ATTACHMENT L: TECHNICAL REQUIREMENTS RESPONSE

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

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

5.2.1 Account Management

5.2.1.1 Overview and Expectations

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

5.2.1.2 Resources

a. Vendor addressed the following in the Minimum Requirements Table or ATTACHMENT K:

   i. Vendor has provided services to at least one (1) public or private self-funded client with more than 100,000 covered lives. Vendor shall provide the Plan with contact information for one (1) such client to complete a reference call related to the services in this RFP.

   ii. Vendor has one (1) or more current or former ASO clients with more than 25,000 Medicare primary members.

   iii. Vendor will exercise loyalty and a duty of care to the Plan and its Members in performing its responsibilities under this Contract. Vendor must assume and exercise the same fiduciary responsibility established in N.C.G.S. § 135-48.2 for the State Treasurer, Executive Administrator, and the Board.

   iv. Vendor will provide subject matter experts, in addition to account management resources, to work directly with Plan and Plan vendor staff.

   v. Vendor has a "firewall" between its TPA services operations and any other service operations, such as a PBM, consulting group, or any other services.

b. Vendor shall confirm it will provide a dedicated resource for each of the following roles:

   i. **Account Executive** – Responsible for overall account relationship including strategic planning in relation to Plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and contract oversight.

   Confirm ☑ Does Not Confirm ☐

ii. **Operations Director** – Provides oversight of Members Services, Claims Services, Enrollment and Group Set-Up.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

v. **Enrollment and Group Set-Up**– Responsible for all enrollment, enrollment files, and reconciliation services.

Confirm ☑ Does Not Confirm ☐

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.

Confirm ☑ Does Not Confirm ☐

vii. **Implementation Manager** - Responsible for development and execution of Implementation Plans and coordinating with the Plan and internal and external resources. The Implementation Manager shall be dedicated to the Plan during the implementation process and must continue to support the Plan for a minimum of 90 days after the implementation date of January 1, 2025, if requested by the Plan. Such support includes, but is not limited to, weekly calls with the Plan and the designated account management team; maintenance of issue tracking logs; and issue resolution.

Confirm ☑ Does Not Confirm ☐

c. While not all resources need to be 100% dedicated, the Plan expects to have access to other resources as needed. Vendor shall confirm that the following resources will be available to the Plan on an as needed basis:

i. **Clinical Director** - Responsible for determining the clinical effectiveness of benefit and program changes, prospectively and retrospectively, as well as for determining outcome-based measures in order to measure clinical effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.). This resource will work proactively and collaboratively with the Plan to identify gaps in care and assist in the development of modified or additional programs to target these gaps and will collaborate with the Plan to fully support strategic initiatives.

Confirm ☑ Does Not Confirm ☐

ii. **Director of Network Management** – Responsible for overall management of Vendor's network including provider contracting, network development, and/or provider relations functions. This resource will work with the Plan to develop, implement, and maintain custom provider reimbursement models or other provider initiatives as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iii. **Actuary** - Responsible for calculating financial impact of benefit and program changes, prospectively and retrospectively. Also responsible for calculating Return on Investment (ROI) in order to measure financial effectiveness of alternative care delivery models (tiered networks, centers of excellence, medical home models, etc.) as well as alternate payment models (Accountable Care Organizations, Clinically Integrated Networks, etc.). Will be required, upon request, to provide sufficient data and documentation to the Plan to independently verify calculations. The Actuary shall be a Fellow of the Society of Actuaries with a primary focus in Health Benefit Systems.

Confirm ☑ Does Not Confirm ☐

iv. **Privacy Officer** - Responsible for ensuring compliance with all applicable laws and regulations, including, but not limited to, HIPAA, Patient Protection and Affordable Care Act (PPACA), and the Employee Retirement Income Security Act of 1974 (ERISA). Responsible for maintaining internal controls to protect Protected Health Information (PHI) and ensuring that adequate and timely steps are taken in the event of a breach of confidentiality.

Confirm ☑ Does Not Confirm ☐

v. **Attorney** - Responsible for communicating program and policy updates to the Plan and coordinating as necessary with the Plan's internal counsel and staff. Responsible for promptly reviewing materials for Vendor and providing appropriate, legally justifiable, feedback to the Plan. This person must be well-versed in Chapter 135 of the North Carolina General Statutes and Chapter 58 of the North Carolina General Statutes, to the extent that North Carolina Department of Insurance (DOI) regulations apply to the Plan.

Confirm ☑ Does Not Confirm ☐

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

a. Vendor shall confirm each of the following:

i. Vendor will meet with the Plan within two (2) weeks of a new request or initiative and will bring to the table the resources with the appropriate subject matter expertise and authority to discuss the specific topic(s) requested by the Plan. Meeting topics could include, but would not be limited to, data requests, network and/or Product development, pilots, and other initiatives.

Confirm ☑ Does Not Confirm ☐

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.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will respond to Plan inquiries regarding legal, financial, or operational matters within 48 hours of the request, unless extended by the Plan. The response shall be received prior to 5:00 p.m. ET.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will respond to Plan inquiries regarding customer and provider matters within 24 hours of the request, unless extended by the Plan.

Confirm ☑ Does Not Confirm ☐

v. Vendor will work with the Plan and other Plan vendors as needed to resolve issues. This includes providing the specific Vendor resources and expertise needed to address the specific issue(s), not just the account management team; and multiple meetings per week prior to and after Go-Live before all services are normalized.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will keep the Plan informed of changing state and federal rules, mandates, or other requirements to ensure compliance.

Confirm ☑ Does Not Confirm ☐

vii. Upon request, Vendor will provide written documents outlining internal processes and procedures and, when requested by the Plan, agree to alter internal processes to meet the needs of the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

5.2.2 Finance and Banking

5.2.2.1 Overview and Expectations

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

5.2.2.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will comply with N.C.G.S. § 147-77 regarding the deposit of funds belonging to the Plan and confirm agreement that all receipts and other moneys belonging to the Plan that are collected or received by Vendor shall be deposited daily to the Plan's bank account(s) as designated by the State Treasurer and reported daily to the Plan.

ii. Vendor will comply with the Plan's requirements regarding the disbursement of funds on the Plan's behalf which are outlined by the Department of State Treasurer's website: https://www.nctreasurer.com/media/3791/open

iii. If Vendor will be disbursing funds from the Plan's bank accounts, Vendor must (1) print checks with the Plan's logo and digitized signature with guidance on the layout from the Department of State Treasurer based upon a standard format; and (2) prepare checks and EFTs for claims and other disbursements to be drawn directly from the Plan's bank account upon approval and release by the Plan. Vendor must be fully operational at least 30 days prior to January 1, 2025.

iv. Vendor will email weekly disbursement requests to the Plan by 9:30 a.m. ET on the first State Business Day of the week and hold disbursements until approved by the Plan.

v. Vendor will support the State of North Carolina's financial processing, banking, and reporting requirements which can be found at the following links or exhibits:

1) State banking: https://www.nctreasurer.com/media/3791/open
2) Cash management: https://www.osc.nc.gov/search?search_api_views_fulltext=cash%20management%20policy
3) Escheats: https://www.nccash.com/holder-information-and-reporting
4) High level daily deposits and disbursements of state funds workflows: Exhibit 1, "Deposits and Disbursement Process."

vi. Vendor will provide a SOC1, Type II, and if applicable, a bridge letter, upon request by the Plan.

b. Vendor shall additionally confirm each of the following:

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

iii. Vendor will complete bank reconciliation for all disbursing accounts, if applicable.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide electronic submission of deposit reports and disbursement funding as well as detailed backup documentation to support the transactions.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide historical check register detail and receipts as well as claims funding data.

Confirm ☑ Does Not Confirm ☐

viii. Vendor has internal quality control programs and audits that will ensure the accuracy of all financial reporting to the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will batch claims and other disbursements for payment via check or automatic clearing house (ACH) from the Plan's bank account on a weekly basis as determined by the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xii. Vendor will deposit checks received into the Plan's bank account within 24 hours of receipt to comply with the State's banking and cash management requirements.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide a daily reporting package of deposited receipts as required by the Plan (see Reporting Section 5.2.11).

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will provide a weekly reporting package of claims and other disbursement as required by the Plan (see Reporting Section 5.2.11).

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xix. Vendor will process ad hoc check requests, such as a settlement check to a Member, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.3 Network Management

5.2.3.1 Overview and Expectations

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

5.2.3.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor agrees the Plan is a government payor.

ii. Vendor will provide a network that will support Plan Members residing in all 100 counties in North Carolina and throughout the United States.

iii. Vendor will work with the Plan to develop and implement provider specific alternative payment arrangements.

iv. Vendor will develop a "narrow" network, at the regional or state level, of lower cost, high quality providers to be paired with a custom Plan Design, if requested by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

v. Vendor's current network includes bundled/episodic payment and clinically integrated network arrangements.

vi. Vendor will work with the Plan to expand, and if necessary, customize bundled/episodic payment arrangements.

vii. Vendor will work with the Plan to develop and administer a custom network for the Plan with a Medicare-based reimbursement methodology model that will include, at a minimum, different reimbursement rates for professional, inpatient, and outpatient services, upon request by the Plan.

viii. If the Plan implements a Medicare-based reimbursement model, Vendor will adjust any payment and/or medical policies required to better align with Medicare pricing guidelines.

ix. If the Plan implements a Medicare-based reimbursement model, Vendor will administer any other Medicare medical and payment policies adopted by the Plan.

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

xi. Upon request, Vendor will supplement the Plan's custom network with other providers contracted directly by Vendor for services such as reference labs, durable medical equipment, and other commodity services as well as to ensure access to care standards are met in North Carolina.

xii. Vendor will administer other reference-based pricing models, if requested by the Plan.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support transparency by allowing the Plan, at its request, to directly view any contracts associated with Vendor's network. This includes, but is not limited to, the terms of any risk sharing arrangements, incentives, pay-for-performance reimbursement, future contractual rate increases, and fee schedules. The Plan will take steps to protect Vendor's confidential data and proprietary information in accordance with applicable state and federal laws and regulations.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will provide services to Members who travel outside the United States and have an urgent medical need.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will customize "hidden providers" (e.g., an out-of-network anesthesiologist used at an in-network facility whose status is unknown to the Member receiving a procedure by an in-network surgeon) payment policies, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

v. Vendor will work with the Plan to ensure reimbursement rates for virtual visits with network providers are set appropriately.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide transition of care services to assist Members when their provider is no longer in the network.

Confirm ☑ Does Not Confirm ☐

vii. Vendor offers a "narrow" network in North Carolina that may be utilized by the Plan. This offering may be a full replacement or offered alongside other Plan Design options.

Confirm ☑ Does Not Confirm ☐

viii. Vendor has a network management team that will support the Plan on any custom or private label network solutions.

Confirm ☑ Does Not Confirm ☐

ix. Vendor has a provider credentialing team that could be utilized to credential potential network providers if the Plan were to develop a network solution that may include providers that are not currently enrolled in Vendor's other networks.

Confirm ☑ Does Not Confirm ☐

x. Vendor has the ability to communicate directly with providers and will communicate Plan specific information to providers, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xii. Vendor has experience with each of the following alternative models of care or clinically integrated systems and will work with the Plan to deploy Vendor's solution or develop a similar custom solution for the Plan. Vendor shall confirm it has experience with each alternative payment model listed below:

1) Patient-Centered Medical Homes.

Confirm ☑ Does Not Confirm ☐

2) Hospital At Home Programs.

Confirm ☑ Does Not Confirm ☐

3) Accountable Care Organizations.

Confirm ☑ Does Not Confirm ☐

4) Community Care Organizations.

Confirm ☑ Does Not Confirm ☐

5) Integrated Delivery Networks.

Confirm ☑ Does Not Confirm ☐

6) Shared Risk/Savings.

Confirm ☑ Does Not Confirm ☐

7) Pay-for-Performance.

Confirm ☑ Does Not Confirm ☐

8) Global Payment/Capitation.

Confirm ☑ Does Not Confirm ☐

9) Primary Care Incentives.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will support the integration and ongoing operations of any of the aforementioned alternative payment models or clinically integrated systems that may be designed and managed by other Plan vendors.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xvi. If the Plan deploys a custom network or reimbursement models, Vendor's provider portal will allow Providers to submit claims, access policies, receive announcements, and perform other functions necessary for proper participation in the Plan's custom network.

Confirm ☑ Does Not Confirm ☐

xvii. If the Plan deploys a custom network, Vendor will administer Plan specific provider contract documents which may include, but is not limited to, network participation agreements (NPA), reimbursement exhibits, pricing policies, fee schedules, and pricing development and maintenance policies.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor acknowledges any NPA developed to support a custom network for the Plan is not subject to review by DOI since the Plan is self-funded and not subject to DOI regulations except for those specifically noted in Chapters 58 and 135 of the North Carolina General Statutes.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will develop, maintain, and administer medical and payment policies with input as desired by the Plan to support any custom alternative payment models or networks implemented for the Plan.

Confirm ☑ Does Not Confirm ☐

xx. Vendor will provide a dedicated provider call center, with a Plan specific phone number and greeting if the Plan implements a full, custom provider network.

Confirm ☑ Does Not Confirm ☐

5.2.4 Product and Plan Design Management

5.2.4.1 Overview and Expectations

The Plan seeks a Vendor that offers innovation in both Product and Plan Designs. Vendor should have an efficient business rules-based claims system that can not only support state, federal, and other custom benefits but also accommodate unique medical and claims processing policies. Vendor should be nimble in its approach to piloting new programs and demonstrate "speed to market" when rolling out new Products, Plan Designs, and benefit features to meet the challenges facing state government health plans.

5.2.4.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will administer the covered benefits and exclusions as outlined in the Enhanced PPO Plan (80/20), Base PPO Plan (70/30) and HDHP benefit booklets. The Plan understands that utilization and Medical Management programs as well as out-of-network processes may vary from the Plan's current programs.

1) Enhanced PPO Plan (80/20): https://www.shpnc.org/media/2583/download?attachment
2) Base PPO Plan (70/30): https://www.shpnc.org/media/2582/download?attachment
3) HDHP: https://www.shpnc.org/media/2584/open

ii. Vendor will administer a tiered copay program that will reduce a copay when the Member visits the PCP listed on his or her ID card or another PCP in the same practice, regardless of practice location. See grid in Exhibit 2, "PCP Copay Incentive Scenarios," for more detailed information about the current program.

iii. Vendor will customize its current value-based and incentive Plan Design features and/or implement new, customized ones, if requested by the Plan.

iv. Vendor will integrate real-time or near real-time deductible and/or OOP accumulators with the Plan's PBM to support a combined Medical/Rx deductible and OOP maximums.

v. Vendor will administer all benefits as required by Article 3B of Chapter 135 and, to the extent applicable, Chapter 58 of the North Carolina General Statutes and as may be amended from time to time.

vi. Vendor will administer benefits in accordance with all Federal and State requirements and notify the Plan of new mandates, or other requirements, that will require benefit changes to maintain compliance.

vii. Vendor will partner with the Plan to design custom benefits and/or Plan Design features, as requested by the Plan and provide associated financial/actuarial impact analysis.

b. Vendor shall additionally confirm each of the following:

i. Vendor's systems will support each of the following Plan Design features. Vendor shall confirm each Plan design feature below:

1) Applying a copay and a deductible to the same service.

Confirm ☑ Does Not Confirm ☐

2) Applying a copay based on the providers network tier.

Confirm ☑ Does Not Confirm ☐

3) Waiving the emergency room copay when the Member is admitted for an inpatient stay and/or an observation stay.

Confirm ☑ Does Not Confirm ☐

4) Applying a different cost-sharing arrangement (deductible, copay, coinsurance, etc.) for each of the following:
a) PCP.

Confirm ☑ Does Not Confirm ☐

b) Specialist.

Confirm ☑ Does Not Confirm ☐

c) Urgent Care.

Confirm ☑ Does Not Confirm ☐

d) Emergency Room (ER).

Confirm ☑ Does Not Confirm ☐

e) Physical Therapy.

Confirm ☑ Does Not Confirm ☐

f) Occupational Therapy.

Confirm ☑ Does Not Confirm ☐

g) Speech and Hearing Therapy.

Confirm ☑ Does Not Confirm ☐

h) Outpatient Behavioral Health.

Confirm ☑ Does Not Confirm ☐

i) Per Inpatient Confinement.

Confirm ☑ Does Not Confirm ☐

5) Setting benefit limits by age.

Confirm ☑ Does Not Confirm ☐

6) Setting benefit limits by frequency of service.

Confirm ☑ Does Not Confirm ☐

7) Setting benefit limits by confinement.

Confirm ☑ Does Not Confirm ☐

8) Cross-accumulate out-of-network OOP with in-network OOP, but not the in-network OOP to the out-of-network OOP.

Confirm ☑ Does Not Confirm ☐

ii. Upon request, Vendor will customize and support medical policies according to Plan needs and requirements.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will, upon request, administer a four-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, an out-of-area (OOA) benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, a Tier 2 network benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

v. Vendor will, upon request, administer a three-level PPO benefit with a Tier 1 network benefit, an OOA benefit, and a non-network benefit.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will administer member cost-sharing (co-pay, deductible, coinsurance) for a specific service based on place of service.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will implement incentive programs where Plan Members are given gift cards, or other incentives, for seeing certain providers and/or completing certain tasks.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will, upon request, integrate with other Plan vendors or Partners to deliver value-based and/or incentive benefits.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will, upon request, implement a Health Reimbursement Account (HRA) for Plan Members with each of the following features. Vendor shall confirm each HRA feature below:

1) HRA annual balances based on the number of family Members enrolled.

Example:

Subscriber only = $600 starting balance.

Subscriber + one (1) Dependent = $1200 starting balance.

Subscriber + two (2) or more Dependents = $1800 starting balance.

Confirm ☑ Does Not Confirm ☐

2) Virtual funding that meets all the banking and financial reporting requirements that are outlined in Section 5.2.2.

Confirm ☑ Does Not Confirm ☐

3) HRA account reconciliation services to support the Plan's banking and financial reporting requirements.

Confirm ☑ Does Not Confirm ☐

4) Proration that reduces the starting HRA amount for Members who enroll after the beginning of the Benefit Year.

Confirm ☑ Does Not Confirm ☐

5) Ability to add funds to Members' HRA accounts throughout the year based on incentives earned through programs offered by Vendor and by other Plan vendors.

Confirm ☑ Does Not Confirm ☐

6) Automatic claims reimbursement functionality from the HRA.

Confirm ☑ Does Not Confirm ☐

7) Ability to integrate with the Plan's PBM so that pharmacy claims can be processed by the Members' HRA.

Confirm ☑ Does Not Confirm ☐

8) Annual HRA rollover functionality.

Confirm ☑ Does Not Confirm ☐

9) Ability to customize the HRA Member portal, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

10) Ability to customize the HRA Member materials, including system generated letters, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

11) HRA Administrative Portal that can be accessed by the Plan to run ad hoc reports and review Member level data.

Confirm ☑ Does Not Confirm ☐

12) HRA Debit Card.

Confirm ☑ Does Not Confirm ☐

13) Ability to integrate with Plan's Vendor(s) to receive Member level information via ongoing EDI files to apply virtual HRA incentive funds to Member HRA accounts.

Confirm ☑ Does Not Confirm ☐

14) Ability to provide an HRA on a copay-based plan like the Enhanced PPO Plan (80/20).

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

x. Vendor offers Health Savings Account (HSA) administration and/or will integrate with an HSA administrator preferred by the Plan.

Confirm ☑ Does Not Confirm ☐

xi. Upon request, Vendor will administer a self-funded Group Medicare Supplement Plan.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will work with the Plan to implement benefits that may not be finalized and/or approved until close to the effective date. While it is the Plan's preference to have all benefits approved by the Board more than six (6) months in advance, there are dependencies, such as final budget approval by the North Carolina General Assembly or simply reaching final Board consensus that may impact the timing of final benefit approval.

Confirm ☑ Does Not Confirm ☐

5.2.5 Medical Management Programs

5.2.5.1 Overview and Expectations

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

5.2.5.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

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

iii. Vendor will customize any of the Medical Management programs, if requested by the Plan.

b. Vendor shall additionally confirm each of the following:

i. Vendor will customize any medical policy, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will provide comprehensive, holistic, evidence-based medical policies and Medical Management of Members' physical and behavioral health, including substance misuses, which focus on quality, positive Member outcomes, and cost efficiencies.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will partner with the Plan on Medical Management initiatives and provide relevant clinical and financial outcome data to support project implementation and evaluation, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will keep the Plan apprised of disease trends within the population and provide reporting that summarizes overall Plan health.

Confirm ☑ Does Not Confirm ☐

v. Vendor will appropriately identify and engage Members in each of the following types of programs:

1) Transition of Care (TOC) programs;

Confirm ☑ Does Not Confirm ☐

2) High utilizer outreach and management programs; and,

Confirm ☑ Does Not Confirm ☐

3) Complex case management programs.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide "Hospital at Home" and/or other programs to promote transition from inpatient-hospital to home setting when appropriate.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will offer wellness and prevention programs to support Plan Members.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will integrate with other Plan vendors and/or Partners to deliver a care management program for Plan Members, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will work with the Plan to define all new care management, or other programs, in Business Requirement Documents which will be approved by the Plan, Vendor, and any other Plan vendors or Plan Partners involved in the program administration.

Confirm ☑ Does Not Confirm ☐

x. Vendor will provide disease management Health Coaching Services.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will transition specific specialty pharmacy medication coverage to the Plan's PBM, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide claims and analytical data to support the transition of specific specialty medications to the Plan's PBM.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide specific claims data or other clinical data, as requested by the Plan to support benefits that may be administered by the Plan's PBM.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will integrate data from the Plan's PBM or other Plan vendors to administer benefits on Vendor's platform. Any such plan design will be implemented after Business Requirements and an Implementation Plan are completed and if required, an amendment is executed.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will meet with the Plan and the Plan's PBM to coordinate medical and pharmacy management programs.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will perform warm transfers to Plan vendors and/or Plan Partners who provide specific services and/or supports for Plan Members.

Confirm ☑ Does Not Confirm ☐

5.2.6 Enrollment, EDI, and Data Management

5.2.6.1 Overview and Expectations

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

5.2.6.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

ii. Vendor will support the addition of new Groups throughout the year and assist with any Group name changes or reporting requirements, as needed.

iii. Vendor will have the capability to accept and at least 500,000 transactions in a single file transmission.

iv. Vendor will have the capability to extract and send up to 500,000 transactions to Plan vendors in a single file.

v. Vendor will accept and load a daily industry standard and/or custom data files from the Plan's EES vendor. The data file will be received between 5:00 – 9:00 p.m. ET each night and must be processed and loaded by Vendor by 8:00 a.m. ET the following State Business Day.

vi. Vendor will produce recurring outbound data files for Plan vendors, the Plan and/or Plan Partners. For inbound and outbound data flows, see Exhibit 4, "Vendor Data Feeds."

vii. Vendor's daily outbound data file to the Plan's EES vendor must be sent by 12:00 p.m. ET on the first day after the daily data file from the Plan's EES vendor is received.

viii. Vendor will support the receipt of monthly Audit Files from the Plan's EES vendor and work with the Plan and the EES vendor to review and correct discrepancies. Refer to Exhibit 5 "Monthly Audit & Reconciliation" for Vendor audit process.

ix. Vendor will agree to other enrollment audits, as requested by the Plan, to address specific issues.

x. Vendor will enroll and accurately process claims for both Medicare primary and Non-Medicare primary Members within the same Group and Plan Design.

Example: Employing Unit – Department of State Treasurer

Enhanced PPO Plan (80/20) includes:

- Non-Medicare primary Members
- Medicare primary Members

Base PPO Plan (70/30) includes:

- Non-Medicare primary Members
- Medicare primary Members

xi. Vendor will serve as the Plan's RRE under Section 111 of MMSEA Expanded Reporting Option.

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

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

xiv. Vendor will store and utilize the MBI, in addition to other Member identification numbers, such as SSN.

xv. Vendor will maintain Medicare Eligibility effective and termination dates as well as Medicare Part A and Part B effective and termination dates.

xvi. Vendor will maintain Medicare primacy effective and termination dates.

xvii. Vendor will maintain multiple Medicare entitlement reasons.

xviii. Vendor will collect, store, and utilize other commercial insurance information to coordinate benefits for Plan Members. The EES Vendor will only collect Medicare information. All other commercial insurance information will be managed by the TPA.

xix. Vendor will enroll split-contracts where the family Members are split between Vendor and another carrier (i.e., Medicare primary Subscriber enrolled in a Medicare Advantage plan with another carrier and non-Medicare primary Dependents are enrolled on a Plan provided by Vendor).

xx. Vendor will support enrollments where one or more family Members are enrolled in one Plan Design as Medicare primary and other family Member(s) are enrolled in another Plan Design as Non-Medicare primary, or vice versa.

xxi. Vendor will provide a PCP selection tool that can be integrated with the Plan's EES vendor's enrollment portal to facilitate the Members' PCP elections. See Exhibit 6, "PCP Selection Tool and Maintenance," for PCP selection overview.

xxii. Vendor will routinely perform provider maintenance of PCP data to ensure that the PCP selection tool contains the most current PCP data and that only valid PCPs may be elected. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP maintenance requirements.

xxiii. Vendor will implement workflows that support the maintenance of the PCPs which may require that Vendor notify Members if their elected PCP is no longer in network and notify the EES vendor, via the daily return file to the EES vendor, if any PCP code information, including provider termination, has occurred. The Member communication should include instructions for electing a

new PCP. The final workflows will be defined during Contract implementation. See Exhibit 6, "PCP Selection Tool and Maintenance" for high level overview of PCP synchronization requirements.

xxiv. Vendor will customize ID cards with all data elements requested by the Plan, including, but not limited to, each of the following: (See Exhibit 7, "Sample ID Cards," for examples of the Plan's current ID card.)

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

xxv. Vendor will meet all Plan, Federal, and State mandated Plan enrollment communication and/or reporting requirements such as, but not limited to, the production of CCC and reporting needs under sections 6055 and 6056 of the IRS code.

xxvi. Vendor will provide a custom claims data files to the Plan on a monthly basis, or more frequently, if requested by the Plan. The file requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.

xxvii. Vendor will provide a custom provider data file(s) to the Plan on a bi-weekly basis. The file(s) requirements will be documented in a BRD during implementation and may be updated from time to time throughout the lifetime of the Contract, as requested by the Plan.

xxviii. Vendor will provide other, ad hoc data files, as requested by the Plan. The specifics of the data file requests will be outlined in an ADM and/or BRD.

xxix. Vendor will implement a process with the Plan to respond to DQ issues with any files provided to the Plan. The specifics of the DQ checks will be developed during implementation and may be amended throughout the lifetime of the Contract, as requested by the Plan.

xxx. Vendor will release data to the Plan as described in state and federal law.

xxxi. Vendor will not place limitations on the Plan's use of data that are more restrictive than described in state and federal law.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support Plan eligibility as defined by North Carolina General Statutes Chapter 135, Article 3B, Part 4.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will accept industry standard and/or custom data files from Plan vendors and/or Plan Partners, as requested by the Plan, which includes but is not limited to:

1) ASC X12 EDI transaction sets.

2) XML files.

3) Flat/ Fixed Files.

4) APIs.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

v. Vendor will process "change" records as either terminated or added records.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will load and process "terminated" and "add" transactions for the same Members within the same day.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will exchange the enrollment and eligibility data using secure protocols.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide a copy of outbound files delivered to other Plan vendors to the Plan via SFTP or SharePoint based on instructions from the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

x. Vendor will configure thresholds to reject an entire file based on how many records successfully passed business edits. Thresholds will be determined during implementation.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will have a Load-Rate of at least 98% on accurate transactions received via EDI from the Plan's EES vendor.

Confirm ☑ Does Not Confirm ☐

xii. In addition to accepting and processing daily enrollment data file from the Plan's EES vendor, Vendor will manually load any data that cannot be processed automatically within three (3) State Business Days.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will process enrollment updates manually for Members requiring immediate enrollment and benefits. The request to load manually may come from the Plan or the Plan's EES vendor.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will notify the Plan immediately when any event or condition is discovered that adversely affects Members.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will accept and store multiple Member ID numbers from the Plan's EES vendor such as a unique member ID created by the EES vendor and MBI and/or the Member SSN.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will use the unique Member ID number provided by the EES vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the EES vendor will be the sole Member ID on the ID Card.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor will send the unique Member ID number provided by the EES vendor to other Plan vendors.

Confirm ☑ Does Not Confirm ☐

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

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xxxvii. Upon notification by the Plan's COBRA Administration and Billing (CABS) vendor, Vendor will hold claims for individual Groups that have not paid their premium bill.

Confirm ☑ Does Not Confirm ☐

xxxviii. Vendor will confirm that the monthly, custom claims data file that will be provided to the Plan can be sent as a Full File or Change File. The specific requirements will be developed during the implementation.

Confirm ☑ Does Not Confirm ☐

xxxix. Vendor will confirm that it will provide reference tables and data dictionaries, with thorough field descriptions, to support the monthly, custom claims data files and that the reference tables and data dictionaries will be updated as needed and sent to the Plan within three (3) State Business Days of any change.

Confirm ☑ Does Not Confirm ☐

xxxx. Vendor will conduct a Medicare repricing exercise to benchmark Vendor's network rates against Medicare reimbursement rates. The details of the repricing exercise shall be formalized in an ADM and memorialized via an Amendment to the Contract, as needed.

Confirm ☑ Does Not Confirm ☐

5.2.7 Customer Experience

5.2.7.1 Overview and Expectations

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

5.2.7.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will provide a dedicated customer call center with hours of operation from at least 8:00 a.m. to 5:00 p.m. ET, each State Business Day, to respond to Member inquiries.

ii. Vendor will have a dedicated toll-free number for Plan Members.

iii. Vendor will answer the phones with a greeting that identifies the call center as a representative for the Plan.

iv. Vendor will customize its IVR script with a Plan-specific greeting and prompts, and transfers to other Plan vendors.

v. Vendor will make and receive warm and cold transfers to/from other Plan vendors who may be required to resolve the Members' issues.

vi. Vendor will record and track all Member calls including date of initial call, inquiry closed, representative who handled the call, call status, if and where the call was referred for handling, reason for call (issue), and what was communicated to the Member.

vii. Vendor will allow the Plan to include customized inserts or messaging in ID Cards and EOB mailings as well as offer customization of the EOB and ID Cards as directed by the Plan. Refer to Exhibit 7, "Sample ID Cards" and Exhibit 8, "Sample EOB."

viii. Vendor will customize the content of any and all letters or other materials Vendor will send and/or display to Members.

ix. Vendor will co-brand letters or other materials Vendor sends to Members.

x. Vendor will customize the portal with the Plan's branding (logo).

xi. Vendor will provide an employer portal to be utilized by Plan staff to view real-time individual Member enrollment and claim information.

b. Vendor shall additionally confirm each of the following:

i. Vendor will receive emails from Plan Members and respond to their inquiries.

Confirm ☑ Does Not Confirm ☐

ii. Upon request, Vendor will provide expanded hours of operation during the OE period at no additional cost to the Plan. The Plan's enrollment and eligibility call center is generally open on Saturdays during OE.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will provide non-English speaking services for callers who may need assistance in other languages.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will offer Telecommunications Device for Deaf (TTY) services for Plan Members who need them.

Confirm ☑ Does Not Confirm ☐

v. Vendor will provide copies of recorded calls to the Plan within two (2) State Business Days of the request.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide detailed copies of all call notes to the Plan within two (2) State Business Days of the request.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide copies of call notes to Members upon request.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide reports, based on call reason type, to the Plan upon request.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide an escalation team to respond and resolve inquiries from the Plan.

Confirm ☑ Does Not Confirm ☐

x. When appropriate, Vendor will mail apology letters to Plan Members who have been impacted by a Vendor error.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will provide a secure Member web portal that is available 24/7, excluding periodic scheduled maintenance.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will support single sign-on to and from the Plan's PBM customer portal, the Plan's EES vendor and other Plan vendor sites, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will customize the materials available to Plan Members via the secure Member portal.

Confirm ☑ Does Not Confirm ☐

xiv. In addition to displaying the Plan's branding, Vendor will display the name of the Member's Employing Unit (e.g., Department of State Treasurer, Retirement System, Wake County Schools, etc.) once the Member has logged into the secure member site.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will, upon request, segregate and provide secure Member portal access to a Dependent, or a Dependent's designee, in a court-ordered scenario such as a Medical Support Notice.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor's secure member portal will capture Plan Members' preferences for communication.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor's secure portal will allow a Plan Member to print a temporary ID card that include the Plan's PBM information and custom ID card elements.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor's mobile application and secure portal will allow Members to order a new ID card.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will provide a mobile application that includes a virtual ID card for Members who prefer to use mobile technology.

Confirm ☑ Does Not Confirm ☐

xx. Vendor's portal will provide health/condition-specific resources to Members, such as educational videos, recipes, digital coaching modules, webinars, links to Plan approved/promoted websites, evidenced-based articles, and tools for self-management.

Confirm ☑ Does Not Confirm ☐

xxi. Vendor's member portal will provide and moderate online forums and live chat groups.

Confirm ☑ Does Not Confirm ☐

xxii. Vendor's member portal will receive and display timely data from various providers such as, but not limited to, lab results from large independent labs, prescriptions from pharmacies, and other data from physicians' offices. This information could be used by Plan Members to gather information necessary to complete annual Health Assessment or validate Member actions to earn incentives.

Confirm ☑ Does Not Confirm ☐

xxiii. Vendor's member portal will allow Members to:

1) View claims and claim payment status.

Confirm ☑ Does Not Confirm ☐

2) View and print EOBs.

Confirm ☑ Does Not Confirm ☐

3) View deductible and OOP accumulations.

Confirm ☑ Does Not Confirm ☐

4) Single-Sign-On (SSO) to the HSA vendor, if applicable.

Confirm ☑ Does Not Confirm ☐

5) View HRA claims, if applicable.

Confirm ☑ Does Not Confirm ☐

6) View HRA Balances, if applicable, including, but not limited to:

a) Initial HRA Funding.

b) Rollover Funds.

c) Incentive Funds.

Confirm ☑ Does Not Confirm ☐

7) Order new HRA or HSA debit cards, if applicable.

Confirm ☑ Does Not Confirm ☐

8) Track incentive programs and benefit designs (e.g., cash rewards, health reimbursement account contributions) and administer the reward for participation, as defined by the Plan.

Confirm ☑ Does Not Confirm ☐

9) Complete a Health Assessment that could be customized by the Plan.

Confirm ☑ Does Not Confirm ☐

xxiv. Vendor's member portal will accept and display Member-specific information from the other systems and Vendor's health team, including each of the following. Vendor shall confirm each below:

1) Electronic medical and health records.

Confirm ☑ Does Not Confirm ☐

2) Disease Management Nurse notes.

Confirm ☑ Does Not Confirm ☐

3) Case Management notes.

Confirm ☑ Does Not Confirm ☐

4) Health Coach notes.

Confirm ☑ Does Not Confirm ☐

5) Vendor analytical system alerts, such as gaps in care.

Confirm ☑ Does Not Confirm ☐

6) Progress towards Incentives earned, if applicable.

Confirm ☑ Does Not Confirm ☐

xxv. Vendor will provide the following services whether the Member is logged into the secure member portal or accessing Vendor's external site:

1) Search for providers by specialty.

Confirm ☑ Does Not Confirm ☐

2) Search for procedure/service cost.

Confirm ☑ Does Not Confirm ☐

xxvi. Vendor will participate in routine joint Plan vendor and Partner calls to discuss Plan initiative, upcoming Plan mailers and/or events, and develop and implement process improvements between the Plan vendors and Partners.

Confirm ☑ Does Not Confirm ☐

xxvii. Vendor, if instructed by the Plan, will conduct an annual Member Satisfaction Survey for all Plan Members, including Members who are not enrolled in plans administered by Vendor. The Plan will be responsible for communicating the survey to Plan Members and may provide a link to the survey on the Plan's website. Vendor will be responsible for developing the custom survey, as directed by the Plan, hosting the survey, and providing a summary of results.

Confirm ☑ Does Not Confirm ☐

xxviii. Vendor will conduct other surveys, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxix. Vendor will attend Plan-hosted OE events to educate members on Plan options. The Plan representatives are generally on the road across the State or hosting online webinars during most of September and October promoting OE. Representatives from the TPA and Medicare Advantage carriers generally attend and may provide presentations to Members, primarily retirees.

Confirm ☑ Does Not Confirm ☐

xxx. Vendor will assist with web-based training or meetings hosted by the Plan to educate Members and/or HBRs on Plan benefits.

Confirm ☑ Does Not Confirm ☐

xxxi. Vendor will attend Wellness Fairs and other promotional events around the State, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxii. Upon request, Vendor will provide resources to conduct biometric screenings at wellness events. If requested, Vendor shall have the ability to send the biometric results to the Members' PCPs.

Confirm ☑ Does Not Confirm ☐

xxxiii. Vendor will provide language interpreters, including sign language, at events as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxxiv. Vendor will, upon request, provide Marketing and Communication resources to the Plan to develop materials.

Confirm ☑ Does Not Confirm ☐

xxxv. Vendor will assist with the Plan's benefit booklet review and/or provide guidance regarding the Plan's benefit booklets which includes individual books for each plan offered.

Confirm ☑ Does Not Confirm ☐

xxxvi. Vendor will develop and implement new letters and/or communication materials for Members and/or Providers to support any programs implemented for the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

xxxviii. Vendor will suppress specific Member communications, upon request from the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.8 Claims Processing and Appeals Management

5.2.8.1 Overview and Expectations

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

5.2.8.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina's Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.

ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.

iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan's PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.

iv. Vendor will customize any appeals letters, as requested by the Plan.

v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance's Smart NC Program.

vi. Vendor will support the Plan's methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, "Claims Processing Phantom Plan – Medicare Part B."

vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor's action, inaction, or system failure.

viii. Vendor will customize EOBs with the Plan's logo and if applicable, custom network and other information as illustrated in Exhibit 8, "Sample EOB."

b. Vendor shall additionally confirm each of the following:

i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).

Confirm ☑ Does Not Confirm ☐

iv. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add edits at the Plan's request.

Confirm ☑ Does Not Confirm ☐

v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.

Confirm ☑ Does Not Confirm ☐

vi. 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.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will coordinate benefits with other commercial payors.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will support all future state and federal requirements at no additional cost to the Plan.

Confirm ☑ Does Not Confirm ☐

x. Vendor will produce EOBs that meet all Federal requirements.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will prevent Subscribers from having access to the Dependents EOBs when the Subscriber does not have custodial rights.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will mail EOBs directly to Dependents 18 years of age or older without a copy to the Subscriber.

Confirm ☑ Does Not Confirm ☐

xiii. Vendors will mail a Dependent's EOB to a different address if a different address exists in the Dependent's demographic record.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will provide a single, combined Medical and HRA EOB, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

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

Confirm ☑ Does Not Confirm ☐

5.2.9 Claims Audit, Recovery, and Investigation

5.2.9.1 Overview and Expectations

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

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

5.2.9.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

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

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

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

ii. Vendor will, in addition to supporting ongoing quarterly claims accuracy audits, support Focus Audits, such as, but not limited to, COB audits, duplicate claims audits, eligibility audits, and comprehensive electronic Audits conducted by the Plan's auditor vendor on an as needed basis. All the rules outlined in Section 5.2.9.2.a.i above will apply to these audits.

iii. Vendor's recovery processes will follow all deposit and financial reporting requirements outlined in Section 5.2.2, Finance and Banking.

iv. Vendor will recover any overpayments to Providers by offsetting future payments or by demand without any limitation as to time since the Plan as a government payor is not subject to the two-year limitation established in N.C.G.S. § 58-3-225(h).

v. Vendor will support the Plan's participation in the North Carolina Debt Setoff Program (North Carolina General Statutes Chapter 105A, Article 1), the Retirement/Disability Offset Program (N.C.G.S. §§ 135-9(b), 128-31, 120-4.29), Wage Garnishment (N.C.G.S. § 135-48.37A), and Credit Card Intercepts (N.C.G.S. § 1-359) and implement an accounts receivable collection process as outlined under the North Carolina Office of State Controller, Statewide Accounts Receivable Program. Refer to Exhibit 10, "State Health Plan Recovery Workflows."

vi. Vendor will ensure the Plan's compliance with all federal and state regulations not otherwise stated previously (i.e., prompt pay, mental health parity, disclosures, reporting, etc.).

vii. Vendor has an investigation or similar unit to investigate possible fraud and abuse and will share details about specific investigations that impact the Plan, including the names of the providers involved.

b. Vendor shall additionally confirm each of the following:

i. Vendor will support any other audit requested by the NC OSA.

Confirm ☑ Does Not Confirm ☐

ii. Vendor will support multiple audits simultaneously. Although the Plan will work with Vendor to manage the scope, duration, number, and timing of audits whenever possible, audits may occur simultaneously and for extended periods of time.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will provide the Plan's Auditors access to all necessary data, systems, and any other materials needed to successfully perform the audits including remote, view only access to view the claims adjudication system used by Vendor to process the Plan's claims.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will provide on-site office space at Vendor's facilities that are actually processing Plan claims, including system access for the Plan's Auditors, the Plan, or the NC OSA.

Confirm ☑ Does Not Confirm ☐

v. Vendor will customize any standard audit reports to meet the Plan's specific audit needs.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will provide claims files to the Plan's Auditors on a monthly basis.

Confirm ☑ Does Not Confirm ☐

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.

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide a corrective action plan for the Plan's review, approval, and monitoring within 30 days of the final report, or another timeframe as specified by the Plan.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide full impact reports, and review and recover out-of-sample claims for any audit findings that reveal systemic or easily repeatable issues. These out-of-sample claim recoveries will not impact performance guarantee measures.

Confirm ☑ Does Not Confirm ☐

x. Vendor will not enter into a settlement on the Plan's behalf with a Provider, a Member, or anyone else, without first obtaining the Plan's approval.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will support the Plan's third-party liability vendor, or any other recovery vendor the Plan may work with, by providing data, adjusting claims, and posting payments.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide Plan specific recovery reports on a monthly basis that include both summary and detail information outlining the programs' results.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will customize any recovery or investigation reports, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will implement debt collections processes with a collection agency approved by the NC AGO. The list of approved collections agencies may change during the life of the Contract, as required by the NC AGO.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will adjust Member claims based on recoveries received on behalf of the Plan, including, but not limited to, those from the collection agency, Plan vendors, or Members within 30 days of notification. Plan vendors or State Collections Agencies that seek recoveries on behalf of the Plan, must work with Vendor to ensure the claims are appropriately adjusted and recoveries are deposited in the Plan's depository accounts.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will, upon request from a Member covered through an Employing Unit, the Direct Bill Group, the Sponsored Dependent Group, or the COBRA Group, establish a payment plan; however, payment plans shall not exceed 12 months without the Plan's prior approval.

Confirm ☑ Does Not Confirm ☐

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.

Confirm ☑ Does Not Confirm ☐

xviii. Vendor will consider any Member or former Member to be in default who misses one (1) payment. If any Member or former Member sends in a partial payment, Member or former Member must be caught up in one (1) month or Member or former Member will be considered to be in default.

Confirm ☑ Does Not Confirm ☐

xix. Vendor will allow the Plan to perform onsite reviews and validations of Vendor's internal processes.

Confirm ☑ Does Not Confirm ☐

xx. Vendor will provide workflows, data, and other materials to review Vendor's processes within 30 days of request.

Confirm ☑ Does Not Confirm ☐

xxi. Vendor will work with the Plan to develop process improvement plans.

Confirm ☑ Does Not Confirm ☐

xxii. Vendor will provide monthly recovery reports and will customize those reports, if requested by the Plan.

Confirm ☑ Does Not Confirm ☐

xxiii. Vendor will track and report actual cost savings dollars against targets, and if available, benchmarks.

Confirm ☑ Does Not Confirm ☐

xxiv. Vendor will not charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.

Confirm ☑ Does Not Confirm ☐

xxv. Vendor will provide Plan specific investigation reports on a monthly basis and customize these reports, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

5.2.10 Initial Implementation and Ongoing Testing

5.2.10.1 Overview and Expectations

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

5.2.10.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

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

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

Other workstreams will kick-off throughout 2023.

ii. Vendor will have the depository bank account(s) setup and tested at least 45 days prior to January 1, 2025.

iii. If applicable, Vendor will have the disbursement account(s) setup and tested at least 30 days prior to January 1, 2025.

iv. Vendor will have all services, including custom programs, operational by January 1, 2025.

v. Vendor will work with the Plan to document in an ADM all custom processes developed to meet the Plan's unique requirements. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.

vi. Vendor will work with the Plan to finalize Vendor Audit Schedule for 2025 and subsequent years. The Audit Schedule will be updated via ADM. The Plan's Contract Administrator for day-to-day activities is authorized to sign ADMs for the Plan.

vii. For all technical components of the initial implementation as well as any implementations throughout the lifetime of the Contract, Vendor will develop functional requirements documents, Implementation Plans, Test Plans, Deployment Plans, and Close-Out Documentation derived from the Plan's Business Requirements. These documents must be mutually agreed upon by Vendor, the Plan, and any impacted Plan vendor. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.

viii. Vendor will support both Unit Testing and End-to-End Testing prior to Go-Live of any initiative. To support testing, Vendor must not only have the resources, but also the test environments, necessary to support multiple work streams at one time. As mentioned above, the Test Plan will be mutually agreed upon by Vendor, the Plan, and impacted Plan vendors. The Plan's Contract Administrator for day-to-day activities is authorized to sign these documents for the Plan.

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

b. Vendor shall additionally confirm each of the following:

i. Vendor will ensure there are no data latency issues that would delay initiating any audits with the Plan's Auditors after the first quarter, or any subsequent quarter, of operation.

Confirm ☑ Does Not Confirm ☐

ii. If during the implementation, a decision is made that Members will need welcome kits, Vendor will ensure that those kits are mailed prior to January 1, 2025.

Confirm ☑ Does Not Confirm ☐

iii. If requested by the Plan, Vendor will support a readiness review and/or implementation audit at least 60 days prior to January 1, 2025. Vendor shall participate in all readiness review and/or implementation audit activities conducted by the Plan or by Plan vendors to ensure Vendor's operational readiness.

Confirm ☑ Does Not Confirm ☐

5.2.11 Reporting

5.2.11.1 Overview and Expectations

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

5.2.11.2 Services

a. Vendor confirmed the following Minimum Requirement:

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

b. Vendor shall additionally confirm each of the following. Note: Final individual report or reporting package format and content will be finalized during implementation and may be updated throughout the lifetime of the Contract via ADM:

i. Vendor will provide standard and ad hoc reports in any of the following formats, as requested by the Plan:

1) Excel.
2) PDF.
3) Text.
4) XML.
5) HTML.
6) CSV (raw format).

Confirm ☑ Does Not Confirm ☐

ii. Vendor will customize any report, as requested by the Plan.

Confirm ☑ Does Not Confirm ☐

iii. Vendor will combine claims and financial data in reporting.

Confirm ☑ Does Not Confirm ☐

iv. Vendor will email all standard reports, to the email addresses provided by the Plan. If PHI is included, the reports shall be sent via secure email.

Confirm ☑ Does Not Confirm ☐

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.

Confirm ☑ Does Not Confirm ☐

vi. Vendor will include Book of Business and other internal and/or external benchmarks in reports, when requested by the Plan.

Confirm ☑ Does Not Confirm ☐

vii. Vendor will provide other enterprise-level, executive reports as well as departmental and ad-hoc reporting, as requested by the Plan. Stratifications may include:

1) Demographics.
   a) Gender.
   b) Age.
   c) Race.
2) Employing unit, work location.
3) Geography.
   a) Zip Code.
   b) County.
   c) Hospital Service Area.
   d) Healthcare Referral Region (HRR).
   e) Out-Of-State.
4) Subscriber versus Member.
5) Active and Retiree (Pre and Post-65).
6) Plan Type.
7) Time period.
   a) Calendar Year (CY).
   b) Year-to-Date (YTD).
   c) Month-to-Month.
   d) Fiscal Year.
   e) Quarterly.
   f) Ad-hoc.
8) Paid, incurred, capitated claims.
9) Provider Level.

a) By NPI, DEA #, In/Out-of-Network, Vendor's unique provider number.

b) PCP, Specialist, Hospital.

10) Network.

a) In/Out-of-Network.

b) Quality Outcomes.

11) Utilization Trends.

a) High Cost Claimants.

b) High Volume Claims Utilizers.

12) Disease Categories via ICD-10, DRG, MDC, or ad hoc criteria.

a) Chronic conditions.

b) Acute conditions.

c) Catastrophic (cost-driving outliers).

Confirm ☑ Does Not Confirm ☐

viii. Vendor will provide each of the following enrollment reports or reporting packages. The method for providing the report will be determined during implementation.

1) Weekly membership reports that include, but are not limited to, the following information:

a) Group Number.

b) All internal and external member Identification numbers (i.e., EES assigned ID, SSN, MBI, Employer ID, etc.).

c) Subscriber number.

d) Hire date.

e) Coverage effective date.

f) Coverage expiration date.

g) Current benefit effective date.

h) Current benefit expiration date.

i) Member First Name.

j) Member Last Name.

k) Member SSN.

l) Member date of birth.

m) Member tier.

n) Member benefit identifier code(s).

o) Medicare primary flag.

p) Medicare Coverage.

- Medicare A effective date
- Medicare B effective date.

q) Medicare effective date.

r) Medicare expiration date.

Confirm ☑ Does Not Confirm ☐

2) Monthly Member reporting package based on enrollment the last day of the previous month that includes each of the following:

a) Enrollment by Plan Design, Entity, Group, Tier, and Medicare Status.

b) In-state Member counts by county broken down by Plan Design, then totaled.

c) Out-of-state Member counts by state or country broken down by Plan Design, then totaled.

d) Enrollment by Group number broken down by Subscriber and Dependent, then totaled.

e) Graphs (pie charts) that include:

- All Members by Plan Design.
  - In-state Members by Plan Design.
  - Out-of-state Members by Plan Design.
- All Members by Coverage Tier.
- Top 10 Counties.

Confirm ☑ Does Not Confirm ☐

3) Monthly PCP Election report that includes, but is not limited to:

a) Total number of Members that have elected a PCP broken down by Plan Design.

b) Statistics about the Members who see the PCP on their card and those that see other PCPs.

c) Types of PCP elected (i.e., general practice, pediatrician, family medicine, etc.).

d) List of elected providers and number of Members who have elected them as their PCP.

Confirm ☑ Does Not Confirm ☐

ix. Vendor will provide each of the following Banking and Finance reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly accounts receivable aging report that includes, but is not limited to:

a) The amount of recoveries due, but not received.

b) The amount of any unapplied receipts.

c) Intervals of aging 1-30 days; 31-60 days; 61-90 days; 91-120 days; and over 120 days.

d) Supporting documentation from which these amounts are derived.

Confirm ☑ Does Not Confirm ☐

2) Quarterly report of any uncollectible accounts:

a) Recommended for debt write-off which includes, but is not limited to:

- Account name.
- Subscriber number, if applicable.

- Description/justification of the reason for write-off.
- The provider code, if applicable.
- Dollar amount and date originally paid, if applicable.
- Payee status.
- Identifying number (e.g., invoice, claim, case).
- Total amount proposed for write-off.

Confirm ☑ Does Not Confirm ☐

b) Recommended for exhausted debt (debt Vendor should stop tracking and pursuing when agreed upon recovery process has been completed) which includes, but is not limited to:

- Account name.
- Subscriber number, if applicable.
- Description/justification of the reason for exhausted debt.
- Provider code, if applicable.
- Dollar amount and date originally paid, if applicable.
- Payee status.
- Identifying number (e.g., invoice, claim, case).
- Total amount proposed for exhausted debt.

Confirm ☑ Does Not Confirm ☐

3) Daily deposited receipts reporting package, reported separately by Product type, e.g., PPO, HSA, HRA, etc., including:

a) Summary report, which includes, but is not limited to:

- Date of deposit.
- Total amount received by check.
- Total amount received by ACH.
- Distinct identification of which amounts relate to claims and which amounts relate to other types of deposits.
- Descriptive labeling of other deposits.
- Grand total of the daily deposits.

Confirm ☑ Does Not Confirm ☐

b) Any documentation from the banking institution of the deposited amounts posted daily, e.g., bank deposit slips, electronic deposit report, lockbox report, etc.

Confirm ☑ Does Not Confirm ☐

c) Daily deposit supporting documentation report, which includes, but is not limited to:

- Type of deposit, i.e., checks, ACH, and/or wire.

- Amount of each individual deposit and a grand total per deposit type.

Confirm ☑ Does Not Confirm ☐

d) Ability to produce Member level detail when requested by the Plan.

Confirm ☑ Does Not Confirm ☐

4) Daily NSF report listing all NSF for the previous months which includes:

a) Subscriber number, if applicable.

b) Provider information, if applicable.

c) Date returned.

d) Dollar amount.

Confirm ☑ Does Not Confirm ☐

5) Monthly misapplied deposits and/or collections report (e.g., applied deposit to wrong Member or wrong client) which includes date originally deposited and how they were corrected.

Confirm ☑ Does Not Confirm ☐

6) Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:

a) Number of checks processed weekly.

b) Number of EFTs processed weekly.

c) Payment amount(s) by type e.g., claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.

d) Weekly total by type.

e) Month to date total by type.

f) Supporting documentation of all disbursements and an explanation of any adjustments and/or miscellaneous payments, e.g., check register, any system generated reports of check writes, etc.

Confirm ☑ Does Not Confirm ☐

7) Monthly deposit reconciliation which includes, but is not limited to:

a) Date of each daily deposit.

b) Total amount of deposit for each day.

c) Breakdown of amount by type of deposit, i.e., checks, wires, ACH (drafts).

d) Monthly total of each type.

Confirm ☑ Does Not Confirm ☐

8) Monthly reconciliation of claims and other disbursements which includes, but is not limited to:

   a) Daily transactions listed individually with a daily total as well as a summary total.

   b) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds, and other disbursements.

   Confirm ☑ Does Not Confirm ☐

9) As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:

   a) Final due date to escheat the warrants/checks.

   b) Name of state and dormancy period for each state.

   c) Number of warrants for each state and dollar amount.

   d) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all Product types.

   e) Explanation of any special circumstances or issues.

   Confirm ☑ Does Not Confirm ☐

10) Monthly Summary of Billed Charges by State Fiscal Year which includes a summary of claims paid for the period which includes both medical and pharmacy claims.

   Confirm ☑ Does Not Confirm ☐

11) Monthly Statement of Account (SOA) which includes all charges including claims and administrative fees s paid. It is a full picture of all income/expenses for the month.

   Confirm ☑ Does Not Confirm ☐

x. Vendor will provide each of the following Financial Performance reports or reporting packages. The method for providing the report will be determined during implementation.

   1) Performance Guarantees (PG), as outlined in Section 6.3, reports as follows:

      a) Monthly PG status report.

      b) Quarterly PG report cards.

      c) Annual PG report cards that include summary data and year end PG results.

      Confirm ☑ Does Not Confirm ☐

   2) Monthly Performance Matrix reports as outlined in Exhibit 12, “Matrix Reports,” and listed below:

      a) Reports 1 and 2: Charge Summary Paid and Incurred Reports.

      b) Reports 3 and 4: Charge Summary Trend Paid and Incurred.

      c) Reports 5 and 6: Coinsurance and Deductible, Full Population-Paid and Incurred.

      d) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.

      e) Reports 9 and 10: Copay-Incurred and Paid.

      f) Report 11: Copay-Incurred (Claims Run out).

g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.

h) Reports 14 and15: Financial Summary-Paid and Incurred.

i) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.

j) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

Confirm ☑ Does Not Confirm ☐

3) Monthly Triangulations reports with the following stratifications:

a) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.

b) Plan Design and/or Product, including a summary based on total membership.

Confirm ☑ Does Not Confirm ☐

4) Monthly prompt payment interest claims report that includes, but are not limited to:

a) Prompt pay for adjusted claims.

b) Prompt pay for new claims.

c) Claim count.

d) Total interest paid.

Confirm ☑ Does Not Confirm ☐

xi. Vendor will provide each of the following Claims and Appeals reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly processed claims reports that include, but are not limited to:

a) Claims type.

b) Total claims billed.

c) Total claims paid.

Confirm ☑ Does Not Confirm ☐

2) Monthly Deductible and Out-of-Pocket reports, by Plan Design, by month.

Confirm ☑ Does Not Confirm ☐

3) Monthly COB reports that identify savings associated with both Medicare and Commercial COB.

Confirm ☑ Does Not Confirm ☐

4) Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:

a) Denial reason.

b) Number of claims for each denial reason.

c) Total charges for each denial reason.

Confirm ☑ Does Not Confirm ☐

5) Quarterly high claimant reports that include, but are not limited to (the dollar threshold for including Members on the report will be determined during implementation):

a) Member ID.

b) Plan ID.

c) Member age.

d) Diagnosis.

e) Service start date.

f) Encounter service type.

g) Place of service.

h) Provider specialty description.

i) Paid amount.

Confirm ☑ Does Not Confirm ☐

6) Monthly medical and pharmacy appeals reports that include, but are not limited to:

a) Number of first level appeals received.

b) Number of first level appeals approved.

c) Number of first level appeals denied.

d) Number of second level appeals received.

e) Number of second level appeals approved.

f) Number of second level appeals denied.

g) Statistics on types of appeals received, approved, and denied at both first and second level.

Confirm ☑ Does Not Confirm ☐

7) A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:

a) Member ID.

b) Member First Name.

c) Member Last Name.

d) Type of Appeal Review Decision.

e) Type of Appeal Category.

f) Date Appeal Initiated.

g) Final Written Date.

h) Appeal Decision Description.

i) Medication Name, Strength, and Dosage.

j) Method Appeal Received.

k) Appeal Origin.

l) Drug Class.

Confirm ☑ Does Not Confirm ☐

xii. Vendor will provide the following Network report or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.

Confirm ☑ Does Not Confirm ☐

xiii. Vendor will provide each of the following Medical Management reports or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly Medical Cost and Clinical Outcomes reports across diagnosis categories, highly prevalent, costly, and/or determined by the Plan to be clinically significant, to include HEDIS measures, and state, national, and book-of-business data segregated by Plan Designs (70/30, 80/20, HDHP,) Medicare and Non-Medicare primary status, and by Group.

Confirm ☑ Does Not Confirm ☐

2) Quarterly Case Management Clinical Outcomes.

Confirm ☑ Does Not Confirm ☐

3) Quarterly Preventive Care Service Utilization.

Confirm ☑ Does Not Confirm ☐

xiv. Vendor will provide each of the following Utilization Management reports or reporting packages. The method for providing the report will be determined during implementation.

1) Quarterly Utilization Management Cause, Cost and Clinical Outcomes, including, but not limited to, inpatient admissions, readmissions, emergency department visits, urgent care visits, outpatient services, behavioral health services, ambulance services, private duty nursing, pharmacy services and polypharmacy, primary care physician visits, specialist visits, prior authorizations and approvals, and high cost claims and claimants across Plan Products (70/30, 80/20, HDHP, non-Medicare) and Employing Units.

Confirm ☑ Does Not Confirm ☐

2) Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.

Confirm ☑ Does Not Confirm ☐

xv. Vendor will provide the following specialty pharmacy management report or reporting package. The method for providing the report will be determined during implementation.

1) A quarterly utilization report detailing specialty pharmacy Rebates.

Confirm ☑ Does Not Confirm ☐

xvi. Vendor will provide each of the following Customer Experience reports or reporting packages. The method for providing the report will be determined during implementation.

1) The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:

a) Total Member calls received.

b) Weekly ASA rate for Member calls.

c) Weekly first contact resolution rate.

d) Weekly second contact resolution rate.

e) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.

f) TAT for completing manual enrollment updates.

g) Enrollment accuracy rate for the current month.

h) Number and percentage of clean claims processed ≤ 30 days.

i) Number and percentage of claims processed > 30 days.

j) Number and percentage of claims processed > 60 days.

k) Number and percentage of claims processed > 90 days.

Confirm ☑ Does Not Confirm ☐

2) A Quarterly Web Trends Report that provides statistics on Plan Members transaction history compared to Vendors' Book of Business data.

Confirm ☑ Does Not Confirm ☐

xvii. Vendor will provide each of the following Recovery and Special Investigation reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly recovery reporting package that includes, but it not limited to the following:

a) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).

b) Total requested or saved, by recovery type and recovery subcontractor.

c) Total received, by recovery type and recovery subcontractor included Plan recovery Vendors. (Example: The Plan's Subrogation Vendor's results included in reporting package alongside Vendor's other recovery results.)

d) Total by subcontractor, including Plan recovery Vendors.

e) Quarter and year to date results.

f) Trends.

g) If available, benchmark data.

Confirm ☑ Does Not Confirm ☐

2) Monthly Plan specific investigation reports that include, but are not limited to, the following data:

a) Name of provider.

b) Number of Members impacted.

c) Date case opened.

d) Basis for review.

e) Summary of case.

f) Status of the case.

g) Total projected Plan claims dollars associated with the case.

h) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.

Confirm ☑ Does Not Confirm ☐

3) A quarterly medical audit repayment report that includes, but is not limited to, the following data:

a) Date of Service.

b) Member Name.

c) Subscriber Number.

d) Claim Number.

e) Original Paid Amount.

f) Appropriate Paid Amount.

g) Overpayment Amount.

h) Amount Repaid to the Plan.

i) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.

j) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

Confirm ☑ Does Not Confirm ☐