Office Visit	Services	-0.3%	2.7%	5.0%	7.4%
Specialist Office Visit	Services	-1.7%	2.8%	2.6%	3.7%
Inpatient Visit	Services	0.4%	3.8%	0.1%	4.3%
Preventive Medicine	Services	-1.2%	3.6%	-1.0%	1.3%
Emergency Room Visit	Services	-1.6%	3.1%	-0.1%	1.3%
Immunization	Claims	1.8%	1.9%	-0.7%	3.1%
Consultant	Services	-3.5%	2.4%	2.8%	1.7%
PT/OT/ST	Claims	4.7%	-0.2%	0.7%	5.1%
MHSA	Services	2.4%	0.7%	3.8%	7.0%
Surgery	Services	-3.1%	3.1%	0.8%	0.6%
Anesthesia	Claims	-5.7%	7.5%	1.0%	2.4%
Obstetrics	Services	10.2%	-2.8%	-0.6%	6.5%
Pathology/Laboratory	Services	-3.1%	3.6%	3.6%	4.0%
Radiology	Services	1.6%	2.8%	0.7%	5.2%
Other Service	Claims	7.3%	9.0%	-0.1%	16.8%
Total		-0.4%	3.4%	1.7%	4.7%
Pharmacy					
Generic	Scripts	-2.8%	5.2%	-2.4%	-0.2%
Brand Name	Scripts	1.7%	10.4%	1.4%	13.6%
Specialty	Scripts	9.6%	3.1%	-0.5%	12.4%
Total		-2.2%	12.8%	0.3%	10.7%
Ancillary					
SNF	Claims	-95.5%	284.3%	20.0%	-62.6%
DME	Claims	-2.7%	-0.2%	-0.7%	-3.6%
Ambulance	Claims	-4.3%	11.5%	1.7%	8.4%
Hospice	Claims	114.7%	10.4%	-0.9%	136.1%
Total		5.6%	-2.2%	1.1%	4.3%
Grand Total		**-0.3%**	**4.3%**	**0.4%**	**4.4%**
		Allowed	**4.0%**		

State of North Carolina
Trend Analysis - Allowed

Cost Component	Unit	CY 2017 Utilization per 1000	CY 2017 Price (Allowed)	CY 2017 PMPY	CY 2018 Utilization per 1000	CY 2018 Price (Allowed)	CY 2018 PMPY	Annual Trends Utilization	Annual Trends Price	Fixed Utilization PMPY	Fixed Unit Prices PMPY
Hospital Inpatient											
Medical	Admits	19	14,115	262	17	15,294	266	-6.1%	8.4%	283.36	245.48
Surgical	Admits	15	37,650	548	14	39,533	561	-2.4%	5.0%	575.03	534.62
Maternity	Admits	22	7,092	158	22	7,202	159	-1.2%	1.5%	160.74	156.40
MHSA	Admits	5	5,625	30	6	5,320	33	18.4%	-5.4%	28.04	35.11
Transplant	Admits	0	240,512	34	0	300,891	41	-5.3%	25.1%	42.93	32.49
Unknown	Admits	0	4,145	0	0	3,090	0	299.0%	-25.5%	0.01	0.03
Hospital Outpatient											
Emergency Room	Claims	187	2,061	386	185	2,168	400	-1.4%	5.2%	406.23	380.65
Surgery	Claims	163	4,047	661	157	4,242	665	-4.1%	4.8%	693.27	634.35
Dialysis	Claims	72	881	63	71	809	57	-1.7%	-8.2%	58.04	62.17
Pathology/Laboratory	Claims	384	635	244	394	631	249	2.5%	-0.7%	242.58	250.40
Radiology	Claims	346	914	317	336	920	309	-2.9%	0.6%	318.45	307.39
Cardiology	Claims	66	1,124	74	65	1,167	75	-2.1%	3.8%	76.92	72.54
Maternity	Claims	21	592	13	20	622	12	-5.6%	5.0%	13.20	11.88
PT/OT/ST	Claims	164	185	30	133	200	27	-19.1%	8.2%	32.84	24.55
MHSA	Claims	29	435	12	32	419	13	10.9%	-3.6%	12.00	13.81
Anesthesia	Claims	9	1,317	12	10	1,245	13	6.9%	-5.4%	11.81	13.36
Other Service	Claims	82	566	46	80	600	48	-2.4%	6.0%	49.03	45.15
Physician											
PCP Office Visit	Services	2,529	127	322	2,522	131	330	-0.3%	2.7%	331.03	321.38
Specialist Office Visit	Services	1,182	143	169	1,162	147	171	-1.7%	2.8%	173.89	166.40
Inpatient Visit	Services	203	162	33	203	169	34	0.4%	3.8%	34.14	33.02
Preventive Medicine	Services	624	166	104	616	172	106	-1.2%	3.6%	107.43	102.38
Emergency Room Visit	Services	203	248	50	200	256	51	-1.6%	3.1%	52.04	49.66
Immunization	Claims	1,235	48	60	1,258	49	62	1.8%	1.9%	60.78	60.77
Consultant	Services	174	268	47	168	274	46	-3.5%	2.4%	47.64	44.89
PT/OT/ST	Claims	1,436	36	52	1,504	36	54	4.7%	-0.2%	51.74	54.26
MHSA	Services	745	103	77	763	104	79	2.4%	0.7%	77.61	78.89
Surgery	Services	842	415	350	816	428	349	-3.1%	3.1%	360.61	338.85
Anesthesia	Claims	165	740	122	155	795	123	-5.7%	7.5%	130.90	114.89
Obstetrics	Services	224	293	66	247	285	70	10.2%	-2.8%	63.82	72.32
Pathology/Laboratory	Services	6,305	22	142	6,109	23	142	-3.1%	3.6%	146.67	137.15
Radiology	Services	1,496	178	267	1,520	183	279	1.6%	2.8%	274.09	271.03
Other Service	Claims	627	176	111	673	192	129	7.3%	9.0%	120.56	118.73
Pharmacy											
Generic	Scripts	11,433	29	332	11,115	31	339	-2.8%	5.2%	349.05	322.56
Brand Name	Scripts	1,527	429	655	1,552	474	735	1.7%	10.4%	723.26	666.20
Specialty	Scripts	103	5,506	566	113	5,678	640	9.6%	3.1%	583.96	620.28
Ancillary											
SNF	Claims	0	139	0	0	534	0	-95.5%	284.3%	0.02	0.00
DME	Claims	255	254	65	248	253	63	-2.7%	-0.2%	64.61	63.00
Ambulance	Claims	25	740	18	24	825	19	-4.3%	11.5%	20.29	17.40
Hospice	Claims	22	116	3	46	128	6	114.7%	10.4%	2.77	5.39
Grand Total				**6,500**			**6,759**			**6,781**	**6,480**
				542			563				
							3.984%		**Util. Trend***		-0.3%
									Price Trend**		4.3%
									Total Trend		4.0%

* Utilization Trend calculated by holding unit prices at Base Period levels, and included demographic impact

** Price Trend is residual amount to produce Total Trend

State of North Carolina
Trend Analysis - Paid

Cost Component	Unit	CY 2017 Utilization per 1000	CY 2017 Price (Paid)	CY 2017 PMPY	CY 2018 Utilization per 1000	CY 2018 Price (Paid)	CY 2018 PMPY	Annual Trends Utilization	Annual Trends Price	Fixed Utilization PMPY	Fixed Unit Prices PMPY
Hospital Inpatient											
Medical	Admits	19	12,799	237	17	13,758	239	-6.1%	7.5%	254.91	222.59
Surgical	Admits	15	36,011	524	14	37,620	534	-2.4%	4.5%	547.20	511.34
Maternity	Admits	22	5,968	133	22	5,935	131	-1.2%	-0.6%	132.46	131.59
MHSA	Admits	5	4,544	24	6	4,302	27	18.4%	-5.3%	22.68	28.36
Transplant	Admits	0	242,060	35	0	300,649	41	-5.3%	24.2%	42.90	32.70
Unknown	Admits	0	2,233	0	0	1,649	0	299.0%	-26.2%	0.00	0.02
Hospital Outpatient											
Emergency Room	Claims	187	1,188	223	185	1,240	229	-1.4%	4.4%	232.37	219.38
Surgery	Claims	163	3,392	554	157	3,536	554	-4.1%	4.3%	578.01	531.60
Dialysis	Claims	72	863	62	71	794	56	-1.7%	-8.0%	56.96	60.86
Pathology/Laboratory	Claims	384	590	227	394	587	232	2.5%	-0.5%	225.79	232.75
Radiology	Claims	346	728	252	336	721	242	-2.9%	-1.0%	249.67	244.82
Cardiology	Claims	66	883	58	65	903	58	-2.1%	2.2%	59.50	57.03
Maternity	Claims	21	391	8	20	414	8	-5.6%	6.0%	8.79	7.84
PT/OT/ST	Claims	164	140	23	133	145	19	-19.1%	4.0%	23.85	18.56
MHSA	Claims	29	340	10	32	333	11	10.9%	-2.2%	9.53	10.81
Anesthesia	Claims	9	1,150	11	10	1,036	11	6.9%	-9.9%	9.83	11.67
Other Service	Claims	82	475	39	80	498	40	-2.4%	4.8%	40.68	37.89
Physician											
PCP Office Visit	Services	2,529	92	233	2,522	99	251	-0.3%	7.7%	251.32	232.71
Specialist Office Visit	Services	1,182	92	109	1,162	97	113	-1.7%	5.4%	115.07	107.35
Inpatient Visit	Services	203	135	27	203	141	29	0.4%	3.9%	28.47	27.52
Preventive Medicine	Services	624	154	96	616	158	97	-1.2%	2.6%	98.59	94.93
Emergency Room Visit	Services	203	151	31	200	156	31	-1.6%	2.9%	31.69	30.28
Immunization	Claims	1,235	49	60	1,258	49	62	1.8%	1.2%	60.73	61.13
Consultant	Services	174	191	33	168	202	34	-3.5%	5.4%	35.08	32.12
PT/OT/ST	Claims	1,436	18	25	1,504	18	27	4.7%	0.4%	25.36	26.43
MHSA	Services	745	73	54	763	76	58	2.4%	4.5%	56.41	55.30
Surgery	Services	842	348	293	816	361	294	-3.1%	3.9%	303.99	283.51
Anesthesia	Claims	165	624	103	155	677	105	-5.7%	8.5%	111.45	96.85
Obstetrics	Services	224	233	52	247	225	56	10.2%	-3.3%	50.45	57.48
Pathology/Laboratory	Services	6,305	21	133	6,109	23	138	-3.1%	7.4%	142.38	128.48
Radiology	Services	1,496	149	223	1,520	154	235	1.6%	3.5%	230.92	226.76
Other Service	Claims	627	167	105	673	182	122	7.3%	8.9%	113.85	112.24
Pharmacy											
Generic	Scripts	11,433	22	251	11,115	23	250	-2.8%	2.7%	257.45	243.75
Brand Name	Scripts	1,527	385	588	1,552	430	668	1.7%	11.7%	656.84	597.55
Specialty	Scripts	103	5,361	551	113	5,503	620	9.6%	2.6%	565.88	604.01
Ancillary											
SNF	Claims	0	65	0	0	534	0	-95.5%	725.1%	0.02	0.00
DME	Claims	255	184	47	248	182	45	-2.7%	-1.0%	46.48	45.66
Ambulance	Claims	25	594	15	24	673	16	-4.3%	13.3%	16.55	13.97
Hospice	Claims	22	110	2	46	121	6	114.7%	10.0%	2.61	5.09
Grand Total				**5,450**			**5,687**			**5,697**	**5,443**

Util. Trend*	-0.1%
Price Trend**	4.5%
Total Trend	4.4%

* Utilization Trend calculated by holding unit prices at Base Period levels, and included demographic impact

** Price Trend is residual amount to produce Total Trend

Date:	November 21, 2019
RFP Number:	270-20191001TPAS
RFP Description:	Third Party Administrative Services
Addendum Number:	4
Using Agency:	The North Carolina State Health Plan for Teachers and State Employees
Purchaser:	Sharon L. Smith
Opening Date / Time:	January 3, 2020 @ 2:00 p.m. ET

INSTRUCTIONS:

1. Attached to this Addendum is a sample Administrative Decision Memo that was referenced in the response to Question 24 in Addendum 3.

****

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Health Plan Decision Memo

1.0 Decision Information

Decision Topic Name:	New Project		
Requested by:	Caroline Smart	**Decision Date:**	11/8/19
Date Decision is Effective:	January 1, 2020		

2.0 Reason for Request

XXX

3.0 Details of Request

XXX

4.0 Supporting Documentation

Required Project Documentation			
Req	**Document Name**	**Owner**	**Target / Due Date**
☐	ADM (this document)	NCSHP	
☐	Business Requirement Document (BRD)	NCSHP	Within 30 days from signed ADM
☐	Solution Document (SD)	Blue Cross NC	Within 30 days from signed BRD
☐	Amendment (AMD)	Blue Cross NC NCSHP	Target Date -Pending legal review and approval
☐	Project Plan (PP)	Blue Cross NC	Within 15 days after SD has been accepted
☐	Implementation Plan (IP)	Blue Cross NC	Finalized with AMD
☐	Testing Plan (TP)	Blue Cross NC	Delivered with SD
☐	Deployment Plan (DP)	Blue Cross NC	Finalized with AMD
☐	Close-Out Documentation (COD)	Blue Cross NC NCSHP	7 days prior to Go-Live date Sign-off after successful production validation period defined in DP

5.0 Assumptions

XXX

6.0 Risks

XXX

State Health Plan Decision Memo

7.0 Out of Scope

XXX

8.0 Approval

Name	Title & Department	Signature	Date
Caroline Smart	Sr. Director Plan Integration, State Health Plan		
XXX	Vendor Title		

Date: December 3, 2019

RFP Number: 270-20191001TPAS

RFP Description: Third Party Administrative Services

Addendum Number: 5

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Sharon L. Smith

Opening Date / Time: January 3, 2020 @ 2:00 p.m. ET

INSTRUCTIONS:

1. RFP Section 2.6.3 a) is amended to allow for the submission of individual attachments, exhibits, and/or supporting documentation greater than 100 pages in length in electronic copy only on flash drives. RFP Section 2.6.3 a) is amended and restated in its entirety below:

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 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 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 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 100 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.

2. Return two properly executed originals of Addendum Number 3 and Addendum Number 5 with your Technical Proposal. Failure to sign and return Addenda Numbers 3 and 5 may result in the rejection of your proposal. Vendors are not required to return Addendum Number 4.

****

Execute Addendum Number 5, RFP Number 270-20191001TPAS:

Vendor: _____

Authorized Signature: _____

Name and Title (Print): _____

_____

Date: _____

Date: December 6, 2019

RFP Number: 270-20191001TPAS

RFP Description: Third Party Administrative Services

Addendum Number: 6

Using Agency: The North Carolina State Health Plan for Teachers and State Employees

Purchaser: Sharon L. Smith

Opening Date / Time: January 3, 2020 @ 2:00 p.m. ET

INSTRUCTIONS:

1. Attachment A-4: Repricing Summary – Service Category is amended and restated in its entirety as the First Amended and Restated Attachment A-4: Repricing Summary – Service Category. The following revisions were made:

    a) Revised Service Category codes in "Table" tab to match those listed on the "Service Codes" tab in Attachment A-3: Repricing Layout.

    b) Revised query descriptions on the "Query" tab.

    c) Revised field names on the "Input" tab to match field names in the claims file.

    Vendors will receive a system-generated notification from Segal's Secure File Transfer Protocol (SFTP) system stating that a new file has been posted. Vendors shall complete and submit the First Amended and Restated Attachment A-4: Repricing Summary – Service Category with the Cost Proposal, as described in the RFP and further clarified via email from Segal (Gina Sander), dated 11/20/19.

2. Attachment A-5: Repricing Summary – By Provider includes a column for the "Provider Name". As noted in response to Question #100 in Addendum 3, the "Provider Name" was not included in the source data and is not available. When completing Attachment A-5: Repricing Summary – By Provider, it is acceptable for Vendors to leave the "Provider Name" column blank.

3. Return two properly executed originals of Addendum Number 6 with your Technical Proposal. Failure to sign and return Addendum Number 6 may result in the rejection of your proposal.

****

Execute Addendum Number 6, RFP Number 270-20191001TPAS:

Vendor: _____

Authorized Signature: _____

Name and Title (Print): _____

_____

Date: _____