State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Jim Gibbons
Governor

Greg Smith
Administrator

Division of Purchasing
Request For Proposal No. 1893
for

THIRD PARTY ADMINISTRATION (TPA) SERVICES FOR THE STATE OF NEVADA'S SELF-FUNDED MEDICAL, DENTAL AND VISION PLANS

Release Date: **September 16, 2010**
Deadline for Submission and Opening Date and Time: **October 26, 2010, @ 2:00PM**

For additional information, please contact:
Colleen G. Janes, Purchasing Officer
cjanes@purchasing.state.nv.us
(775) 684-0186
(TTY for the Hearing Impaired: 1-800-326-6868.
Ask the relay agent to dial 1-775-684-0186/V.)

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

See Page 32, for instructions on submitting proposals.

Contact Information

Company Name **HealthSCOPE Benefits**

Address **27 Corporate Hill Drive** City **Little Rock** State **AR** Zip **72015**

Telephone (**501**) **218-7513** Fax (**501**) **225-9150**

E-Mail Address: **mary.person@healthscopebenefits.com**

Prices contained in this proposal are subject to acceptance within **365** calendar days.

Contact Person **Mary Catherine Person, President**

Print Name & Title Mary Catherine Person, President

Approved 05/07/02
Revised 10/1/09

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A Request for Proposal process is different from an Invitation to Bid. The State expects vendors to propose creative, competitive solutions to the agency's stated problem or need, as specified below. Vendors may take exception to any section of the RFP. Exceptions should be clearly stated in Attachment B (Certification of Indemnification and Compliance with Terms and Conditions of RFP) and will be considered during the evaluation process. The State reserves the right to limit the Scope of Work prior to award, if deemed in the best interest of the State NRS §333.350(1).

1. OVERVIEW OF PROJECT

The State of Nevada's Purchasing Division on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for a Third Party Administrator (TPA) to administer and manage the healthcare benefits program for PEBP's self-funded medical, dental and vision PPO plans.

PEBP is seeking a vendor who will provide the participants of the self-funded medical, dental and vision plans with prompt and accurate claims handling and superior customer service. Solicitations should also include web based benefit review and claim status assessment for approved PEBP staff, PEBP participants and healthcare providers. Minimum web functionality to include:

- Claims inquiry
- Eligibility inquiry
- Deductible status
- Out of Pocket Maximum status
- Online Explanation of Benefits (EOB)
- Benefit Summary information
- PPO provider search
- Link to PEBP's other business partners, including PEBP's Pharmacy Benefit Manager (PBM)
- Frequently Asked Questions (FAQ)
- Online forms access
- Online email and Personal Identification Number (PIN) update capabilities
- Real time viewing (not a batch based system)
- Integrate prescription drug claims from PEBP's (PBM) into the data warehouse for analysis and reporting, including deductible and out of pocket maximum calculations for participants

Proposals should include information regarding the vendor's capability to provide a web based reporting tool mechanism with the following minimum capabilities:

- Updated at least monthly
- Benchmarking capabilities
- Export capabilities to Excel
- Predictive modeling
- Integration of medical and prescription drug data
- Maintain a minimum of five (5) years history

PEBP is also interested in the vendor's ability to provide a web based consumer tool that would allow PEBP participants to research and understand a medical condition or procedure, build a framework for what the PEBP participant needs to know to make informed decisions regarding possible treatment options, compare hospitals, assist in preparation for office visits and understand drug options. Additionally, the tool(s) must allow PEBP participants to predict future medical costs and compare the various plans offered PEBP participants to determine the most cost effective option.

Since no two customers are ever exactly alike in their needs and communication style or requirements, each of our clients has a custom website, with tools developed specifically for their own benefit design, and aimed at communicating effectively with whatever type of population using the technology. With HealthSCOPE, "custom" is our hallmark. We are not a cookie cutter organization or a "one size fits all".

HealthSCOPE Benefits, through our partnership with Empowered Benefits, provides extensive web tools that are developed specifically for our clients. We believe members will use web tools when they are specific to the plan and the area and are not just averages. We have multiple tools available for customization:

Plan Cost Comparison
Procedure Cost Comparison

We also have hospital quality tools, minimally invasive procedure information, and materials to help members get the most from their provider visits. Our plan cost comparison is unparalleled in its ability to help members make plan choices. We include the premiums based on their usage including PCP, Specialist, ER visits, Outpatient Services, Inpatient Hospitalizations, Therapy visits, MRIs/CTs, and prescriptions based on tiers; the ability to show the amount the member spent in the previous plan year and allow them to increase or decrease that by dollar amount; and the ability to include plans we do not administer.

Our procedure cost comparison focuses on the top episodes of care for specific customers and provides average actual costs by top facilities/providers for services ranging from maternity, MRI, CT, ER visits, Outpatient Surgeries, and Joint replacements.

Our tools will inform your members better than any other and our constant refresh of the site keeps members coming back. For one customer with these tools, more than 60% of their employees used the plan cost compare for annual enrollment and we have had more than 88% visit our site for information on being a good consumer.

In addition, we have all of the tools outlined above including:

- **Claims Status & History**
- **Account Balances**
- **Service Type**
- **Method of Payment (e.g. direct deposit, check)**
- **Claim Forms**
- **Health Care Account Benefit Calculator**
- **Dependent Care Account Benefit Calculator**
- **Eligible Expenses for FSA**

- Eligible Over-the Counter Expenses for FSA
- SPD
- Eligibility Status
- Health & Wellness Information
- Summary of Benefits
- View/Print EOBs
- Links to PPO Directory
- Consumer Driven Tools
- Procedure Cost Comparison
- Hospital Quality
- Links to PBM

Our Web portal provides participants with numerous online tools and opportunities to help them change behaviors that negatively affect their lifestyle, including an online Health Assessment, Online Health Coaching, Personal Health Record, Live 24/7 Nurse Chat, symptom checker, disease and condition center, resources such as weight and health information tools, quizzes, glossaries, self-care tools, lifestyle topics, prescription drug guide, an online health encyclopedia, and much more!

We offer optional access to our data warehouse and analytics product called DataSCOPE, a powerful information reporting system developed by HealthSCOPE Benefits to help our clients understand and manage the factors that drive cost and quality of healthcare delivery. DataSCOPE compiles data from the client's health plan into valuable reports on factors such as provider performance, employee health status, and disease management.

DataSCOPE surpasses other information systems in its ability to apply advanced Clinical methodologies to healthcare claim data. Where other systems monitor only cost and utilization, DataSCOPE considers the data from a clinical perspective. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan an provider performance. Therefore, DataSCOPE is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan-management activities.

DataSCOPE is our internal data warehousing product made available to all of our clients, which includes:

- Data Management and Warehousing
- Health Care Information Reporting and Analysis
- Benefit Plan Design Modeling & Evaluation
- Provider Quality & Cost Analysis
- Clinical Predictive Modeling
- Cost and Care Management Analysis
- Ongoing Support Activities

The DataSCOPE information reporting system can positively impact your medical plan by providing benchmarking data and analysis to identify specific drivers

behind increasing health care costs. DataSCOPE compiles data from your health plan into valuable reports on factors such as provider performance, employee health status, and disease management.

DataSCOPE's number one goal is to provide actionable information in a timely manner to impact health care costs and utilization as they are happening, not years later.

DataSCOPE surpasses other information systems in its ability to apply advanced clinical methodologies to health care claim data. Where other systems monitor only cost and utilization, DataSCOPE considers the data from a clinical perspective, as well as cost and utilization. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan and provider performance. Because of this, DataSCOPE is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan management activities.

Distinctive Advantages:

- **Clinically Adjusted Claim Data: DRGs, MDCs, NDCs, ETGs**
- **Data Capture and Analysis System aggregates Multiple Vendor Data Feeds**
- **Mapping and Editing Expertise**
- **Data Analytic Staff produces actionable information**

Integration = One Source Reporting

- **Health Assessments**
- **Pharmacy Benefit Managers**
- **Medical Management**
- **Mental Health / Chemical Dependency Management**
- **Disability Managers**
- **Dental Claims Data**
- **Workers Compensation**
- **Biometric Screening Data**
- **Lab Values**

Analytic and Support Services:

- **Physician, Plan and Network Data**
- **Identify, Drill-down and Research Area of Concern**
- **Provide Solutions-oriented Recommendations**
- **Cost Benefit Analysis**
- **Blend Technology with Health Care Expertise**
- **Chronic Illness Compliance**
- **Predictive Modeling**

It is PEBP's intention to move to a Consumer Driven/High Deductible Health Plan in 2011, and PEBP will be looking to its vendors to work in partnership to communicate to participants the costs of medical procedures and enable PEBP participants to be informed and prepared consumers of their medical care.

PEBP does not contract with the same vendor for the Eligibility and Enrollment system and TPA services. The TPA vendor shall be responsible for coordinating enrollment updates via electronic interface with the Eligibility and Enrollment Information System vendor.

Note: PEBP is the system of record regarding participant eligibility; this means that PEBP has the responsibility for eligibility final determination, maintenance of eligibility records and

reporting of eligibility for its participants and their dependents. Please confirm your organization's willingness to accept these terms.

Accepted

For information on PEBP's eligibility requirements, please refer to the Master Plan Document (MPD) at www.pebp.state.nv.us.

Please note that the MPD posted on the PEBP website is indicative of the current plan year only. Due to budget constraints and pending legislative impact, the PEBP plan could change drastically in the coming plan year. All plan changes will be posted on the PEBP website and, vendors are encouraged to follow the PEBP Board as they make these decisions in 2010 to affect the plan year starting July 1, 2011.

As of June 2010, PEBP has approximately 44,000 plan participants who include active and retired state employees and active and retired non-state participants who are eligible for medical coverage. Of those, approximately 30,000 have elected the Self-funded Medical PPO Plan. The other 13,000 participants have elected a Health Maintenance Organization (HMO) plan. Dental coverage is provided under the self-funded Dental PPO plan and is offered to all participants, including those in the HMO plans. Vision benefits are administered under the plan the participant selects. These counts do not include dependents, but do include Medicare retirees, who are proposed to be moved to an Exchange for their health care, dental and vision coverage.

The effective and termination dates for the TPA contract, pursuant to this RFP, are tentative and subject to change. Currently, the effective date of this contract will be upon Board of Examiners approval (anticipated to be April 13, 2011), with a termination date of June 30, 2016. Possible term extensions may be entertained depending upon the successful vendor's performance.

1.1 PEBP ADMINISTRATION

1.1.1 Background

The Public Employees' Benefits Program (PEBP) oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time state employees, certain non-state local government agencies, full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. Dependents of the above-mentioned groups may also be covered. Benefits are also extended to retirees who are receiving benefits from specified public retirement systems and their surviving spouses and/or eligible dependent children.

PEBP currently contracts with UMR, Inc (a United Healthcare Company) in San Antonio, Texas for TPA services and Morneau Sobeco for Eligibility and Enrollment services. Morneau Sobeco manages the premium bill generation process, and PEBP updates the system for all payments received. Morneau Sobeco is also responsible for generating enrollment file updates for PEBP

vendors on a daily and monthly basis. Morneau Sobeco maintains all reference data in their system, such as premium rates and group demographic information, and manages the process of interfacing enrollment information to the TPA.

PEBP is soliciting a vendor who can provide TPA claims management services only.

1.1.2 Current Vendors

PEBP also contracts with the following vendors:

- UMR – Third Party Claims Administrator (PPO Plan)
- Catalyst RX – Pharmacy Benefits Manager (PPO Plan)
- Walgreens Pharmacy and Walgreens Specialty Pharmacy – Subcontractor of Catalyst RX for mail order and specialty drug services
- APS Healthcare – Utilization Management Review, Large Case Management
- Sierra Healthcare Options and Hometown Health Providers – Nevada Statewide Medical PPO Network (PPO Plan)
- Beech Street – National Medical PPO Network (PPO Plan)
- Diversified Dental Services – Dental PPO Network (PPO and HMO)
- Health Claim Auditors – Health Plan Auditor services (Excludes HMO vendors)
- AON Consultants – Actuary services
- ASI – Flexible Spending Account
- Hometown Health Plans (HHP) – Northern Nevada HMO
- Health Plan of Nevada (HPN) – Southern Nevada HMO
- US Preventive Medicine- Wellness and Disease Management (Diabetes Only) PPO Plan
- Morneau Sobeco- Eligibility and Enrollment

1.1.3 Plan Design

The Public Employees' Benefits Program (PEBP) oversees the administration of the self-funded medical, dental and vision plans (which also includes Mental Health and Chemical Dependency). This requires the services of a Third Party Administrator (TPA) to administer and manage a claims adjudication system.

The self-funded medical, dental and vision plans cover full-time state employees, certain non-state local government agencies, professional full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. Dependents of the above mentioned groups may also be covered. Benefits are also extended to retirees who are receiving benefits from the Public Employees' Retirement System and their surviving spouses and/or eligible dependent children.

Please refer to the PEBP website at www.pebp.state.nv.us for copies of PEBP's most current Master Plan Document (MPD).

Please note that the MPD posted on the PEBP website is indicative of the current plan year only. Due to budget constraints and pending legislative impact, the PEBP plan could change drastically in the coming plan year. All plan changes will be posted on the PEBP website and vendors are encouraged to follow the PEBP Board as they make these decisions in 2010 to affect the plan year starting July 1, 2011.

The most recent changes to the PEBP PPO Plan are a proposed move to a Consumer Driven/ High Deductible Health Plan with a Health Savings Account (HAS) for active participants and a Health Reimbursement Arrangement (HRA) for retirees. Medicare eligible retirees are proposed to be moved to a Medicare Exchange for coverage options and will not be covered by the PEBP PPO Plan. PEBP will post all plan design changes on its website.

1.1.4 Claims Volume (Total claims received by current TPA)

For the period of July 2009 through June 2010, the medical claims volume, including vision claims, averaged approximately 14,720 claims received per week or approximately 63,800 per month for an annual total of approximately 765,640 claims. The dental claims averaged approximately 3,000 claims per week, or approximately 12,700 per month for an approximate annual total of 152,542. Approximate total annual claims volume total is 918,182.

1.1.5 Funding

PEBP provides the TPA access to a checking account currently with Bank of America from which claim payments are made. The TPA deposits overpayments/refunds into this account. The TPA is responsible for providing daily check files to Bank of America and a monthly interface of all checks written to the bank. PEBP contracts with the bank to perform a full reconciliation of the account. The TPA is also responsible for reconciling the account activity to their claim system on a monthly basis.

1.1.6 Future Direction

PEBP is soliciting a TPA who will enter into a business partnership, and is willing to take advantage of the latest in technological advances in providing customer service and improving operational efficiencies, e.g. ability to submit claims via the web and consumer knowledge based tools that will allow PEBP participants to make informed decisions regarding their healthcare. The successful vendor will be expected to work cooperatively with PEBP in

implementing future system enhancements to include interfacing with various data sources.

1.1.7 Comprehensive TPA services to include but not be limited to:

- Medical, Dental and Vision Claims Adjudication
- Data Reporting
- Records Retention
- Check, EOB and Letter Issuance
- Overpayment Recovery and Subrogation Recovery
- Resolution of Claimant and Provider inquiries regarding claim processing discrepancies
- Claim Appeal Procedures
- Participation in PEBP Employee Benefit Orientations, Retiree Benefit Orientations and annual Open Enrollment Meetings
- Attendance at *all* PEBP Board meetings
- On-site Customer Service Representative residing in the PEBP office in Carson City, Nevada

1.1.8 Full Disclosure and Independent Review

PEBP contracts with a health plan auditor to perform quarterly claims audits on behalf of PEBP. PEBP and its health plan auditor will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the audit. PEBP has the right to review/audit records for the entire term of the contract without limitation. Any information, documents, etc. which the TPA may deem as containing "trade secrets" or "proprietary" will not preclude an examination of such items through the audit process.

The TPA will cooperate with PEBP and PEBP's health plan auditor in the audit reviews by providing access to all PEBP information including but not limited to claim processing records (hard copy or imaged documents), individual claims history, pended claims records, eligibility records, individual diary notes, prior authorization records, usual and customary data base, PPO provider rates data base, access to support staff to assist with system training and questions from the health plan auditor, and any other information relevant to PEBP as determined by PEBP and PEBP's health plan auditor at no cost to PEBP or PEBP's health plan auditor.

PEBP is responsible for the fees charged by the health plan auditor. The TPA will not delay the audit process by limiting access to the information requested by PEBP's health plan auditor. The TPA will make reasonable accommodations for PEBP's health plan auditor to allow the auditor to proceed with the audits in the time frame established by the health plan auditor, which typically takes four (4) to five (5) working days every quarter.

PEBP's health plan auditor will perform these audits on site at the physical location where the staff servicing the PEBP account is located, as well as the physical location of all PEBP data. To clarify further: PEBP's health plan auditor will be granted access to the claims system, any files, logs or other materials as required to perform a thorough audit of the TPA vendor.

Please confirm your organization's willingness to accept these terms.

Agreed, we will accept these terms.

1.1.9 Current Rates

The rates provided below are charged to PEBP by its current Third Party Administrator, UMR.

Fees	Amount	Basis for Calculation
Medical Claims Administration	$ 13.45	PPPM
Dental Claims Administration	$ 1.90	PPPM
Vision Claims Administration	$ 0.20	PPPM
Claims Repricing (Dental)	$ 0.10	PPPM
Clearinghouse fee for each medical claim that is repriced through EDI by in-state (Nevada) PPO Network vendor(s)	$ 0.35	Per Claim
$36,000 per month multiplied by the number of in-state/in-network claims repriced directly by UMR divided by the total number of in-state claims	$36,000.00	Calculated Per Month
Subrogation Recovery Fee	30% with 25% going to subrogation recovery firm, 5% to UMR	Percent of recovery Per subrogation claim
Overpayment Recovery Fee (not at the fault of UMR)	30% with 25% going to subrogation recovery firm, 5% to UMR	Percent of recovery Per overpayment claim

2. ACRONYMS/DEFINITIONS

For the purposes of this RFP, the following acronyms/definitions will be used:

ASO Administrative Services Only

Awarded Vendor The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFP.

BOE Board of Examiners

Board of Examiners A board comprised of the Governor, Secretary of State, and Attorney General.

Clean Claim	A claim, which can be processed without obtaining additional information from the provider of the service, or from a third party.
COB	Coordination of Benefits
Confidential Information	Any information relating to the amount or source of any income, profits, losses or expenditures of a person, including data relating to cost or price submitted in support of a bid or proposal. The term does not include the amount of a bid or proposal. See NRS §333.020(5)(b).
Customer	A self funded plan member/participant or medical/dental provider
Division	State of Nevada Department of Administration, Division of Purchasing
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
Evaluation Committee	An independent committee comprised of a majority of State officers or employees established to evaluate and score proposals submitted in response to the RFP pursuant to NRS §333.335.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
LOI	Letter of Intent - notification of the State's intent to award a contract to a vendor, pending successful negotiations; all information remains confidential until the issuance of the formal notice of award.
May	Indicates something that is not mandatory but permissible.
NAC	Nevada Administrative Code
NRS	Nevada Revised Statutes
NOA	Notice of Award- formal notification of the State's decision to award a contract, pending Board of Examiners' approval of said contract, any non-confidential information becomes available upon written request.
Participant	An individual enrolled in benefit plans provided by the State of Nevada, Public Employees' Benefits Program
PBM	Pharmacy Benefits Manager
PEBP	Public Employees' Benefits Program
PEBP Board of Directors	The appointed board of nine directors that oversees the Public Employees' Benefits Program operation and staff.

PPO	Preferred Provider Organization
PPPM	Per Participant Per Month
Proprietary Information	Any trade secret or confidential business information that is contained in a bid or proposal submitted on a particular contract.
Public Record	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential (see NRS §333.333 and NRS §600A.030(5)) must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records.
R&C	Reasonable and Customary
RFP	Request for Proposal - a written statement which sets forth the requirements and specifications of a contract to be awarded by competitive selection NRS §333.020(7).
Shall/Must/Will	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.
Should	Indicates something that is recommended but not mandatory. If the vendor fails to provide recommended information, the State may, at its sole option, ask the vendor to provide the information or evaluate the proposal without the information.
State	The State of Nevada and any agency identified herein.
Subcontractor	Third party, not directly employed by the vendor, who will provide services identified in this RFP. This does not include third parties who provide support or incidental services to the vendor.
Suspended/Pended	A claim(s), which requires additional information before it can be processed.
TPA	Third Party Administrator
Trade Secret	Means information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that: derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
UCR	Usual, Customary and Reasonable
Vendor	Organization/individual submitting a proposal in response to this RFP.

3. GENERAL QUESTIONS

In order for your proposal to be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. Reference should not be made to a prior response, or to your contract, unless the question involved specifically provides such an option. Be sure to refer to the earlier sections of this request for proposals (RFP) before responding to any of the questions, so that you have a complete understanding of all of the State's requirements with respect to the procurement.

Confirmed

If your proposal is different in any way (whether more or less favorable) from that indicated in this request for proposals, clearly indicate where. If you do not, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

Confirmed

If you are unable to perform any required service indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

We are able to perform all required services.

Include any additional information in your proposal that you consider useful to PEBP. However, direct responses to all of the questions set forth below must be provided.

At HSB, we treat every customer as a partner, and we always remember that the customer is the one paying the bills. We are an independent TPA. We aren't owned by an insurance company or other big entity. We are owned by Joe Edwards and Mary Catherine Person along with Diamond State Ventures. What makes this unique is that Joe and Mary Catherine make the decisions in the company. There is no having to ask permission or having to conform to the standards of a larger entity. Diamond State is also unique as their partnership with Joe and Mary Catherine was founded on the principle of helping to keep good jobs in Arkansas – not short term gains. We partner with our clients to provide exactly what the client needs or wants. We offer flexibility and a commitment to service that is unmatched in the industry.

We believe we are well suited to partner with PEBP as a result of our long history servicing clients and our ability to help customers manage their costs.

With a headquarters in Little Rock, Arkansas and seven regional offices and over 300 employees across the country, HealthSCOPE Benefits is the 5th largest third party administrator in the nation according to Business Insurance Magazine. HealthSCOPE Benefits goes beyond the offerings of traditional administrators to provide innovative health benefits solutions—a practice we have come to term Total Health Management. This holistic approach allows us to create and manage plans that result in Healthy People, Healthy Business and Healthy Futures. It is not unusual for HSB to take on a new group and see a negative trend in the first year as a result of our cost management programs.

The wellness of your staff has a direct impact on your bottom line. Unlike TPAs or insurance companies that solely manage risk or pay claims, we integrate these services with innovative services that empower employees to make proactive decisions that result in Healthy People.

The well being of your organization is measured through financial success. Our customized programs help control costs by giving you exactly what you need and nothing you don't. We get to know you and your needs, then provide a plan that will help you maintain a Healthy Business. HealthSCOPE Benefits is a forward looking, forward thinking company—generating favorable outcomes with our proactive approach to health. Our goal is to provide long-term programs that will save you a little today and a lot tomorrow, enabling business of all types to enjoy Healthy Futures.

At HealthSCOPE Benefits we do more than talk about innovation, we embody it. The following are just some of the tools and practices we've implemented and the impact for those we serve.

- HealthSCOPE Benefits is licensed to administer benefits in all 50 states.
- We've invested in industry-leading technology, including extensive web access for clients, a state of the art IVR phone system for providers, automated benefits administration applications and DataSCOPE, our sophisticated data warehouse and reporting product.
- Claim turnaround in 2009 averaged 4.2 days with 99.8% accuracy.
- Average answer speed in our Call Centers is 19.65 seconds.
- During 2009, 97% of customer inquiries were resolved during the first call.
- Average claims financial accuracy over 99.5%.

All TPAs are not the same. HealthSCOPE Benefits is different. We back up our claims, guarantee results and maintain long-lasting relationships with our clients. HealthSCOPE Benefits' partnership with you is founded on three tenets. It is our pledge to work with you to develop an attractive, affordable and customer-friendly benefits plan for your employees.

• Healthy People.
Unlike an insurance company, we are not simply accepting risk on behalf of our clients. Unlike a traditional TPA, we are not simply adjudicating and paying claims for the self-insured. Rather, our company empowers clients to proactively monitor and manage the health of their employee populations.

• Healthy Business.
It's well documented that a healthier workforce is a more productive workforce. But HealthSCOPE Benefits goes beyond the basics to help deliver a healthier bottom line – by assertively controlling healthcare costs through networks, discounts and utilization management. Furthermore, HealthSCOPE Benefits' flexible, customized plan design means our client companies are delivering exactly the benefit structure they want.

• Healthy Futures.
HealthSCOPE Benefits is a partner for the long term; the real value of our partnership is unlocked over time. HealthSCOPE Benefits creates sustainable benefit programs. By enabling cost trend management dramatically below the industry's average, HealthSCOPE Benefits helps its clients create healthier futures.

HealthSCOPE Benefits will closely lead in the relationship. All items will go through HealthSCOPE Benefits Account Management.

HealthSCOPE Benefits forms partnerships with the best vendors in the business. We currently manage our partnerships by ensuring continuous due diligence by maintaining constant involvement in day to day processes and procedures regarding vendor integration into the daily

activities of HealthSCOPE Benefits' groups. Regular meetings, quality checks, and various internal processes are imposed to ensure all requirements are met and continued improvement is ensured relating to all aspects of our vendor partnerships and processes.

3.1 THIRD PARTY ADMINISTRATOR SERVICES

3.1.1 Account Service

3.1.1.1 Does your organization have existing capacity within your current operation to manage the PEBP account? Will your organization require additional personnel if you are awarded the contract? If so, what type(s) and how many?

We will require additional personnel if we are awarded the contract. We would use existing staff as the core of the PEBP team. We would expect 20 Customer Service Representatives and 12 Claims Processors to staff PEBP along with a Claims and Customer Service Supervisor.

As with all other areas of client management, our entire account management and leadership team is staffed with long-term, highly capable and knowledgeable individuals who bring a wealth of industry experience and HealthSCOPE history to the table. We stand ready to work with PEBP to evaluate cost/benefit trends and provide proactive strategies to optimize plan performance.

Working with our clients on an individual basis, bringing the right solutions to bear is the hallmark of our organization, and a key component to the HealthSCOPE mission and vision to assist each of our clients in designing programs that promote: Healthy People. Healthy Business. Healthy Futures.

3.1.1.2 PEBP requires that one full-time account representative be located in the PEBP office in Carson City, Nevada, with no exceptions. This staff person will act as a liaison between PEBP and the TPA, perform customer service, have access to claim data, and be able to adjust claims as needed or have the authority to direct the claims payment adjustments to the team lead responsible for PEBP claims. PEBP requires input and participation in the hiring process of this position. The office equipment, necessary insurance compliance and lease arrangements are the responsibility of the vendor. Please confirm your organization's willingness to accept this requirement at no additional cost to PEBP.

Confirmed, we will accept this requirement at no additional cost to PEBP. We would like to hire the existing staff person if that meets PEBP's needs.

3.1.1.3 Will PEBP be assigned an experienced Account Manager whose primary responsibility is servicing PEBP?

Confirmed, Darren Ashby is the VP of Client Services. We would assign Rhonda Huckaby as the Client Relations Manager. She would be dedicated to PEBP. In addition, Mary Catherine Person, President of HSB, would be extremely involved in the successful implementation and management of PEBP.

3.1.1.4 Indicate (YES/NO or N/A) which positions have the authority to perform the following functions:

Position	Pay Claims	Add/change enrollment/eligibility records	Add/change providers	Claim Payment Maximum (if applicable)
Claims Director	Y	N	N	$2,000,000
Claims Manager	Y	N	N	$75,000
Claims Supervisor	Y	N	N	$35,000
Customer Service Manager	N	N	N	0
Claims Examiner	Y	N	N	$5,000/$10,000/ $15,000 – depending on length of service
Customer Service Representative	N	N	N	0
Provider Relations Representative	N	N	Y	0
Quality Control Manager	N	N	N	0
Claims Auditor	N	N	N	0
Eligibility Specialist	N	Y	N	0

3.1.1.5 What is your organization's employee turnover rate from July 1, 2009 through June 30, 2010 in the areas that will handle PEBP's claims?

4%

3.1.1.6 Is your organization capable of coordinating EDI with PEBP's PPO networks?

Yes

3.1.1.7 Does your organization have the capability of handling EDI directly from Medicare? Medicare Direct?

Yes, we receive Medicare claims thru Capario from the Medicare Intermediaries.

3.1.1.8 As indicated in section 1 of the Overview and Scope of Service, PEBP is

interested in a vendor who has the capability to provide a web based reporting tool mechanism. Please describe in detail your organization's reporting capabilities. Please provide this information and a sample of your reporting capabilities as an attachment to your proposal. Please confirm your organization's willingness to provide this at no additional cost to PEBP.

Standard Reports	Frequency
Detailed monthly claims report, including in and out-of-network claims broken out	Monthly
Quarterly claims detail reports, including utilization data and network analysis	Quarterly
Pending claims report (report showing any claims currently in suspense)	Monthly
Copies of current aggregate/specific reports	Monthly
Lag report	Monthly
Case management reports	Quarterly
50% of the specific report: all claims paid @ 50% of the groups specific deductible (with claim amounts listed)	Monthly
Diagnosis and prognosis for any claimants listed on the 50% report	Monthly
Copies of paid stop loss reimbursements (i.e. copies of the letter and check showing that the claim has been settled)	Monthly
Percentage of in-network savings amounts	Monthly
Subrogation activity reports	Quarterly
Summary reports - showing admits (broken out by type), average length of stay, COB (split out) active process	Quarterly
Inpatient utilization by diagnostic category – showing experience by major diagnostic category.	Quarterly
Physician experience – broken out by in-network and out-of-network	Quarterly
Utilization reports for the current month and year to date indicating claims by age, sex, and claims by location	Monthly
Financial accuracy report	Quarterly
Non-payment accuracy report	Quarterly
Claims turnaround time report	Quarterly

We offer access to our data warehouse and analytics product called DataSCOPE, a powerful information reporting system developed by HealthSCOPE Benefits to help our clients understand and manage the factors that drive cost and quality of healthcare delivery. DataSCOPE compiles data from the client's health plan into valuable reports on factors such as provider performance, employee health status, and disease management.

DataSCOPE surpasses other information systems in its ability to apply advanced Clinical methodologies to healthcare claim data. Where other systems monitor only cost and utilization, DataSCOPE considers the data from a clinical perspective. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan an provider performance. Therefore, DataSCOPE is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan-management activities.

DataSCOPE is our internal data warehousing product made available to all of our clients, which includes:

- Data Management and Warehousing
- Health Care Information Reporting and Analysis
- Benefit Plan Design Modeling & Evaluation
- Provider Quality & Cost Analysis
- Clinical Predictive Modeling
- Cost and Care Management Analysis
- Ongoing Support Activities
- Pharmacy Claims Analysis Integrated with Medical

The DataSCOPE information reporting system can positively impact your medical plan by providing benchmarking data and analysis to identify specific drivers behind increasing health care costs. DataSCOPE compiles data from your health plan into valuable reports on factors such as provider performance, employee health status, and disease management.

HealthSCOPE Benefits produces a robust set of monthly reports to its clients. These reports include both clinical and financial data which include: Top Providers; Top Procedures, Top Diagnosis, Monthly Lag Summaries, Utilization and Cost Comparisons to National Benchmarks as well as Clinical Usage information. These reports are available to our clients online on the 12th of every month. Aside from the above detailed reports we also provide monthly check register logs for a client to keep in their records.

For those clients who are heavier utilizers of their claims data, we offer the ability to run your own reports above and beyond normal month-end reports for a nominal fee.

The following standard reports are delivered showing a breakdown of cost in the account structure, subtotals and totals requested by the client. All reporting is available on-line as well as in electronic format (unless hard copy is requested) and downloadable into standard database (Access) or spreadsheet (Excel) format for manipulation.

DataSCOPE's number one goal is to provide actionable information in a timely manner to impact health care costs and utilization as they are happening, not years later.

DataSCOPE surpasses other information systems in its ability to apply advanced clinical methodologies to health care claim data. Where other systems monitor only cost and utilization, DataSCOPE considers the data from a clinical perspective, as well as cost and utilization. As a result, factors such as age, sex, and severity of illness are accounted for when evaluating plan and provider performance. Because of this, DataSCOPE is an extremely accurate and effective tool for provider profiling, benefit plan evaluation and management, and other plan management activities.

Distinctive Advantages:

- Clinically Adjusted Claim Data: DRGs, MDCs, NDCs, ETGs
- Data Capture and Analysis System aggregates Multiple Vendor Data Feeds
- Mapping and Editing Expertise
- Data Analytic Staff produces actionable information

Integration = One Source Reporting

- Health Assessments
- Pharmacy Benefit Managers
- Medical Management
- Mental Health / Chemical Dependency Management

- **Disability Managers**
- **Dental Claims Data**
- **Workers Compensation**
- **Biometric Screening Data**
- **Lab Values**

Analytic and Support Services:

- **Physician, Plan and Network Data**
- **Identify, Drill-down and Research Area of Concern**
- **Provide Solutions-oriented Recommendations**
- **Cost Benefit Analysis**
- **Blend Technology with Health Care Expertise**
- **Chronic Illness Compliance**
- **Predictive Modeling**

Please refer to Exhibit 1 to reference our Sample Reporting Package and Sample DataSCOPE Reporting Package.

3.1.2 Customer Services

3.1.2.1 How many toll free numbers are available to PEBP staff and PEBP plan participants to inquire in to claims status and/or other customer service issues?

A client can have as many numbers as they want. For Whirlpool for instance, we have received as many as 20,000 calls in a month with no issues because we add additional T1 lines to support the call volume. We typically assign a single dedicated number for our clients.

3.1.2.2 What are the normal hours of operation (Pacific Time Zone) for your customer service department? Include extended or weekend shifts.

Hours of operation are 8:00 am. to 5:00 p.m.(Pacific Time), Monday thru Friday. In the event a member must contact us after hours, they have access to our 24 hours a day/365 days a year on-line and Interactive Voice Response Systems regarding claims, coverage, utilization management, or provider network inquiries.

3.1.2.3 Will the customer service department assigned to PEBP be located in the same office where PEBP claims are processed?

We would provide customer service to PEBP at two of our HealthSCOPE Benefit offices located in Little Rock, Arkansas and Columbus, Ohio. We have found having two offices staff a group of this size helps with volumes, time zones, weather and having to best, most qualified people. This would be a fully dedicated unit for PEBP. This is one of the reasons for our multiple offices to allow us the flexibility in hiring.

We will process claims out of Little Rock with back up Columbus, Ohio. This would be a group of processors dedicated to PEBP. All of our offices are on a single network and a single phone system, so being in another office is just like being on a different floor. This allows us to receive help from other offices when it is needed.

3.1.2.4 What claims history information does a customer service representative have access to when responding to an inquiry on a processed or pending claim?

They have access to a member's entire history of claims paid by HealthSCOPE Benefits.

3.1.2.5 Does your organization assign specialist customer service representatives who have the authority to resolve a problem upon first contact from the participant or provider?

All of our Customer Service Representatives can resolve a problem on first contact.

Training that is group-specific in regard to culture, location, general age and blue collar/white collar or technology versus manually driven is part of all initial and ongoing training to make sure our staff is handling the service of each customer with sensitivity and individuality.

HealthSCOPE has always lead the way in best practices and national standards and benchmarks, and are happy to share our impressive statistics in all areas of plan performance such as claims payment and financial accuracy, claims turnaround time, and call wait times. We have the ability to provide detailed reporting on all of these important categories and use this information for continuous quality improvement.

3.1.2.6 Do your customer service representatives have the ability to process claims?

No, they do not process claims. We prefer our CSRs concentrate on customer care.

3.1.2.7 Describe your customer service complaint escalation process (i.e. if resolution is not accomplished at the first level, describe the next step in your internal process).

Questions that cannot be answered or issues that cannot be resolved by a representative are transferred to a team lead, supervisor or manager. The representative is required to provide the member name, ID#, and details regarding the call prior to transfer. If a transfer is not possible, a message is taken and return calls are made by the end of that business day. It is our goal to insure the caller is completely satisfied and therefore require the representative to use all resources available to them to answer the call. If the representative feels they do not have the necessary information we encourage them to transfer the call to a team lead or supervisor for resolution.

3.1.2.8 Provide sample timelines for your organization's appeal process and if they will change due to the impending changes in appeal timeframes due to

the Health Care Reform Act.

Please refer to Exhibit 2 to reference the sample timelines for HealthSCOPE Benefits' Appeal Process.

3.1.2.9 Describe how your organization monitors and tracks customer service inquiries and outcomes.

We track and report all call statistics specific to the customer. All calls are tracked and documented in our online system, attached to the member's record, and recorded. The information is housed online and allows us to report on the types of calls and track first call resolution. Managers can also perform "silent monitoring" of calls. Outcomes of calls are documented by the CSR.

3.1.2.10 What methodologies (e.g. silent call monitoring) are employed by your organization to monitor and control the quality of service provided?

We track and record all calls digitally for one year. We use recordings as training tools with our CSRs. The best training is often grading your own work, and we employee this to assist in providing high quality customer service. We also send a selection of recording to some customers for monthly grading. Managers can also perform "silent monitoring" of calls, and we can provide recordings of calls when necessary. We have a broad listing of categories and have the ability to create PEBP specific categories, if necessary. No one can edit call documentation. Our claims and customer service reps have access to call documentation. We review categories of calls and changes in call reasons monthly at an executive level.

3.1.2.11 For the office that will be responsible for PEBP's customer service needs:

3.1.2.11.1 What was the number of incoming calls your customer service department received July 1, 2009 through June 30, 2010?

535,762

3.1.2.11.2 From July 1, 2009 through June 30, 2010 what was the average telephone response time for incoming customer service calls?

26 seconds

3.1.2.11.3 What was the call abandonment rate (indicate percentage) during this time period?

0.85%

3.1.2.11.4 Does your organization limit the time that a customer service representative may speak with a customer?

No

3.1.2.11.5 From July 1, 2009 through June 30, 2010 what was your organization's average call length?

3:20

3.1.2.11.6 From July 1, 2009 through June 30, 2010, what was your organization's average wait time for return calls, i.e. from your customer service department to a customer?

Average less than one business day

3.1.2.11.7 Specify your internal customer service performance goals for:

- Average wait time
- **30 seconds or less**
- Abandoned call percentage
- **Less than 1.5%**
- Average online time
- **3:20**
- Average return-call time
- **Less than one business day**

3.1.2.12 Are claim related issues identified by a customer service representative also adjusted by a customer service representative? If not, please explain who is responsible for reprocessing claims requiring adjustments.

No, our Customer Service Representatives do not process claims. Our dedicated Claims Analysts would make the adjustments.

3.1.2.13 Please explain your organization's process for adjusting incorrect claims. Include the average turnaround time for making corrections and whether or not the claim history accumulators are updated immediately.

Claims requiring adjustments are electronically suspended to the analyst who paid it. All adjustments are made within 72 hours and accumulators are updated immediately and systematically.

3.1.2.14 Is an adjusted claim assigned a new claim number or is it assigned the same claim number that includes a claim adjustment modifier?

An adjusted claim is assigned a new claim number, but we can track it back to the original very easily.

3.1.2.15 Describe the customer grievance protocols in place. What is the average response time for general plan and eligibility questions? Complicated claim questions?

Grievances & Appeals

When a member has a grievance we take it very seriously. Our supervisors and managers return calls within 24 hours, and CSRs are comfortable escalating issues to them. We respond to general plan and eligibility questions within 24 hours. For complicated claim questions, we will get back to the member in 24 hours and resolve it within 72 hours.

3.1.2.16 Describe what services or information is available to PEBP participants and/ or PEBP staff via your website.

Employees are able to access data and submit inquires online as well as receive responses. HealthSCOPE Benefits offers very comprehensive web access capabilities on a real time basis, including a participant portal that allows employees and their families' access to the following:

- **Claims Status & History**
- **Eligibility Status**
- **Account Balances**
- **Deductible and Out of Pocket Status**
- **Frequently Asked Questions**
- **Claim Forms. Direct Deposit Forms, Etc.**
- **Email for Questions Online**
- **Changing of Passwords if Email is on File**
- **Health Care Account Benefit Calculator**
- **Dependent Care Account Benefit Calculator**
- **Eligible Expenses for FSA**
- **Eligible Over-the Counter Expenses for FSA**
- **SPD**
- **Health & Wellness Information**
- **Summary of Benefits**
- **View/Print EOBs**

- **Links to PPO Directory**
- **Consumer Driven Tools**
- **Plan Cost Comparison**
- **Procedure Cost Comparison**
- **Hospital Quality**
- **Links to PBM**

3.1.2.17 What is your organization's average turnaround time for responding to customer email inquires?

We will respond to customer email inquiries within 24 hours during the business week. Weekend inquiries receive responses on Mondays.

3.1.2.18 Does your organization perform annual customer satisfaction surveys? Please provide a copy of your customer satisfaction survey. Please confirm that your organization will perform this service for PEBP at no additional charge.

We work with our individual customers to conduct surveys at a time that makes sense to their members. We utilize web-based surveys, typically survey once per year, and often do it at the time members are updating COB. Depending on the group, 25%-100% could be surveyed.

Please refer to Exhibit 3 to reference the sample Customer Satisfaction Survey.

We will perform this service at no additional charge.

3.1.3 Management Reporting

The TPA must provide management reports in a format approved by PEBP. Quarterly and annual reports will be provided by the due dates provided by PEBP. The TPA must provide access to assigned PEBP staff to the TPA's web based reporting tools. The TPA is also expected to have the capability of providing ad hoc reports at PEBP's request at no additional cost. Ad hoc reports will be provided to PEBP on a mutually agreed upon date. All reports will be provided to PEBP in electronic media format. A hard copy of reports will be provided if requested by PEBP. An electronic media format copy of each report will be provided to PEBP's actuary if requested by PEBP.

Confirmed

3.1.3.1 PEBP requires a weekly claims inventory report that should include the number of unprocessed claims (medical and dental), pending claim detail (to include number of pending claims and dollar amount of pended claims and the length of time claims have been in a pending

status), a 12-month look back of number of claims and total claim dollars, the prior week's hospital claims received with charges greater than $100,000 to include in network and out of network and ICD-9 codes, claims greater than $100,000 that are pending, continuous list of participants with claims expenses exceeding $750,000 (lifetime), and total number of claims received but not yet processed. Please confirm your organization's willingness to provide this service at no additional cost to PEBP.

Confirmed

3.1.3.2 The TPA is required to provide PEBP staff with access to reporting tools that allows for completion of the quarterly Self-Funded Utilization Report. Currently, PEBP uses MED-STAT as the data source for its utilization reports. Please see the PEBP website for examples of Utilization Reports (http://www.pebp.state.nv.us/informed/financial.htm).

Confirmed

3.1.4 Claim Processing Service

3.1.4.1 What is your organization's expected daily productivity level for medical claims analysts? For dental claims analysts?

We do not have specific dental analysts. All our analysts pay both medical and dental. Expected minimum production for any analyst is 150 per day.

3.1.4.2 What is the average length of employment with your organization for the claims analysts who will manage PEBP's claims?

6 years

3.1.4.3 Does your claims department assign specialty claims such as hospital claims, COB claims or multiple surgery claims to your more experienced claims analysts? Please explain your office procedure for managing these types of claims.

The only specialty review is for claims over $25,000. These claims are reviewed by analysts, supervisors, managers and directors for accuracy. Our analysts are assigned release authority based on experience. New hires have zero dollar authority until they have passed 100% audits for a time. They are gradually increased in authority until they reach first base level of $5,000. More experienced analysts have $10,000 and $15,000 authority based on experience. Supervisors have $35,000 authority, managers $75,000 and director $2,000,000. This authority level ensures that high dollar claims are reviewed by multiple levels before release.

3.1.4.4 Please describe your organization's auto-adjudication process.

The following plan provisions are all automatically adjudicated by our claims system: coordination of benefits, application of deductible

limits, out-of-pocket maximums, R&C fee allowances, frequency of service edits, annual/lifetime maximums, overage dependents, fee schedules, copayments and I-Accounts.

3.1.4.5 Will PEBP have the authority to determine what claims can be auto adjudicated based on factors such as claim type, dollar limits, service type or other?

Yes, we can work with PEBP on this. We think PEBP will agree with our normal procedures, as we stop more claims than most administrators because we want to use the experience of our analysts to manage our customer's costs.

3.1.4.6 For your organization's entire book of business, what percentage of claims from July 1, 2009 through June 30, 2010 was auto-adjudicated? Please report medical and dental claims separately.

For the reporting period or 7/1/2009-6/30/2010, Medical auto-adjudication was 37.30% and Dental was 56.19%. We believe our lower auto-adjudication rates provide a better service to our clients by allowing an additional level of review a human brings to the process.

3.1.4.7 Specify the details of the claims adjudication software system you currently use. Is this system proprietary to your organization or is it leased and maintained by licenses? If your organization leases this system, define who is responsible for upgrading, maintenance and troubleshooting of system issues.

We utilize the Insur-Claims system from Healthaxis for the servicing of our clients. This is a highly automated platform featuring fully integrated enrollment processing, medical management records, claims adjudication, provider record management, and Internet self-service. This system is "paperless" in that all documents received in our office are imaged and indexed to a sophisticated workflow.

Insur-Claims has been utilized for over twenty (20) years. As it is only available on a single-release basis, all clients share a common version with releases received monthly. A significant feature of this system is its "Best Share" program, which enables users to direct and prioritize system enhancements.

Insur-Claims is leased/accessed through HealthAxis on an ASP basis with the system hosted in an IBM Data Center in Pearl River, New York; several back-up facilities are utilized for disaster recovery purposes. HealthAxis is SAS 70 accredited and undergoes annual review.

Seven (7) years of data is stored online, while the remaining data is archived. Service Level Agreements are maintained with HealthAxis in regard to system responsiveness and "up time".

Healthaxis is responsible for upgrades, maintenance and trouble shooting.

3.1.4.8 Please provide specifics on your organization's claims adjudication

system: when the system was implemented, when it was last updated, how maintenance functions for claims history and plan provisions are performed and how soon after plan changes are implemented is the system updated to reflect those changes? Please describe this process in a separate attachment. PEBP encourages proposing vendors to provide a narrative report as well as a flow chart diagram.

HealthSCOPE Benefits utilizes multiple services provided by Healthaxis for client administration and claims adjudication. Healthaxis, based in Dallas, TX, has been HSB's claims system vendor since 1992. Healthaxis does not use a traditional monthly, bi-annual or annual system update release schedule. Instead, Healthaxis provides system updates & modifications based upon their clients' needed; thereby making it easier & quicker for HSB to deliver system changes to its clients. Plan maintenance changes can be implemented as quickly as the same day of notification, or could take several days depending upon the complexity of the change requested.

Please refer to Exhibit 4 to review our flow chart diagram.

3.1.4.9 Can your claims adjudication system be customized to meet the needs of PEBP? Some customization requests could include, but not be limited to: plan design changes, network additions/ deletions, integrating deductibles (medical/ prescription) for individuals and families who are participants of a consumer driven high deductible health plan.

Yes, our system has unlimited customization capabilities. We have never found a benefit we can't program, and integrating deductibles is something we have significant experience in.

3.1.4.10 Does your organization plan to implement or change its claims adjudication system in the next twelve to twenty-four (12-24) months? Does your organization plan to change systems during the length of this contract?

No, we do not plan to implement or change our claims adjudication system or to change systems during the length of this contract.

3.1.4.11 PEBP does not agree to any system upgrades or changes that will affect its claims processing without a minimum of six (6) months notice from the TPA. Permission to move or migrate any PEBP claims to another system other than the one listed in 3.1.3.7 will require written notification at least six (6) months prior to any migration and work will not commence until written approval is given by PEBP and will require coordination with PEBP and PEBP's health plan auditor. Please confirm your organization's acceptance of these terms.

Confirmed

3.1.4.12 Describe your organization's procedure for accepting electronic

submissions of medical, hospital, dental and vision claims from providers. Please describe this process in a separate attachment. PEBP encourages proposing vendors to provide a narrative report as well as a flow chart diagram.

HealthSCOPE has multiple EDI interfaces established with several provider networks - many dictated based upon HSB's clients needs, as well as can accept standard EDI claim via the clearinghouses Emdeon & Availity, with a new EDI interface with the clearinghouse Claimsnet currently being developed. HSB's claims system vendor, HealthAxis, has extensive EDI development expertise and can easily implement additional interfaces based upon a client's unique needs.

3.1.4.13 Explain how checks/drafts, explanation of benefits (EOBs), and/or letters are produced by the system. Where are these produced and mailed? How often are EOB's and checks produced and mailed to participants and providers? Please describe this process in a separate attachment. PEBP encourages proposing vendors to provide a narrative report as well as a flow chart diagram.

Checks/drafts and Explanation of Benefits are generated on a daily basis. The payments/EOBs are generated during an after hours processing in our claim system each day. A transaction file is sent to our electronic payment/consolidation processor to determine which transactions may be paid electronically and which will pay via check. Once the check run has been funded, a file is sent to our print vendor for paper checks and EOBs and the electronic payments/electronic EOBs are generated. The checks print and mail from Dallas, Texas. A family EOB is produced and sent to the members monthly. Or if desired, individual EOBs can be provided with each claim.

Please refer to Exhibit 5 to reference our EOB & Check Production narrative report and flow chart diagram.

3.1.4.14 Will the system link interim hospital bills processed separately for data reporting and/or analysis? Explain how the system links the interim hospital bills.

Yes, our data warehouse will link interim bills by bill type automatically. The system links these based on the type, patient and provider tax ID.

3.1.4.15 Describe your organization's procedure for claim overpayment recovery administration. If your organization utilizes the services of a separate overpayment recovery firm, please indicate this. Please provide a sample copy of the overpayment report that your organization will provide to PEBP.

All claim adjustments processed in our administration system are subject to complete reporting, both internally and to our clients. All adjustments begin with (and are linked back to) the original transaction.

• Underpayment

When the claim is re-adjudicated, an additional payment is issued and the claim is reflected in the system with two (2) parts.

• Overpayment

When the claim is re-adjudicated, the original claim is reversed and the new claim is completed with the overpayment being tracked in the system; a series of requests for payment letters are issued until the overpayment is received and posted.

1. **After creating an overpayment in the system, a letter will generate to the provider explaining the amount needed and an explanation as to why we overpaid the claim.**
2. **Letters will continue to generate until we send a final demand type letter. If money is received during the process of letters, once worked back in system, the letters stop. These letters and checks are worked as a priority.**
3. **After 6 months of no payment, the file is turned over to ORS to collect for us.**

Please refer to Exhibit 6 to reference a sample overpayment report of what can be captured showing outstanding money for a client. The columns would be completed with the client's data related to the claim.

3.1.4.16 Describe your procedures for lost, returned and uncashed checks.

All checks issued by HealthSCOPE Benefits have 180 days before they reach a stale date. The outstanding check list is reviewed and any checks that are over 180 days old may be voided and the client's required funding is reduced by the amount of the voided checks. A record that the check was voided due to stale date is noted in the claims system should the provider/member contact us stating they did not receive the original check. They payment will then be re-issued.

As for lost checks, this would come in via a call from member or provider stating "lost" the check. They have to complete an affidavit of forgery form basically stating they didn't get the check or cash it. We also check to be sure it's not cashed by anyone else and if not, we will void the check and reissue with corrected information obtained in documents.

3.1.4.17 Can the system issue multiple payments on a single transaction (bulk checks)? Please describe your procedure.

Yes, we issue bulk checks to providers based on check release date.

3.1.4.18 Is there a maximum and minimum dollar limit on checks issued? Please describe.

No, unless the client requests.

3.1.4.19 Does your organization have the ability to direct deposit for provider or participant reimbursements at no additional cost to PEBP? Please explain.

Yes, we can direct deposit for provider or participant reimbursements at no additional cost to PEBP. Clients will be required to deposit funds into the account as checks are cut. If checks are cut daily, funds must be deposited at least twice a week. If checks are cut weekly, funds must be deposited on a weekly basis. If the client has their own bank account, they can deposit as the please.

3.1.4.20 PEBP requires notification of any claim payment greater than $100,000 prior to payment. PEBP staff's approval is required for any claim payment greater than $200,000. Please confirm your organization's willingness to comply.

Confirmed. It is our practice to inform clients of all claims over $25,000 prior to payment.

3.1.4.21 Does your system automatically alert analysts of actual and potential errors? How are these errors corrected?

Yes, our claims system has built in edits for some actual and potential errors and prompts analyst to review. Depending on the error, we may call providers and get clarification on bill and document calls, or we may deny the claim and request clarification or correction in writing. Some edits advise to bundle codes together or deny completely so we would follow those edits. The analyst can correct them as they are processing the claim.

3.1.4.22 Explain how the system automatically identifies duplicate data entries and duplicate claims. Describe the criteria used to edit for duplicates. Do the claims analysts have override capabilities for potential and actual duplicate claim entries?

Our claims system uses various combinations of the date of service, providers tax ID, procedure code, modifier, service code, bulled amount and tooth number – all both within the current claims as well as the claim history, to either systematically deny the claim as a duplicate or suspend the claims as a possible duplicate for further investigation by the analyst.

HealthSCOPE Benefits goes above & beyond to help manage our customer's costs. We have the McKesson edits built into our system that looks for bundling and unbundling. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur. We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm, Mulally & Associates. We have done this so that our audits are fully independent and there is no "fox watching the hen house."

In addition, our claims supervisors receive a report each morning to review possible duplicate claims paid the day before to ensure overrides are correct.

3.1.4.23 Are claim dollar limitations and procedural claim restrictions for individual claims analysts provided for in the software program? Please describe in detail your internal process.

Internally, there is an authority level hierarchy in place with established dollar limits for Claims Analysts, Supervisors, Managers and Directors; this will ensure the claim (depending on dollar amount) has several levels of review before release. We also have various reports available through our claims system to ensure timeliness and accuracy of processing.

New Claims Processors undergo a training program of 4-8 weeks (depending on experience level at point of hire). They are initially assigned no release authority when they begin handling live claims, so they are audited 100%. After demonstrating acceptable accuracy rates, they are increased up to $500 every two weeks with a maximum of $2,500 during their first year. During the second and third years the maximum release authority is $5,000. Overall, no processor's authority is above $10,000. Supervisors are able to release $10,000 to $35,000 claims. All claims over $35,000 are reviewed by the analysts/supervisor and signed off by a HealthSCOPE Benefits Claims Director. We require our Claims Processors to process 150 claims per day or 750 claims per week, with a minimum accuracy rate of 99.2%.

3.1.4.24 Describe in detail, your internal fraud and abuse control procedures.

We have a full-time staff of Fraud Investigators in our Nashville office who continually look for provider billing and participant eligibility fraud. This is done through a series of sophisticated databases and complex queries of the claim system.

The HealthAxis claim processing system has functionality built in that assists with detecting questionable claim situations. The scenarios that the system prompts with could contain indicators of fraud and should not be bypassed or overridden without this thought in mind.

Many of our daily claim practices are ways to combat 'soft' fraud where the 'intent' was not to commit fraud. They can also detect 'hard' fraud where the 'intent' was to commit fraud. HealthSCOPE Benefits identified more than 200 cases of fraud or questionable billing practices last year.

3.1.4.25 Are the claims analysts that will be assigned to PEBP trained to detect and report healthcare fraud? How does your organization validate provider claim integrity?

Yes, new hires take online tutorials on detecting possible fraudulent claims and referring such claims to HealthSCOPE's Special Investigations unit. The tutorials main topics include: Medical Provider Fraud, Consumer Fraud, Rent-A-Patient and Drop Box Scams, Prescription Drug

Fraud, and any suspect claims are submitted to our Fraud Investigations unit for handling. Our provider maintenance will validate provider claim integrity prior to payment.

3.1.4.26 Please provide your organization's definition of a "clean claim".

Unless otherwise required by law, a Clean Claim means a completed UB-04 or CMS-1500 paper or electronic forms (or successor forms) as appropriate that meets the requirements of the NUBC guidelines and contains all information reasonably necessary to facilitate processing and payment of such claim that is undisputed and contains accurate initial supporting documentation from the Provider.

A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements of the standard claims forms, along with any attachments and additional elements, of which the provider has knowledge, Claims for inpatient and facility programs and services are to be submitted on the UB-04 and claims for individual professional procedures and services are to be submitted on the CMS-1500. In addition, claims may be submitted electronically through a contracted clearinghouse.

3.1.4.27 Explain how group practices, hospital associations, clinics, and other provider groups who utilize the same tax identification are identified and managed by the system.

Provider groups who have individual practitioners or groups billing with CMS-1500 are handled on one provider record. Provider records are named after the Tax ID's legal name with IRS. Individual practitioners are attached to this record. The provider group locations (both payment and physical) are attached to this record. Any providers that bill with a UB04 and have individual DBA names under the Tax ID will have a provider record for each DBA, each location. Further identification is done using the NPI number.

3.1.4.28 Describe the type of coding your organization uses for the following, i.e. CPT, ICD-9, etc:

- Medical/surgical - **CPT**
- Diagnosis – **ICD-9**
- Dental - **CPT**
- Vision - **CPT**
- Durable Medical Equipment (DME) - **HCPCS**
- Anesthesia - **CPT**

3.1.4.29 Specify the types of claims on which your organization requires ICD-9, HCPCS, CDT and CPT coding before processing will be completed. If a claim is submitted without this information, describe your organization's process for obtaining this information.

- What guidelines are used to differentiate among similar written

descriptions in order to assign an accurate code?

- Are codes entered by claims analysts or special data entry staff? Are codes electronically transferred from the form submitted by the provider? Please explain.

We accept the standard CMS-1500 forms or UB04 forms from facilities. Only in special occasions will we accept a "superbill" which is the paperwork a member would get when they pay for services upfront. For those we would need the cpt or hcpc codes billed, charges, and the diagnosis in order to consider the claim for processing. We accept ICD9 and ICD10 beginning in 2011 for diagnoses.

Our claims can come in via electronic vendors that physicians or facilities may use. Some examples include Emedon, Web MD, and for Medicare primary members, we work with Capario for an automatic feed from the Medicare payor to us as secondary payor. They may also send their claims via paper to the Dallas address. If paper is received, our claims software vendor images and keys those into our system. If the claims are electronically submitted, there is a transfer of data.

Once the claims are in processing system, they roll out to the processor(s) assigned to the client. They are worked in date received order.

All claims must be in English and US dollars to be considered. If foreign claims received, we will need interpretation in order to process claim and we retain a copy of the foreign claim as well for audit purposes.

3.1.4.30 The Center for Medicare and Medicaid Services (CMS) has mandated that by January 1, 2012 all HIPAA covered entities must have EDI Version 5010 implemented. Is your organization prepared to meet this requirement? Give details on how this mandate will affect PEBP and your organization's management of the PEBP account.

Yes, we are prepared to meet this requirement. At this time, we do not anticipate this will greatly affect PEBP. We will develop a transition plan to accept claims in both 4010 and 5010 formats for a period of time as it will take time for providers to also modify their systems for the new format. HealthSCOPE Benefits has a client newsletter, *Healthy Business*, via which we will communicate any potential impacts to our clients and/or our client's members from this transition.

3.1.4.31 Subsequent to the EDI Version 5010 conversion, ICD-10 will be officially adopted by the U.S. on October 1, 2013. Is your organization prepared to meet this mandated deadline? How will your organization prepare PEBP, its providers and participants for any changes that this mandate and the EDI Version 5010 mandate could cause? Please give details on your work plan to implement ICD-10.

Yes, we are prepared. We have a conversion plan in place. This conversion will not interrupt claims processing because of the ability of Healthaxis to do releases on weekend updates.

Similar to our 5010 efforts, we will develop a transition plan to accept

claims using both ICD9 and ICD10 codes for a period of time as it will take time for our providers to also modify their systems for the new codes. We will also utilize the *Healthy Business* newsletter to communicate any potential impacts to our clients and/or our client's members from this transition.

3.1.4.32 Is the system that your organization listed in 3.1.4.7 prepared to manage the implementation of EDI Version 5010 and ICD-10? Is there a conversion plan in place? Will this conversion interrupt the claims processing of PEBP? Provide details.

Yes, Healthaxis and HSB are prepared. We have a conversion plan in place. This conversion will not interrupt claims processing because of the ability of Healthaxis to do releases on weekend updates.

3.1.4.33 Describe in detail your organization's procedure for verification of the accuracy of provider coding (i.e. unbundling, code creeping, etc.).

Our claims system checks for bundling/unbundling of claims. We utilize the latest version of McKesson Clinical Edits Software, which incorporates information from CMS, the AMA and various specialty societies into the edits development and validation process. This approach enables stronger edit rationale backed by industry accepted standards and common clinical practice. The criteria include CPT codes, modifiers, and types of service.

External mechanisms include the outsourcing of our random claims auditing and high dollar claims review to a professional audit firm. Mulally Associates reviews 2% of all claims processed on an ongoing basis. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors.

In addition, AIM Healthcare reviews DRGs and all claims exceeding $50,000 for post-payment onsite review. All claims over $50,000 are reviewed in detail by the President of HealthSCOPE Benefits.

Internally, there is an authority level hierarchy in place with established dollar limits for Claim Analysts, Supervisors, Managers and Directors; this will ensure the claim (depending on dollar amount) has several levels of review before release.

3.1.4.34 Describe in detail how your organization processes anesthesia claims.

We have system software that prompts analyst to enter base rate, time, conversion factor and physical status modifiers. The software then makes the calculation for the allowable. Some PPOs supply the allowable and we are also able to enter that rate.

3.1.4.35 Describe how your organization processes multiple surgery claims.

STEPS FOR PROCESSING CLAIMS WITH MULTIPLE SURGICAL PROCEDURES

>>Determine if multiple procedures in the CPT code range 10000 through 69999 were performed during the same operative session.

10000 – 19999 – INTEGUMENTARY SYSTEM – Skin, Subcutaneous & Accessory Structures
20000 – 29999 – MUSCULOSKELETAL SYSTEM
30000 – 32999 – RESPIRATORY SYSTEM
33000 – 39999 – CARDIOVASCULAR SYSTEM
40000 – 49999 – DIGESTIVE SYSTEM
50000 – 53899 – URINARY SYSTEM
54000 – 59999 – MALE/FEMALE GENITAL SYSTEM
60000 – 64999 – NERVOUS SYSTEM
65000 – 69999 – OCULAR/AUDITORY SYSTEM

>>Check the Plan benefits for any specifics on handling multiple surgery claims.

A Plan may have incremental decreased reimbursement for the second and tertiary procedures (i.e. 100%, 75%, 50%, 25%) during the same operative session.

>>Check the CPT code lists for codes that are exempt from multiple procedure reductions.

>>Check for Modifiers
-50* Bilateral Procedure
- 51* Multiple Procedures
-59* Distinct Procedural Service ("scrubbed" from the claim)

>>Follow guidelines for any edits indicating unbundled or incidental procedures.

>>The allowance is determined by using 100% of the code with the highest allowable amount and 50% for each lesser procedure during the same operative session.

3.1.4.36 Describe how your organization processes assistant surgeon claims.

The Client's Plan Benefits are reviewed for any specifics on handling Assistant Surgeons. If no specifics, 20% of the amount allowed for the surgeon is used as the allowable for the Assistant Surgeon. Based on the CPT code, the system will display an edit if that procedure does not require an Assistant Surgeon.

3.1.4.37 Will your organization, on behalf of PEBP, negotiate with out of network providers to obtain discounts off billed charges? Please explain your process in detail. If there is a fee for this service, please

include your fee in your cost proposal.

Yes, we will negotiate with out of network providers to obtain discounts off billed charges. The fee is 25% of savings. Biologics is charged at $125/hour.

HealthSCOPE Benefits pays between 12% and 25% for access to out of network, negotiation and auditing firms.

Devon Health's Consilium solution provides both out-of-network claim negotiations and the use of secondary network repricing.

Their claim negotiation model uses techniques that provide our clients with discounts that are well above the industry average. A typical claim negotiation process will start at the billed charge on a claim, which is extremely flawed and yields sub-par discounts. With the Consilium solution, Devon Health negotiators have access to a proprietary database containing over $40 billion in paid claims data. This database contains benchmark data from national, regional, and local payers, as well as Medicare, to determine fair market value for reimbursement on services rendered. The focus in our model is shifted from the billed charges to what is considered fair reimbursement. The Consilium solution produces average savings that are up to double the national standard and it mitigates the risks associated with UCR repricing and legacy cost-containment methods. Our negotiators also receive 100% sign off from the providers, which eliminates provider appeals and discount reversals.

Although Devon strongly believes that direct negotiation is the most effective method of receiving higher discounts on out-of-network claims, there is also value in using non-logo secondary networks in some situations. These partners allow non-logo network access, and have contractual arrangements in place with providers to accept the discount.

Devon uses a proprietary algorithm, programmed into its IMPACT claims database, to determine which claims are best suited for negotiations and which would be best to send onto one of its secondary networks. While our primary focus is on leveraging our negotiations program, we have developed a sophisticated program for routing claims to secondary networks as well. We call this "Intelligent Routing". Devon has been able to develop a process whereby we are able to ascertain which is the best network to send each claim to on the *provider level*, rather than regionally or traditionally tiered like most secondary network vendors. Devon also does not own its own secondary non-logo network so it does not have an incentive to push one network over another – Devon will simply pick which network will attain the greatest level of savings to the client.

Cost Containment Programs available include:

We have a department (EDGE) specifically in place to review non-network claims. All non-network claims are routed to this department and in networks claims with low discounts or add changes. The claims will be identified as out-of-network by a claim analyst using the Electronic Data Interchange (EDI) method. Claims can be routed to our out-of-network pricing vendors via Devon Health. HealthSCOPE Benefits has several relationships with out-of-network vendors, Devon Health NPPN, an Multiplan and our own in-house negotiation team .

Dialysis Cost Containment.

HealthSCOPE Benefits, Inc. has partnered with Dialysis Cost Containment, Inc. ("DCC"), a member of the PRN Family of Companies. DCC offers an array of unique programs specifically designed to significantly reduce costs while safeguarding the patient from balance billing. These programs are described below:

UCR Program. This program allows DCC to apply its own UCR payment methodology to the dialysis claim. This UCR methodology is based on the average revenue received by the providers per treatments. Under this program, a health plan can realize an average savings of over 80%.

Home Health Dialysis Program. This program features use of a portable or transportable machine that significantly reduces the side effects seen in center or facility dialysis, extends life expectancy, improves the transplant success rate, and reduces or eliminates dietary restrictions typically necessitated by ESRD. The patient's participation in the program not only enhances the quality of the patient's life, but is also results in a reduction of the patient's medical costs.

Epogen Carve Out Program. This program is designed for those patients who are receiving Epogen treatments (often the highest cost of dialysis) in connection with their ESRD. Under this program, DCC acquires the Epogen and coordinates the dispensation of the drug by working directly with the patient and patient's physician. Under this program, the patient is permitted to self-inject the Epogen in a home setting and DCC is able to arrange the purchase and delivery of the drug at less than the average wholesale price. A patient's participation in this program can result in a reduction of Epogen treatment costs by an average of 90% while, at the same time, giving the patients more control over their treatment and enhanced quality of life.

Negotiated Discounts and Repricing. Under this program, DCC will negotiate directly with networks and providers for purposes of securing a better discount than that which would normally be available under a traditional network arrangement. Through our partnership with DCC, we are pleased to offer the services described above. For more information concerning the DCC programs, contact your HealthSCOPE Benefits, Inc. account executive.

OncoSentrics is a program administered by Biologics, Inc., the premier cancer management company in the U.S. Biologics is based in Cary, NC, and works with payors, manufacturers, cancer researchers, patients and providers throughout the U.S. First introduced in 2005, OncoSentrics has received accolades from payors for its focus on evidence-based guidelines and integrated clinical care teams which have resulted in an average 8:1 net return on investment.

Biologics strongly believes that cancer cost containment begins with optimizing the care for every patient. This is best achieved using national standards of care and highly skilled nursing support for the patient and family. The program includes:

Provider Relations – Our program works with comprehensive cancer centers and community-based technology practices for diagnostic work-up, staging, plan of treatment development and treatment phases with efficiency and high level coordination of care and facilities prompt

and appropriate reimbursement for the provider with the claims administrator.

Chemotherapy Plan of Treatment Review – OncoSentrics begins at the point of diagnosis, collecting a patient's entire plan of treatment – including all drug formulations – and conducting a proactive, ongoing review of the chemotherapy plan of treatment. This unbiased review follows evidence-based guidelines and validates the plan of treatment. Biologics' Oncology Advisory Board is available for additional insight and guidance.

Patient Management – From coping with severe side effects and complex dosing regimens to managing overall concerns about recovery, cancer patients require special support during their course of treatment. OncoSentrics addresses these issues with personal communication telephonically from an expert care team who helps the patient successfully navigate his or her disease between physician appointments. Spanish speaking professionals on staff and language line capabilities for all other languages.

Claim Review – Today's oncologists develop treatment plans that take advantage of the latest and best therapies. This often translates into a complex regimen of multiple drugs, formulations and cycles. A variety of unit sizes, challenging names and billing codes make a claim even more complex. Our cancer treatment expertise allows us to provide a comprehensive, prospective audit of the claim to ensure accuracy and appropriateness based on the plan of treatment.

Performance Reporting – OncoSentrics delivers semi-annual and annual reports demonstrating direct and indirect savings that provide payors a detailed understanding of their cancer spend. By leveraging our cancer care expertise, payors can utilize this information to identify trends and establish forecasting models among their members.

PHX -

Since 2003, PHX has been the industry leader in advanced cost management solutions for health plans. Their results-driven, innovative, customized, integrated solutions allow you to effectively gain control of rapidly increasing healthcare costs and reduce costs at every step of the claims process, from claims routing to data analytics. Using a personalized approach and sophisticated technological tools they can maximize your savings in both the near and long term – while dramatically reducing errors and turnaround time.

Our PHX team includes highly skilled cost management experts, medical professionals, and IT specialists who understand the complexities of data analytics, PPO network management, clinical billing and coding, and claims editing. That experience enables us to develop end-to-end solutions tailored to meet your specific needs – and deliver real value and significant cost savings.

3.1.4.38 Describe in detail how claim inventory (unprocessed claims) is monitored and managed. Please describe this process in a separate attachment. PEBP encourages proposing vendors to provide a narrative report as well as a flow chart diagram.

We have multiple reports available to monitor claims inventory.

1. **Claims Tracking Report (Scan Track Report) – This report is ran by client and is a quick break down of oldest claim and status. Quick entry is status of manually keyed claims. Front end is status of claims that were partially entered and need additional information to continue the data entry process. Fixits are both paper and EDI claims that need manual intervention for proper matching to member, dependent or provider address. DI is status for claims that have to be reviewed for system edits based on specific plan benefits or clinical edits. ES is status for claims that an analyst has suspended for various reasons awaiting additional information.**

2. **Scan Track Report Detail – This report gives individual system detail of report above.**

3. **DS. Trans Report – Gives specific detail by client along with system edits.**

4. **DS. ES. Report – Is an ad hoc report that can be run by client that captures individual notes placed on a claim.**

The Scan Track report is produced and reviewed daily. The other reports are monitored bi-weekly to pinpoint specific claims.

We utilize one additional report to monitor all claims with billed charges greater than $25,000. This report is produced daily for review and distributed bi-weekly. These claims require more time as they are high dollar and we monitor these very closely to make sure we are processing correctly and getting the best discounts available for our clients. These are also claims that are on patients with catastrophic illnesses and require greater interface with case management vendors and reinsurance involvement.

Please refer to Exhibit 7 to reference these sample reports.

3.1.4.39 Describe how turnaround time is monitored and managed.

Please refer to Exhibit 9 to reference a copy of our TAT Report. There is one report by individual client and one by overall claims directory. By using this report which can be run on an ad hoc basis along with the reports above, we can monitor TAT by client.

3.1.4.40 Explain how you measure turnaround time. When is a claim considered "processed" for turnaround measurement purposes?

When claim is adjudicated or finalized.

When is a claim considered received?

The day it is received in our office or claims system for EDI claims.

How are the following claims treated in measuring turnaround time?

We do not differentiate by type of claim. All claims are counted the same

regardless of inpatient or outpatient or type of service. We monitor from the day they are received to the day finalized.

- Inpatient hospital (with precertification)
- Inpatient hospital (without precertification)
- Outpatient hospital
- Multiple surgery claims
- Anesthesia
- Laboratory
- COB
- Pended claims

3.1.4.41 Complete the following for the office that will process PEBP's claims.

Turnaround Time	Percent of Claims Processed In	
	0-14 calendar days	0- 30 calendar days
2008 Objective	**90%**	**99%**
2008 Results	**94.2%**	**99.5%**
2009 Objective	**90%**	**99%**
2009 Results	**92%**	**99.6%**
2010 Objective	**93%**	**99.5%**
2010 Results **YTD**	**94%**	**99.7%**

3.1.4.42 Describe the claim processing workflow including your scanning and OCR process, from point of claim receipt to issuance of a pend letter, deductible notice, claim denial and claim payment. Please attach a copy of a current claim workflow diagram, include the physical location for each of the items on the workflow chart. For example, if incoming mail is received and sorted at another worksite than OCR or claims processing, give the address/ physical location of each.

Please refer to Exhibit 8 to reference our Claims Work-Flow/Cost Control Flow Chart Diagram.

3.1.4.43 Describe your procedures for tracking pended and/or suspended claims.

- Are they maintained on the system?
  - **Yes**
- Are periodic status reports generated?
  - **Yes, everyday**
- How often is the pended/suspended claim report reviewed for possible action?
  - **Daily**
- When is a claim considered "closed"?
  - **When an EOB is sent out**

- How do you define a pended claim?
  - **A pended claim was received and needs pre-certification, repricing or itemization before payment can be made.**
- How do you define a suspended claim?
  - **We do not suspend claims**

Please provide a sample of your pended and/or suspended claim letter to providers and participants.

Please refer to Exhibit 9 to reference our sample pended claim letter.

3.1.4.44 Does your organization attempt to obtain missing claim information via telephone call inquiry rather than pending the claim? If yes, please explain your internal process.

Yes, we do. If we can obtain an itemized bill or coding clarification our analysts will request it by phone prior to denying the claim.

3.1.4.45 What process do you use to evaluate medical and dental services that <u>are not</u> obviously covered or excluded under the plan? Does your organization use the services of an outside medical and dental review company? If there is an additional cost for this service please indicate the cost in your cost proposal.

For questionable services, we use a nurse reviewer to review the services. If we can obtain an itemized bill or coding clarification our analysts will request it by phone prior to denying the claim. Nurse Reviews are $85 per review and Physician Reviews through an IDR are charged at cost.

3.1.4.46 Describe in detail how your organization processes dental pre-estimate requests.

HealthSCOPE Benefits processes dental pre-estimate requests by processing the request as if it was a claim. We enter all of the fields and indicate to the system that it is a pre-estimate. Upon this indicator being flagged, the estimate is complete and an EOB will be mailed to the member the next day.

3.1.4.47 Does your system automatically edit for the following?

- Pre-certification review - **Yes**
- Retrospective review if lacking a pre-certification - **Yes**

3.1.4.48 Does your organization's EOB indicate the status of the deductible, out-of-pocket limit and other inside plan limits? Does the EOB indicate the amount of charges that are the member's responsibility? Do you have the capability to produce electronic EOB's?

Yes, our EOB indicates the status of the deductible, out-of-pocket limit and other inside plan limits.

Yes, the EOB indicates the amount of charges that are the member's

responsibility.

Yes, we have the capability to produce electronic EOB's.

3.1.4.49 Please provide a sample of your organization's typical EOB and Provider Remittance Advice. Can an EOB or Provider Remittance Advice be customized to meet PEBP's needs? Is there an additional charge for customization?

Please refer to Exhibit 10 to reference these sample documents. Yes, these can both be customized to meet PEBP's needs at no additional charge.

3.1.4.50 Indicate the percentage of automation for the items listed below, according to the following categories:

- Automated: The data is accessed and adjudicated automatically by the computer in processing the claim.
- Mixed: Data is accessed by the processor and manually entered into the computer, which then completes the claim processing procedure.
- Manual: The analyst accesses data and the analyst completes the benefit calculation. The computer is not involved or involvement is limited to updating claim history.

Claim Processing Procedure	% Automated	% Mixed	% Manual
Claim Adjudication			
• UB 92	27%	N/A	73%
• HCFA Forms	45%	N/A	65%
• Non UB 92 & HCFA Forms	57%	N/A	43%
UCR Limitations			
• Medical	100%		
• Dental	100%		
• Vision	100%		
PPO provider contracts	80%	15%	5%
Eligibility verification			
• Participant	100%		
• Dependent	100%		
EOB messages	90%	5%	5%
PEBP plan specifications such as:			
Annual Plan year deductibles			
• Individual	100%		
• Family	100%		
Annual Plan Year Coinsurance and Out of Pocket Limits			
• Individual	100%		
• Family	100%		

Claim Processing Procedure	% Automated	% Mixed	% Manual
Plan Annual & Lifetime Maximums or Benefits Paid			
• Dental	100%		
o Annual PPO Maximum	100%		
o Annual Non-PPO Maximum	100%		
• Vision	100%		
• Medical	100%		
Annual Frequency Maximums			
• Dental	100%		
• Vision	100%		
• Routine Physical	100%		
• Preventive Care	100%		
Coordination of Benefits	100%		
Duplicate bills	90%	10%	
Electronic Provider Billing	80%	20%	
Negotiated reimbursements			
• Per diems	50%	25%	25%
• Per case	25%	50%	25%
• Physician fee schedules	100%		
• Discount off charges	100%		

3.1.4.51 Regarding each of the UCR services listed above, please provide:

- The source of your data

  Ingenix

- The percentile used

  90%

- Frequency of updates

  Quarterly

- Method of updates (manual or electronic)

  Electronic

3.1.4.52 Describe how your organization's system will flag PPO providers and apply negotiated PPO rates and discount during claims processing. Also describe the extent to which claims analysts will apply manual processing steps to adjudicate claims form these providers.

When the network allows, we will load the providers and their fee

schedules into our systems for automated pricing. For physicians no manual intervention is needed for pricing that is loaded into our system. Most facility claims can also be automated in our system. Manual pricing is only done with very complex contracts or low volume providers.

3.1.5 Quality Control

3.1.5.1 Describe in detail your quality control program and auditing processes.

Quality control is one of our most important services. Accuracy is paramount for member satisfaction. As a result, we have outsourced our internal audits to Mulally, and we have them review 2% of claims paid every day. This includes 2% of every analyst's claims and 2% of every client's claims. Daily audits allow fast identification of issues. In addition, we welcome external audits because we believe we grow and learn from all audits. We will welcome the interaction with the PEBP auditors and we hope they will visit us for a pre-implementation audit to make sure everything is ready prior to 7/1/11.

Our claims system uses various combinations of the date of service, providers tax ID, procedure code, modifier, service code, bulled amount and tooth number – all both within the current claims as well as the claim history, to either systematically deny the claim as a duplicate or suspend the claims as a possible duplicate for further investigation by the analyst.

HealthSCOPE Benefits goes above & beyond to help manage our customer's costs. We have the McKesson edits built into our system with looks for bundling and unbundling. We have extensive processes to prevent duplicates in the system and reports to make sure overrides don't occur. We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm.

In addition, our claims supervisors receive a report each morning to review possible duplicate claims paid the day before to ensure overrides are correct.

3.1.5.2 Please describe your organization's quality improvement efforts/initiatives aimed at continuously improving the service you provide to all your business partners.

Electronic interfaces, web applications, electronic methods of adjudication and telecommunications are all areas where HealthSCOPE Benefits excels. HealthSCOPE prides itself on our ability to develop and put in place technologies that meet the needs of our customers. We have been receiving and transmitting claims data electronically for years, with a consistent accuracy rate that exceeds 99%. Our claims turnaround time has routinely been well under industry averages, and our ability to move data and eligibility electronically are second to none.

Our flexibility as a privately owned and held company with hands-on ownership that actively leads the company, allows us to make decisions and respond immediately when clients come to us with needs that would include but certainly not limited to benefit design changes, legislative requirements, and population changes. We are committed to providing exactly what our customers want when they want it.

In keeping with the hands on approach to the management of each of our

individual valued clients, we are constantly monitoring our internal infrastructure to make sure we are maintaining standards that are above industry measurements. Our requirements for the number of processors and customer care representatives remain under constant scrutiny. Through years of experience, we have designed staffing models that service our clients into in a manner that exceeds expectations. We manage staff to those criteria adding new associates where necessary. Just as each client is unique in their infrastructure and design, each client is also individual in the needs of their members. Training that is group-specific in regard to culture, location, general age and blue collar/white collar or technology versus manually driven is part of all initial and ongoing training to make sure our staff is handling the service of each customer with sensitivity and individuality. HealthSCOPE has always lead the way in best practices and national standards and benchmarks, and are happy to share our impressive statistics in all areas of plan performance such as claims payment and financial recovery, claims turnaround time, and call wait times. We have the ability to provide detailed reporting on all of these important categories and use this information for continuous quality improvement.

Vendor coordination with external parties is incorporated in the process of managing specific cases. Documentation of pertinent patient information from the vendor is reported in the case notes and is an element of the initial planning and monitoring process for the plan of care developed. Such vendor coordination interaction insures no duplication of services and efficient and effective referral hand-off at the point of closure providing appropriate intervention in the continuum of care for the patient. At all times, data exchange of information follows HIPAA requirements regarding case information.

Specific vendor coordination/integration elements and processes include the following:

- Program Referrals - HealthSCOPE Benefits has experience with client programs where we perform specific services while additional vendors supply other healthcare services (i.e. disease management). An agreed upon criteria/trigger list is set up in the system which provides a patient alert screen to the nurse reviewer indicating potential referral. At any time, clinical judgment is also weighed in a case for potential referral and can be flagged as well.

3.1.5.3 What methods and/or tools does your organization utilize to measure the success of your quality improvement efforts?

Any quality improvement efforts are measured from the initial point of review against results once the improvement is in place. Recent efforts include increasing referrals and participation in Disease Management for one customer by 20%, while another focused on getting 100% of transplant cases managed under a COE arrangement.

3.1.5.4 Describe in detail, your internal claims analyst-training program (content, timing, and performance requirements). Please describe this process in a separate attachment. PEBP encourages proposing vendors to provide a narrative report as well as a flow chart diagram.

Analysts are placed on 100% audit with a zero dollar authority when they begin processing claims.

The sole responsibility of our claims staff is to adjudicate claims. Our Claims Examiners and Claims Supervisors do not handle telephone inquiries, as all calls are taken by Customer Care Representatives.

New Claims Processors undergo a training program of 4-8 weeks (depending on experience level at point of hire). They are initially assigned no release authority when they begin handling live claims, so they are audited 100%. After demonstrating acceptable accuracy rates, they are increased up to $500 every two weeks with a maximum of $2,500 during their first year. During the second and third years the maximum release authority is $5,000. Overall, no processor's authority is above $15,000. Supervisors are able to release $10,000 to $35,000 claims. All claims over $35,000 are reviewed by our external audit vendor and signed off by a HealthSCOPE Benefits Claims Director. We require our Claims Processors to process 150 claims per day or 800 claims per week, with a minimum accuracy rate of 99.2%.

The average tenure of our claims analysts is 10 years.

Sample Class Plan: Please refer to Exhibit 21 to reference the sample claims processing training schedule.

3.1.5.5 What percentages of claims per analyst, per data entry clerk and per adjudicated claim are reviewed on a daily, weekly and monthly basis to assure accuracy of payment? What triggers a review and/or an audit?

Two percent per analyst per adjudicated claim are reviewed on a daily, weekly and monthly basis to assure accuracy of payment. We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm. Mulally Associates reviews 2% of all claims processed on an ongoing basis. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors. This part of our medical admin fee at no additional charge to the customer.

3.1.5.6 Describe your organization's quality control reports? How frequently and under what circumstances are the results maintained? By client? By office? How are the results used?

Audits are done daily with next day feedback to our claims analyst with management team copied. Analysts are expected to respond to potential errors within 24 hours with reasoning if they disagree with audit findings. If external auditor does not accept analyst response it goes to management to review and determine if error stands or not. The final results are kept by client and by analyst in our monthly reports from the auditor. These reports are reviewed for trends by client to see if we have any discrepancies in plan load, etc. The analyst reports are used for performance reviews and training opportunities.

We have reports by client and by office. We receive ongoing reports, weekly and monthly review. Results are used in training to assist our

analysts in quality improvement.

3.1.5.7 What is the ratio of quality control reviewers to claim examiners?

All of our quality control is outsourced to Mulally Associates. We have outsourced this function so that it is truly independent.

3.1.5.8 What types of internal audits are in place to monitor claims administration? What is the frequency of these audits and who performs them?

We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm. Mulally Associates reviews 2% of all claims processed daily. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors. All claims exceeding $25,000 prior to payment are reviewed by 3 internal staff; this is in addition to a HealthSCOPE Benefits Claim Supervisor reviews of all claims exceeding $50,000 for post-payment review. All claims over $50,000 are reviewed in detail by the President of HealthSCOPE Benefits.

3.1.5.9 Explain how your organization will measure and track quality control for the department managing the PEBP account.

We would use Mulally to review 2% of each analyst's claims and 2% of all PEBP claims. We would receive weekly and monthly report sand we are happy to share these with PEBP.

Please attach a copy of your organization's most recent internal audit report(s), with each labeled and explained clearly.

Please refer to Exhibit 11 to review these reports.

3.1.5.11 PEBP contracts with an independent third party to perform external quarterly claims audits of PEBP's TPA. These audits are done on-site at the TPA office responsible for processing PEBP's medical, dental and vision claims. Please describe your organization's experience with independent auditors. Please confirm that your organization will cooperate with PEBP and PEBP's health plan auditor. Does your organization charge for cooperating and providing information to PEBP's auditor during a claim audit? If yes, what is the fee per audit?

We believe independent auditors only make us better. We welcome such a process and we will do all we can to assist them in their audits. There is no charge. We welcome many client specific audits per year, and PEBP will receive nothing but our full cooperation.

3.1.5.12 Please attach a copy of your organization's most recent external claims processing audit report. This question is not referring to your organization's SAS70 report.

Please refer to Exhibit 12 to review our most recent external claims processing audit report from one of our clients, the County of El Paso, TX.

3.1.5.13 Complete the following for the office that will process the PEBP's claims:

Claim Processing Accuracy Objectives	Financial Payment Accuracy	Payment Accuracy Rate	Procedural Accuracy Rate	Overall Accuracy Rate
2008 Objectives	**99%**	**98%**	**98%**	**N/A**
2008 Results	**99.2%**	**99.7%**	**99.36%**	**N/A**
2009 Objectives	**99%**	**98%**	**98%**	**N/A**
2009 Results	**99.4%**	**99.66%**	**99.46%**	**N/A**
2010 Objectives	**99%**	**98%**	**98%**	**N/A**
2010 Results YTD	**99.5%**	**99.66%**	**99.42%**	**N/A**

3.1.6 Coordination of Benefits, Subrogation and Workers Compensation Claims Identification

3.1.6.1 Describe your organization's system controls regarding Coordination of Benefits (COB) administration. Can analysts override these controls? Please furnish a sample of any reports that are generated by your system in the event of such an override. Who reviews the report and what guidelines are used in the review?

COB updates are handled by our eligibility unit. COB is updated in various ways. For some clients, we do annual letters requesting COB information; others supply this information to us through our website for updates or they collect during annual enrollment. At any time we identify other insurance either by notification on a claim or an attached EOB and the screens where we capture COB information is not current, that information is forwarded to the eligibility unit for research and updating. They will obtain effective date and other carrier information to update the claims system. Analysts are able to override these controls. We have plans that cover items that Medicare or a primary carrier does not cover.

Reports are reviewed by client-specific supervisor and researched for valid overrides on a daily basis

Please refer to Exhibit 13 to review sample report.

3.1.6.2 Do all claim analysts have responsibility for identifying and pursuing COB, or is there a special unit? If specialized, describe the interface and communication between your organization's divisions/units responsible for the PEBP account.

All of our analysts have responsibility for identifying and pursuing COB.

At the time of enrollment, employment by the spouse is reviewed along with any indication of other insurance. If there is an indication of another insurance serving as primary on the spouse, an indicator in the system is

activated. That indicator will not allow a claim to be processed until information from the primary carrier EOB is entered. If children are covered by both plans, the Birthday Rule is used to determine primary/secondary responsibility for the plans. If the other plan is primary, the COB indicator is activated.

During the year, any indication on a claim form that other insurance may have paid primary, results in the claim being pended while an investigation is completed by our enrollment unit. This generally includes a letter requesting coverage information being sent to the family. The claim is not released until the investigation is completed. Once per year, a coverage survey is sent to all families covered by the plan to verify that no other insurance has been put in place requiring the COB indicator to be activated.

We maintain a complete history for each participant (employee and all dependents), including all changed records. This includes demographic and coverage information. Each transaction is "tagged" with a date, time and user so a complete audit trail is maintained. An additional function is the linkage of all enrollment-related documentation (e.g., HIPAA Certificates, Letters, full-time student verification, COB investigation, proof of dependent status, etc.) to the group and participant. The system allows for programming of edits related to Plan Document provisions, such as an annual COB review or semi-annual full-time student review. HealthSCOPE Benefits maintains all eligibility data in our system for as long as the client is active (including run-out periods).

3.1.6.3 Are COB savings tracked online?

Yes, the system tracks them automatically.

3.1.6.4 PEBP requires the TPA to provide a weekly COB update file to PEBP's PBM. The COB file contains information regarding PEBP participants who have primary health insurance coverage (other than Medicare). Please confirm your organization's willingness to continue and possibly improve this process.

Confirmed, we would welcome the opportunity to work with PEBP on improving the process.

3.1.6.5 Explain your organization's standard subrogation policy and procedures; include the criteria used to identify potential subrogation claims.

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group:

"Chase & Pay" Approach

A claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third

party. The case is then passed on to our vendor for tracking and recovery.

"Pay & Chase" Approach

The claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan of Columbus, Ohio, for pursuit of a recovery agreement, tracking and recovery.

The cost of subrogation services is 25% of recoveries gained through intervention. LNL keeps 13% and HSB is paid 12% for its administrative work on the claim.

Because of our experience, we were able to develop highly efficient and effective software that allows us to maximize recoveries. Our claims review process allows us to quickly and accurately identify potential subrogation situations. Once a subrogation file is opened, our software and practice methods allow us to spend time on an exceptionally high volume of cases, including those with low total paid claim amounts. Our experience with subrogation recovery has shown that a high number of low dollar cases will result in a dramatic increase in savings for the health plans. Others in our industry have adopted the belief that only high dollar cases should be reviewed, and our research and experience has concluded to the contrary.

Our attorneys use their legal experience and negotiation/litigation knowledge to maximize recoveries, but perhaps even more importantly, to limit the liability of customers and groups, thus avoiding unnecessary risk and expensive legal fees.

Our superior subrogation computer program and subrogation practice methods allow for intricate investigations on a high volume of cases while maximizing recoveries for our clients. Our experienced lawyers and our dedicated staff provide high quality service which translates into increased savings to our clients.

As noted above, potential Subrogation claims are identified through a claims mining process. Our Claims Review program will filter out the appropriate ICD-9 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident or 'slip and fall' cases.

A more detailed description of our subrogation services' processes is provided below.

3.1.6.6 How do you investigate for potential subrogation or other third party liability claims?

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase & pay" or "pay & chase" approach, depending on the preference of the group. In the "chase & pay" approach, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is requested to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our

vendor for tracking and recovery. In the "pay & chase" approach, the claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan, for pursuit of a recovery agreement, tracking and recovery.

Review and Identification of Potential Claims
The process begins by receiving the paid or denied claims from the client, and importing these claims into our Claims Review system via an electronic data transfer. Our Claims Review program will filter out the appropriate ICD-9 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident or 'slip and fall' cases. Once imported, theses claims are appropriately categorized by the program.

Our staff will then begin the process of pulling up the member's claims records and reviewing the information and at this point make a decision to investigate further or not. Claims that are targeted (they appear with a check mark next to them) will be reviewed first because these targeted codes are most likely subrogation situations. If the claims appear as though they will not yield the potential for subrogation, the member is sent into a 90 day follow up. In 90 days, the member's record will be re-opened if new claims have been received since the date the diary was started. The staff member will be able to review any claims that have been imported since the last 90 day diary and again make a decision as to whether or not a letter should be sent.

If the decision has been made to send a letter and questionnaire, a letter will be sent that day.

There are two different types of letters that are sent. There are letters for definite auto accidents and letters for more general medical treatments. Each letter has different language and a different questionnaire so that it is more specific to the situation.

If the member does not respond to the first letter, a second follow up letter and questionnaire will be automatically sent in 20 days. If the member does not respond to the 2nd letter, they will appear on a Non-Response report, which can be sent to the client if they wish. The staff will review this report at the end of each month and pull the members that have high dollar amount claims. Additional research and attempts to contact the members will be made if it appears that the potential for subrogation is high.

During this process, if a member receives a letter and has a question, they may respond to an online questionnaire or call a toll free number to contact a staff member for direction. Our staff will also follow up with a phone call to members that have questions or have not responded.

If a letter is sent and the individual responds and indicates there was no accident, and this is consistent with our experience and any other investigation information, the member's records will be appropriately noted that a response was received, and they will be sent into the 90 day follow up process once again.

If a response to a letter indicates that the potential for subrogation exists, a subrogation file will be opened and an investigation will begin.

Investigation

Once a response is received and there appears be an opportunity for subrogation, our staff will begin the research to identify all of the appropriate parties that are involved. Our questionnaires have proven to be very effective in obtaining the information we require to proceed, although there are instances where we must research further.

One valuable feature of our subrogation program is that it contains an extensive database of attorney names and addresses, insurance company names and addresses, and insurance adjuster names and phone/fax numbers. We can search by insurance company name, by the adjuster's name, or by attorney name and find the information quickly. Our program also contains numerous other search methods. This has proven to be a valuable tool and has allowed us to quickly proceed with all necessary action. This database is constantly updated as new insurance adjusters or attorneys are added. Basically, if we are provided with only a name, we can search within our database to attempt to locate the adjuster or attorney. This allows us to focus our time and energy on presenting the lien quickly, therefore protecting the health plan's recovery rights.

Sometimes additional research may be necessary and phone calls will be made by our experienced staff members to gather all of the information required. We exhaust all efforts in gathering information. This includes but is not limited to using the internet, contacting the plan member via phone, contacting the liable third party for insurance information, calling insurance companies to locate the appropriate file handler, searching for police reports, and researching court records. If the member has not set up a claim for an accident, we will contact the responsible insurance company and set up a claim for the health plan.

In addition, our program contains a series of standard forms for different types of incidents that we use to obtain additional information. These forms are specific to the situation that occurred and have yielded positive results in obtaining the required information. For example, we have a separate form for each of the following: slip and falls; boat accidents; dog bite incidents; assaults; ATV accidents; one car accidents; and multiple vehicle accidents.

We continue to investigate until answers are received, while others may choose to terminate the investigation and close the file.

Once all of the information is received, all of the involved parties are placed on notice of the subrogation lien.

Working and Tracking Open Files/Cases
Once a file has been opened and all of the appropriate parties have been placed on notice, the file will go into our maintenance and follow-up stage. Typically, once the parties have been placed on notice, they will request the amount of our client's lien or copies of additional documents. Our staff members will update the files by researching our client's claims database and obtain all of the required and/or requested information (strictly following HIPAA guidelines). We provide this information upon request and often numerous times within the life of one file.

Our subrogation program allows us to update the lien amounts easily. Our program is highly efficient and allows for quick turn-around.

Our program utilizes "Reminders" for file follow up. Basically, once a file is opened and the initial notice letters are sent, a reminder will automatically be placed on the file. No file will ever "fall through the cracks" because there will always be a reminder on the file. Every letter that is sent from our subrogation program is associated with a reminder. Therefore, once a letter is printed, a reminder will be placed on the file for later follow up.

If the designated time expires and a response has not been received from the other party, these reminders will re-open in a "Reminder" Database. The Reminders are reviewed daily by our staff members. Each reminder is very specific and will let the staff member know exactly what needs to be done next. When a member opens a Reminder, they will be taken into the related file record. The staff member will have all of the pertinent information available to them and will evaluate the file appropriately.

We obtain status updates on a regular basis for every file that is opened. We request the status from the member's attorney and insurance adjusters, among others. If we do not receive a response to our first status request, we will follow up with phone calls until a response is received. We feel it is extremely important to call the other parties if there is no response.

When we receive a response to one of our letters, all of the pertinent information is entered into the file history. A new reminder will be placed on the file that tells us to follow up in the specified number of days.

The file history is where we keep track of the history of the file from beginning to end. We keep a physical file that contains important documents, but we also use the file history in the subrogation program to keep detailed records. This is much like a journal and it contains a historically sorted and dated written record of the following: All letters that have been sent, staff member journal entries, synopsis of phone conversations, copies of emails, faxes, written description of all letters received, and lists any recoveries that have been received.

Once again, all of our files are carefully and skillfully tracked to their conclusion.

Attorney Involvement / Legal Expertise

When there are legal questions such as assertions of state law "made whole" or other statutes, ERISA queries, excess carrier, issues of contributory negligence, priority of coverages based upon contract language, and numerous others, one of our attorneys is immediately involved to respond, educate or explain to opposing parties, negotiate or contest up to and threatening or commencing litigation.

File Resolution and Settlement

Once a subrogation file has reached the point of conclusion, our educated and experienced staff will work to resolve the matter.

Customized Reporting

The deposits that have been made within a given month are listed on the Subrogation Recovery Report. We break down each reimbursement that has been received and list the associated claim number to which the recovery applies. This is very important because it allows the client to accurately and easily update their records to reflect the correct information. We are also able to create customized reports for depending on the client's specific needs

3.1.6.7 Does your organization utilize the services of a subrogation recovery company? If yes, please indicate the name of the company, their fee for recovery services, their criteria that triggers a recovery action, and their average rate of return for 2008 and 2009.

Confirmed, Luper, Neidenthal & Logan of Columbus, Ohio, provides our subrogation recovery services. Their fee is 25% of Recoveries gained through intervention with LNL keeping 13%

Average rate of return for 2008 /2009
IMPORTANT: Many of the files that were opened in any given year are still active in following year(s) and therefore recovery has not yet been obtained. As people continue to treat under the health plan, the amount paid by the plan will continue to increase. Settling some cases too quickly would result in the plan being unable to collect reimbursement on claims that are paid after the settlement date. It is important to note that subrogation files sometimes take years to conclude and therefore it is difficult to provide an accurate number of recoveries obtained when only reviewing one specific year. Also, not all of the total dollars identified for subrogation are actually subrogation opportunities. Many times we will learn through the process of our investigations that no other insurance exists, so there is nothing to subrogate. These dollars are included in the "total dollars identified for possible subrogation" number, even though they are not actually subrogation dollars.

Total dollars identified for possible subrogation in 2008 = $11,442,993.70

Total dollars recovered in 2008 = $2,100,802.31

Luper Neidenthal & Logan recovered 18% of all total possible dollars identified in 2008

Total dollars indentified for subrogation in 2009 = $8,971,570.16
Total dollars recovered in 2009 = $2,404,757.52
LNL recovered 27% of all total possible dollars identified in 2009

3.1.6.8 List in detail the fees your organization charges for subrogation. Are these fees based on a percentage of recovered funds? Be as specific as possible. Include this information in your cost proposal.

Subrogation is charged at 25% of Recoveries gained through

Customized Reporting

The deposits that have been made within a given month are listed on the Subrogation Recovery Report. We break down each reimbursement that has been received and list the associated claim number to which the recovery applies. This is very important because it allows the client to accurately and easily update their records to reflect the correct information. We are also able to create customized reports for depending on the client's specific needs

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IMPORTANT: Many of the files that were opened in any given year are still active in following year(s) and therefore recovery has not yet been obtained. As people continue to treat under the health plan, the amount paid by the plan will continue to increase. Settling some cases too quickly would result in the plan being unable to collect reimbursement on claims that are paid after the settlement date. It is important to note that subrogation files sometimes take years to conclude and therefore it is difficult to provide an accurate number of recoveries obtained when only reviewing one specific year. Also, not all of the total dollars identified for subrogation are actually subrogation opportunities. Many times we will learn through the process of our investigations that no other insurance exists, so there is nothing to subrogate. These dollars are included in the "total dollars identified for possible subrogation" number, even though they are not actually subrogation dollars.

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LNL recovered 27% of all total possible dollars identified in 2009

3.1.6.8 List in detail the fees your organization charges for subrogation. Are these fees based on a percentage of recovered funds? Be as specific as possible. Include this information in your cost proposal.

Subrogation is charged at 25% of Recoveries gained through

intervention.

We charge 50% if we have to hire an attorney. I've pasted the language below from our usual contracts.

In the event TPA collects a subrogation claim of Plan Sponsor without retaining an attorney to represent the interests of Plan Sponsor, Plan Sponsor will pay TPA a fee for its services under this Agreement equal to twenty-five percent (25%) of the gross amount recovered for such claim.

In the event TPA collects a subrogation claim of Plan Sponsor but such collection requires retaining an attorney to represent the interests of Plan Sponsor, Plan Sponsor will pay TPA a fee for its services not to exceed fifty percent (50%) of the gross amount recovered for such claim, which includes all litigation expenses, if any, and attorneys' fees.

3.1.6.9 Please describe in detail, how your organization investigates potential workers' compensation claims?

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase and pay" or "pay and chase" approach depending on the preference of the PEBP. In the "chase and pay" approach, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is requested to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed to our vendor for tracking and recovery. In the "pay and chase" approach, the claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal and Logan for pursuit of a recovery agreement, tracking and recovery.

3.1.7 Financial Management

3.1.7.1 Describe how the claims processing system will be reconciled with the Bank of America account and provide sample reports that would be submitted to PEBP. Please provide a reconciliation schedule with your proposal.

HealthSCOPE Benefits utilizes positive pay and full reconciliation services with Bank of America. A file is sent from our claims system to Bank of America for any check issued, voided or stopped. We receive a monthly reconciliation reports from Bank of America. We reconcile the information from our systems monthly check register against the Bank of America reports. Any variances are then researched and resolved.

Please refer to Exhibit 14 to reference our sample reconciliation schedule.

3.1.7.2 Describe what type, if any, of self-audits are performed to review compliance with internal financial controls and reconciliation of the claims account. Include how often any self-audits are completed.

A detailed review of all monthly bank reconciliations is performed by the Supervisor of Financial Operations. The Director of Financial Operations does a quarterly review of the approved reconciliations. In addition, HealthSCOPE Benefits has an annual SAS 70 audit in which all of our controls are reviewed and tested.

4. PRIVACY and SECURITY

4.1 Does your organization certify that it is in full compliance with HIPAA's administrative simplification standards relating to electronic data interchange (EDI)?

Confirmed

4.2 If applicable, does your organization certify that it reports to the national Healthcare Integrity and Protection Databank (HIPDB) as required and, as may be necessary, submits inquiries to the HIPDB to determine whether any final adverse legal actions have been taken against its member providers?

Yes

4.3 Does your organization certify that it will not require that enrollment and eligibility information and eligibility information electronically transmitted by Client to Vendor comply with EDI?

Confirmed

4.4 Does your organization certify that it is in full compliance with HIPAA's regulation protecting the privacy of individually identifiable health information (the Privacy Rule)?

Confirmed

4.5 Please provide a copy of your organization's HIPAA privacy procedures and any certification you have with respect to HIPAA compliance.

HealthSCOPE Benefits is fully compliant with HIPAA's transaction, privacy and security standards. Our compliance department, Privacy Officers and Security Officers have completed intensive HIPAA training. In addition to ongoing monitoring, we also complete testing of procedures as part of our SAS-70 certification.

Our legal/compliance department is responsible for drafting and implementing policies concerning privacy/confidentiality with regards to protected client information. From a privacy perspective, we have completed significant training of our entire staff and all subcontractors/external vendors as well as implemented several procedural and system controls. All vendor relationships are tightly controlled and audited on an ongoing basis.

For security, we have implemented tight controls on data exchanges and the storage of data. For transmitted data that contains HIPAA/PHI, we utilize file transfer protocol (ftp) and PGP encryption. We also utilize ANSI for claims and eligibility received. In addition,

our client's HR/benefit staff is able to interact with HealthSCOPE Benefits personnel via encrypted e-mail per HIPAA security standards.

All HealthSCOPE Benefits employees adhere to strict HIPAA regulations and guidelines. Benefit Analysts/Claim Examiners complete ongoing training that includes weekly "round table" discussions of procedures, as well as formalized monthly training on topics such as HIPAA privacy and security, fraud, clinical editing, and new procedures. A final element of training includes a briefing on the plans and special requirements of all new clients.

To help you comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), HealthSCOPE provides complete HIPAA Certification Administration. These services include identifying employees and dependents whose coverage has terminated and generating corresponding HIPAA Certificates of Creditable Coverage from their previous plan, and calculating the amount of creditable coverage each person should have.

Please refer to Exhibit 15 to reference our HIPAA Certification.

4.6 Does your organization agree to provide PEBP's Actuary/Consultant access to protected health information under the employer's health plan (PEBP) if the Consultant/Actuary executes a Business Associate Agreement with PEBP?

Confirmed

4.7 Has your organization reviewed the American Recovery and Reinvestment Act (ARRA) of 2009 and performed an analysis to determine changes needed within your organization? Do you have an action plan to address these changes and how they would affect PEBP?

Yes, we have reviewed ARRA, we have implemented its changes, and we have action plans in place to address changes and how it affects PEBP.

4.8 Has your organization reviewed Health Care Reform (PPACA) of 2010 and performed an analysis to determine changes needed within your organization? Do you have an action plan to address these changes and how they would affect PEBP?

Yes, we have reviewed PRACA. We are working with each of our clients individually to address the changes, and we would work with PEBP to review options and determine implementation steps.

4.9 PEBP requires all its vendors to sign a Business Associates Agreement (Attachment F), please confirm that your organization agrees to the provisions in PEBP's Business Associates Agreement and will return the executed document to PEBP within the stated timelines upon issuance.

Confirmed

5. IMPLEMENTATION REQUIREMENTS

5.1 Assuming the contract is effective upon Board of Examiner's approval (anticipated to be April 13, 2011), please provide a detailed implementation schedule, which outlines the transition process, critical deadlines, key staff, and coordination with the Eligibility and

Enrollment Information System, to include Open Enrollment deadlines for plan year 2011. Open Enrollment is tentatively scheduled for May 2011 with July 1, 2011 effective date of change.

Please refer to Exhibit 16 to review our detailed implementation schedule.

6. PERFORMANCE STANDARDS/GUARANTEES and PERFORMANCE PENALTIES

6.1 The requirements as indicated in Attachment F are areas where the awarded vendor will guarantee performance. Failure to meet the required standards will result in the assessment of liquidated damages in the amount of the penalties stated in Attachment F. PEBP will reduce future payment of administrative fees to the vendor by the amount of the liquidated damages. If future payments are less than the amount of liquidated damages, vendor will pay the amount of liquidated damages to PEBP immediately. Prompt resolution of problems or issues is expected, but will not reduce or eliminate any liquidated damages imposed due to failure to meet the performance standards outlined.

PEBP will determine compliance with service performance standards and guarantees through quarterly audits performed by the PEBP's health plan auditor. If vendor fails to meet the required standard, liquidated damages will be assessed per failed standard for each period audited. For example, if the Third Party Administrator is found to be in non-compliance for TAT (turnaround time) for July through September – a penalty of 2.5% of the administrative fees paid for July through September will be assessed. If the Third Party Administrator is found to be in non-compliance in all five performance standard areas, the maximum penalty assessed shall not exceed 25% of the administrative fee for the quarter audited.

Please note the awarded vendor will have the opportunity to dispute any findings by PEBP's health plan auditor. The final outcome of the dispute, however, will be decided by PEBP.

Assessment of the liquidated damages does not preclude declaration of breach of assessment of other damages that the State may be entitled to recover.

Confirmed

While PEBP is adamant that Performance Guarantees and Penalties remain part of the TPA contract, PEBP encourages proposing vendors to propose an alternate method for possible consideration.

Confirmed, please refer to Section III to reference alternate performance guarantees.

7. INSURANCE SCHEDULE/BOND REQUIREMENTS

Vendor must meet and provide proof of all insurance schedule requirements outlined in the attached State of Nevada Insurance Requirement Schedule (contained in Attachment C) before a contract shall be awarded. These documents must be included with your RFP response.

Please refer to Section III review all HSB proof of insurance certificates.

8. COMPANY BACKGROUND AND REFERENCES

8.1 PRIMARY VENDOR INFORMATION

Vendors must provide a company profile. Information provided shall include:

8.1.1 Company ownership (sole proprietor, partnership, etc).

HealthSCOPE Benefits is a privately held corporation.

8.1.1.1 Incorporated companies must identify the state in which the company is incorporated and the date of incorporation. **Please be advised**, pursuant to NRS §80.010, incorporated companies must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS §80.015.

State in which company incorporated – Deleware

Date of Incorporation – October 26, 2000

8.1.1.2 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the Office of the Secretary of State pursuant to NRS §76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us. Vendors must provide the following:

- Nevada Business License Number
- **NV20011223201**
- Legal Entity Name
- **HealthSCOPE Benefits**
- Is "Legal Entity Name" the same name as vendor is doing business as?
  [√] Yes [ ] No
  If "No," provide explanation.

8.1.2 Disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigation pending which involves the vendor or in which the vendor has been judged guilty or liable.

Please refer to Exhibit 17 to reference current pending cases. Please note all of these cases are very typical cases for a TPA. We many have included more than you would want here, but we in no way believe we had any significant contract failures or breaches.

8.1.3 Location(s) of the company offices and location of the office that will provide the services described in this RFP.

HealthSCOPE Benefits' Office Locations:

Headquarters:

HealthSCOPE Benefits
27 Corporate Hill Drive
Little Rock, AR 72205

HealthSCOPE Benefits
8800 Lyra Drive, Suite 650
Columbus, Ohio 43240

HealthSCOPE Benefits
2731 Sutton Blvd., Suite 110
St. Louis, MO 63143

HealthSCOPE Benefits
2630 Elm Hill Pike, #203
Nashville, TN 37214

HealthSCOPE Benefits
9045 E. 59th Street
Indianapolis, IN 46216

HealthSCOPE Benefits
7430 Remcon, Building C
El Paso, TX 79912

HealthSCOPE Benefits
815 Colorado Blvd., 4th Floor
Los Angeles, CA 90041

HealthSCOPE Benefits will provide services to the PEBP at our Little Rock, Arkansas and Columbus, Ohio offices.

8.1.4 Number of employees both locally and nationally.

315

8.1.5 Location(s) from which employees will be assigned.

HealthSCOPE Benefits
27 Corporate Hill Drive
Little Rock, AR 72205

HealthSCOPE Benefits
8800 Lyra Drive, Suite 650
Columbus, Ohio 43240

8.1.6 Name, address and telephone number of the vendor's point of contact for a contract resulting from this RFP.

Mary Catherine Person, President
27 Corporate Hill Drive
Little Rock, AR 72205
Phone: 501-218-7513
Email: mary.person@heatlhscopebenefits.com

8.1.7 Company background/history and why vendor is qualified to provide the services described in this RFP.

Founded in 1985, our company was originally incorporated as Burgett Dietrich (B&D) and specialized in developing and managing "non-metropolitan area" managed care networks, mainly for Fortune 500 manufacturing companies. Since our inception, we have developed over 130 custom Point-of-Service (POS) gatekeeper and PPO networks in more than 30 states.

In 1992, B&D was acquired by CoreSource, then the third largest Third Party Administrator (TPA) in the country. This acquisition and our client's needs spurred the development of a complete portfolio of employee benefit services, including claims and other administrative support services to accommodate large, national accounts.

In 1996, the former B&D was spun off from CoreSource and became a wholly owned subsidiary of CNA (Chicago, IL) and was re-named, CNA Health Partners, Inc. (CNAHP). Our expansion of services and growth continued as CNAHP added supplemental services such as COBRA, Flexible Benefits Administration, Short-Term Disability, HIPAA and Retiree Administration to meet the needs of our clients.

On March 1, 2001 our company became a freestanding company with a commitment to technology to support our clients, with a new name – HealthSCOPE Benefits, Inc. (HSB). In August 1, 2002, HSB was acquired by and was a wholly owned subsidiary of Central Benefits Mutual Insurance Company (which also included Central Benefits Administrators, Morris Associates, and The Plan Handlers).

On December 31, 2007, all TPAs were merged into HealthSCOPE Benefits, and purchased through a management buyout to become a freestanding independent company. Our independence and flexibility will allow us to provide the services described. Since becoming and independent entity, HSB has seen significant business growth, high client satisfaction and excellent cost trends.

All TPAs are not the same. HSB is different. We back up our claims, guarantee results and maintain long-lasting relationships with our clients. HSB's partnership with you is founded on three tenets. It is our pledge to work with you to develop an attractive, affordable and customer-friendly benefits plan for your employees.

Healthy People
Unlike an insurance company, we are not simply accepting risk on behalf of our clients. Unlike a traditional TPA, we are not simply adjudicating and paying claims for the self-insured. Rather, our company empowers clients to proactively monitor and manage the health of their employee populations.

Healthy Business
It's well documented that a healthier workforce is a more productive workforce. But HealthSCOPE Benefits goes beyond the basics to help deliver a healthier bottom line – by assertively controlling healthcare costs through networks, discounts and utilization management. Furthermore, HealthSCOPE's flexible, customized plan design means our client companies are delivering exactly the benefit structure they want.

Healthy Futures
HealthSCOPE Benefits is a partner for the long term; the real value of our partnership is unlocked over time. HealthSCOPE creates sustainable benefit programs. By enabling cost trend management dramatically below the industry's average, HealthSCOPE helps its clients create healthier futures. HSB has been

able to manage it's clients cost trends aggressively while our customers have made limited benefit changes. Our average trend over the last 6 years is 3.5%

8.1.8 Length of time vendor has been providing services described in this RFP to the **public and/or private sector**. Please provide a brief description.

We have been providing claims administration services since 1992 when our clients asked us to get begin processing claims. Our first client is still a client, showing our commitment to service and innovation.

8.1.9 Has the vendor ever been engaged under contract by any State of Nevada agency?
[ ] Yes [√] No If "Yes," specify when, for what duties, and for which agency.

8.1.10 Is the vendor or any of the vendor's employees employed by the State of Nevada, any of its political subdivisions or by any other government?
[ ] Yes [√] No If "Yes," is that employee planning to render services while on annual leave, compensatory time, sick leave, or on his own time?

8.1.11 Is the vendor currently involved in litigation with the State of Nevada or any other entity?
[√] Yes [ ] No If "Yes," list details.

Like all TPAs, we are pulled into disputes based on client plan design or other entities failure to execute their duties.

- Baylor University Medical Center, Baylor Medical Center at Grapevine v. James Hardie Building Products Inc.; HealthSCOPE Benefits, Inc. Case No.: CC-10-05503-A. The County Court of Dallas, Texas. Plaintiff alleged breach of contract in regard to the client's plan taking certain discounts for provider services. Settlement negotiations are underway as of 8/31/10.
- Hot Springs National Park Hospital Holdings, LLC v. Sheryl Pitchford, Employers' Health Coalition, Triumph Airborne Structures, Inc. and HealthSCOPE Benefits, Inc. Case No. CV 2008-468. The Circuit Court of Garland County, Arkansas. Plaintiff alleged breach of contract for discounts taken by the client's plan. The case is pending in trial court.
- Irma Contreras v. Clint Independent School District and Access Administrators. Case No: 2009-041. District Court of El Paso County 448th District, Texas. Plaintiff alleged breach of contract related to the plan's decision to deny a procedure the plan found to be cosmetic. Plaintiff is currently appealing a trial court's decision in favor of the defendants.
- James Hardie Building Products, Inc. v. Best Life and Health Insurance Co. Best Re, Inc.; Plan Handlers, Inc.; and HealthSCOPE Benefits, Inc. Case No: 37-2010-00086933-CU-BC-CTL. San Diego Superior Court, California. Plaintiff alleged negligence and breach of contract related to the stop loss carrier's decision to deny certain claims of Plaintiff's. The case is pending in trial court.
- Tri-City Medical Center, administered by Tri-City Healthcare District v. North County Ford, Inc.; HealthSCOPE Benefits, Inc. Case No.: 37-2010-00058039-CU-BC-NC. Superior Court of California, County of San Diego. Plaintiff alleged breach of contract for discounts taken by the client's plan. Defendants are preparing their response. The case is pending in trial court.

8.1.12 Resumes for key staff to be responsible for performance of any contract resulting from this RFP.

Please refer to Exhibit 18 to review all resumes for key staff to be responsible for performance of any contract resulting from this RFP.

8.1.13 ***Financial information and documentation to be included in Part III of your response in accordance with the Submittal Instructions.***

8.1.13.1 Dun and Bradstreet number - **94-555-7239**

8.1.13.2 Federal Tax Identification Number - **710847266**

8.1.13.3 The last two - (2) years and current year interim: **Included**
Profit and Loss Statement
Balance Statement

8.2 REFERENCES

Vendors should provide a minimum of three (3) references from similar projects performed for private, state and/or large local government clients within the last three years. **Vendors are required to submit Attachment D, Reference Form to the business references they list. The business references must submit the Reference Form directly to the Purchasing Division.** It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the proposal submission deadline for inclusion in the evaluation process. Business References not received, or not complete, may adversely affect the vendor's score in the evaluation process. The Purchasing Division may contact any or all business references for validation of information submitted.

8.2.1 Client name;
8.2.2 Project description;
8.2.3 Project dates (starting and ending);
8.2.4 Technical environment; (i.e., Software applications, Internet capabilities, Data communications, Network, Hardware)
8.2.5 Staff assigned to reference engagement that will be designated for work per this RFP;
8.2.6 Client project manager name, telephone number, fax number and e-mail address.

Confirmed, we have sent Attachment D, Reference Form, to three references including: Whirlpool, CONSOL Energy, and Toledo Public Schools. We included Whirlpool and CONSOL because their size is similar to PEBP and their complexity is similar. We includes TPS because we wanted you to have the options of a public entity, as well.

Whirlpool
Judy Locatis, Benefits Manager
2000 M-63 North
Benton Harbor, MI 49022
Phone: 269-923-7291
Client since 1989

CONSOL Energy
Vanessa Davis
1000 Consol Energy Drive

Canonsburg, PA 15317
Phone: 724-485-4290
Client since 2004

Toledo Public Schools
Mike Coutuier
420 E. Manhattan Boulevard
Toledo, OH 43608
Phone: 419-671-8349
Client since 2007

8.3 SUBCONTRACTOR INFORMATION

8.3.1 Does this proposal include the use of subcontractors?

Yes __√__ No _____ Unknown _____

If "Yes", vendor must:

8.3.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

Client Name:

Mulally Insurance Services

Contact:

Mary Jean Mullally, President
MIS, Inc.
16017 North Florida Ave.
Suite 132
Lutz, Florida 33549
Office 813.973.8700
Direct Line 813.994.6353
Cell 813-787-5191
Fax 832.550.0401

Project Dates: 01/01/97 to Present

Description:

Provides claims auditing services based on industry standards and client specific benefits as outlined in client's summary plan document.

The rising cost of medical care is forcing more employers and their consultants to become involved in their own employee benefit programs. That involvement is changing both the patterns of obtaining benefits and the methods of funding them.

The employer is now finding it necessary to assume a larger portion of the risk. Myriads of managed care health products have emerged to help the employer and their consultants control their health care expenditures.

Information has become the most powerful weapon in the war on escalating medical costs. Utilization review programs, catastrophic case management, and data analysis packages all attempt to generate reports to help identify and analyze utilization patterns.

Employers and their consultants are relying on these reports to make crucial decisions about plan designs and cost containment measures. The astonishing truth is that most of these decisions are made without ever questioning the integrity of the basic information used to generate the reports Millions of dollars are spent each year for the purchase of managed care programs. Nothing is spent on auditing the credibility of the most basic source of information

If your insurance company or third party administrator is not adjudicating claims accurately and according to the plan design, all other information that follows is useless.

MULLALLY INSURANCE SERVICES, INC. emerged from the experience of professionals with both health insurance and claims administration backgrounds. They realized that the accuracy of claims administration increased dramatically when the claims examiners are subject to independent audits.

Client Name:

Empowered Benefits

Contact:

John Gage
Vice President
Empowered Benefits
124 N. McDowell Ct.
Charlotte NC 28204
704-369-0190 ext. 110
jgage@empoweredbenefits.com

www.empoweredbenefits.com

Project Dates: 01/01/2006 - Present

Description:

Based in Charlotte, NC, Empowered Benefits is a 10-year-old technology company that creates personalized and secure web platforms to allow TPAs, Health Plans , and large employers to communicate, deliver and enroll employees in benefits programs.

Empowered Benefits has developed a rules-based online benefits and communication platform that we've adapted, customized and installed for large and multi-locational companies that require complex business rules and eligibility rules and who require integration with multiple vendors and technology platforms.

We've grown our business by solving real-world problems the hard way — through careful listening, analysis, project management, follow-through and delivery. We've never stopped refining our core product.

Client Name:

Luper, Neidenthal and Logan

Contact:

Matthew Anderson, Esq.
Luper Neidenthal & Logan
A Legal Professional Association
50 West Broad Street, Suite 1200
Columbus, OH 43215-3374
Telephone: (614) 229-4473
Fax: (866) 345-4948
E-mail: manderson@lnlattorneys.com
Website: www.lnlattorneys.com

Project Dates: 2007 to Present

Description:

We use the latest in Microsoft technology, in addition to a proprietary software application that we have developed over the years. So whether it is downloading status reports directly into our volume clients' websites or uploading subrogation claims directly into our system, we are able to remain flexible and responsive to the needs of our clients.

Back-ups are performed daily and stored off-site to protect our clients' valuable data. In case of a catastrophic event, our downtime is minimized by the use of virtualization technology for our servers, which will enable us to quickly restore client data.

LNL was the first and is one of the few Ohio firms certified as a "Climate Challenge Partner" by the American Bar Association/Environmental Protection Agency's Law Office Climate Challenge. We are sensitive to environmental issues. As that relates to technology, we have designed a scanning program which has allowed many of our practice areas to become paperless. Wherever possible, our incoming documents are scanned and converted to a digital format, and our outgoing documents are generated and stored electronically. We have virtually eliminated all paper faxing. We send all faxes electronically, and all incoming faxes are delivered electronically directly to the recipient's desktop, eliminating the need for paper. When printing can't be avoided, we use high post-consumer content recycled paper.

Historically a Legal Technology Leader

Almost from the beginning, Luper Neidenthal and Logan has been a leader in law firm technology. Our efforts to stay ahead of the technological curve date back to the days of the IBM System 3X and Wang systems which provided some of the original functionality that is commonly found in law firms today. Our continued investment in the evolution of this type of technology afforded us unmatched client service, operational efficiency and decision support. Among the most notable effects on our firm and clients is the fact that we have enjoyed, over the last decade, exceptional integration of key data through a custom developed system now known as TotumWare (see more about this below). The benefits that we realized, and continue to realize, from the TotumWare initiative are profound. They include:

- **Unification of Time, Billing & Accounting Data in one system.**

- Integration of documents, journals, tasks and workflows with client and matter records providing a 360 degree view of our clients and the related work effort.

- Business Intelligence capabilities allowing us to analyze our practice across what are normally unrelated dimensions, including the correlation of such things as time, realization, profit, costs, client and matter count, type of law, attorney, originator and more.

- The integration of production law data from such areas as foreclosure, collection and subrogation with our core client system eliminating the need for multiple software systems and redundant data entry.

- Automation of bi-directional, secure data feeds between us and our partners and clients reducing overhead on all sides and improving data quality.

- Much more planned for release soon.

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system through our subcontractor, Luper, Neidenthal and Logan. We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group:

"Chase & Pay" Approach

A claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our vendor for tracking and recovery.

"Pay & Chase" Approach

The claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan of Columbus, Ohio, for pursuit of a recovery agreement, tracking and recovery.

The cost of subrogation services is25% of recoveries gained through intervention.

Client Name:

AIM Healthcare (Nashville, TN)
Review hospital credit balances and DRGs.

Contact:

Clay Gregory
Client Management Director
1021 Windcross Court
Franklin, TN 37067
cgregory@aimhealth.com
Phone- 615-503-1268

Project Dates: 2005 to Present

Description:

AIM Traditional Credit Balance Resolution: identifies and validates overpayments on patient accounts in healthcare provider environments utilizing AIM's Account

Managers located on-site at over 1,700 Hospitals and Health Systems across the country;

AIM Overpayment Recovery Solutions: strategic recovery and resolution programs that maximize recoveries while maintaining and enhancing provider relationships; AIM Medicare Advantage Solutions: comprehensive revenue management services that provide the

Medical Bill Audit (MBA):MBA provides line-by-line, peer-to-peer review by registered nurses trained in recognizing overpayments, unsupported billing and errant coding practices. The registered nurse auditors in AIM's nationwide network are highly experienced RNs who have existing relationships with the providers in their local markets.

By comparing bills with medical records, MBA equips payers to repair gaps that allow inappropriate billing. Common errors uncovered include billing for medications that were never administered and charges for services that were not provided. In addition to delivering direct cost savings, MBA equips our clients to reach the root causes of costly billing issues.

DRG Validation

Ingenix DRG Validation delivers deep reductions of overpayments through the expertise of detail-oriented, certified coders.

Core Capabilities

- Good Audit Potential analysis provides concentrated focus on claims most likely to be overpaid
- Expert assessment of DRGs used throughout the country
- Identification of billing inconsistencies and errors in DRG coding
- Recovery of overpaid dollars

Audit Complete

Ingenix Audit Complete brings together the final solution to the service offerings to verify that all other coding and compliance areas are audited through a systematic and skilled approach.

Core Capabilities

- Coding audits using medical records to verify proper coding involving CPT codes
- Highly analytical approach to determine Good Audit Potential
- Ancillary, physician, and facility claims reviewed during audit process
- Clinical and Compliance audits using industry standard, and customized based on our client's processing guidelines

Client Name:

Dialysis Cost Containment, Inc. (DCC) (Sandpoint, ID)
Negotiate reasonable and customary charges on dialysis services.

Contact:

Kea Crotty
Program Director
DCC, Inc.
P.O. Box 718
Sandpoint, Idaho 83864
Office: 208-265-1719 ext. 112

Fax: 208-263-0824

Project Dates: 2007 to Present

Description:

HealthSCOPE Benefits, Inc. has partnered with Dialysis Cost Containment, Inc. ("DCC"), a member of the PRN Family of Companies. DCC offers an array of unique programs specifically designed to significantly reduce costs while safeguarding the patient from balance billing. These programs are described below:

- UCR Program. This program allows DCC to apply its own UCR payment methodology to the dialysis claim. This UCR methodology is based on the average revenue received by the providers per treatments. Under this program, a health plan can realize an average savings of over 80%.

- Home Health Dialysis Program. This program features use of a portable or transportable machine that significantly reduces the side effects seen in center or facility dialysis, extends life expectancy, improves the transplant success rate, and reduces or eliminates dietary restrictions typically necessitated by ESRD. The patient's participation in the program not only enhances the quality of the patient's life, but is also results in a reduction of the patient's medical costs.

- Epogen Carve Out Program. This program is designed for those patients who are receiving Epogen treatments (often the highest cost of dialysis) in connection with their ESRD. Under this program, DCC acquires the Epogen and coordinates the dispensation of the drug by working directly with the patient and patient's physician. Under this program, the patient is permitted to self-inject the Epogen in a home setting and DCC is able to arrange the purchase and delivery of the drug at less than the average wholesale price. A patient's participation in this program can result in a reduction of Epogen treatment costs by an average of 90% while, at the same time, giving the patients more control over their treatment and enhanced quality of life.

- Negotiated Discounts and Repricing. Under this program, DCC will negotiate directly with networks and providers for purposes of securing a better discount than that which would normally be available under a traditional network arrangement. Through our partnership with DCC, we are pleased to offer the services described above. For more information concerning the DCC programs, contact your HealthSCOPE Benefits, Inc. account executive.

The statistics on the price tag for cancer health care are staggering. A recent study conducted by IMS Health indicates that cancer care accounts for about 15% of a health plan's health care costs. With this in mind,

Client Name: Biologics

Contact:

Shayne A. Malone
Vice President of Sales
Biologics, Inc.
120 Weston Oaks Court
Cary, NC 27513

Project Dates: July 2009 to Present

Description:

Biologics - Oncology Management
HealthSCOPE Benefits, Inc. has partnered with Biologics, Incorporated ("Biologics"), in order to bring its customers a world-class cancer management process, known as the Oncology Management Solution ("OMS Program").

Biologics is a company with over 30 years of experience in the manufacturing of laboratory and medical instrumentation for the clinical, research, chemical, environmental, industrial and pharmaceutical laboratories throughout the world.

Biologic's OMS Program will minimize the plan's vulnerability to excessive financial risks in connection with the payment for chemotherapy charges associated with cancer care. In fact, Biologics has demonstrated that self-funded plans who access the OMS Program can realize cost savings of as much as 30% or more while providing members access to specialized cancer clinical support and education in between visits to their oncologist's office.

Under the OMS Program, participating employers will be provided with a comprehensive oncology-specific strategy for patient management, medication management, provider management and claims management that results in:

- **Intense clinical support to help members have a safe and successful therapy cycle, resulting in improved patient outcomes.**
- **Side effect mitigation through early intervention that could otherwise result in costly emergency and inpatient care.**
- **Cost avoidance for unnecessary and inappropriate chemotherapy treatment through proactive medication management.**

When a member is referred to the OMS Program, a certified oncology nurse coordinator and pharmacist are assigned as the key resource to both the member and treating physician during the course of the treatment. The nurse coordinator and pharmacist will be responsible for guiding members through the entire treatment process as they maintain ongoing communication with the patient's physician concerning the patient's therapy compliance, side effects management and general well-being.

Statistics show that the cost of cancer treatment and chemotherapy will only continue to rise; therefore, Biologics and HealthSCOPE Benefits, Inc. are pleased to make this cancer management program available to help defer these escalating costs.

Client Name: PHX

Contact:

Lori Sempervine
2 Crossroads Drive, Suite 101-B
Bedminster, NJ 07921
lsempervive@phx-online.com

Project Dates: April 12, 2010 to Present

Description:

Since 2003, PHX has been the industry leader in advanced cost management solutions for health plans. Our results-driven, innovative, customized, integrated solutions allow you to effectively gain control of rapidly increasing healthcare costs and reduce costs at every step of the claims process, from claims routing to data analytics. Using a personalized approach and sophisticated technological tools we can maximize your savings in both the near and long term – while dramatically reducing errors and turnaround time.

Our team includes highly skilled cost management experts, medical professionals, and IT specialists who understand the complexities of data analytics, PPO network management, clinical billing and coding, and claims editing. That experience enables us to develop end-to-end solutions tailored to meet your specific needs – and deliver real value and significant cost savings.

Every claim, every day.

Key benefits:
About Us

- **With nearly a decade of leadership and research in cost management for health plans, PHX has a thorough understanding of the complexities of PPO network management, clinical billing and coding requirements, claims editing and reporting issues, and the importance of an integrated approach to data analytics that drives meaningful insight for informed business decisions.**
- **We provide comprehensive solutions that contain costs at every step of the claims process – and seamlessly integrate into your organization.**
- **Our unique collaborative process helps us become a true long-term partner to your business – so we can understand your evolving needs and deliver the fastest, most cost-effective ways to meet your objectives.**
- **PHX offers significant IT infrastructure and data warehousing capabilities, sophisticated claims editing software, and robust yet user-friendly reporting tools.**
- **Our services save you money – at a very competitive price.**

Client Name: Devon Health Services, Inc.

Contact:

Trisha Leh
VP, Business Services
Devon Health Services, Inc.
1100 First Avenue, Suite 100
King of Prussia, PA 19406
P: 610-757-4127
F: 800-221-0002
tleh@devonhealth.com

Project Dates: February 2008 to Present

Description:

analysts in quality improvement.

3.1.5.7 What is the ratio of quality control reviewers to claim examiners?

All of our quality control is outsourced to Mulally Associates. We have outsourced this function so that it is truly independent.

3.1.5.8 What types of internal audits are in place to monitor claims administration? What is the frequency of these audits and who performs them?

We have outsourced our audit functions of our random claims auditing and high dollar claims review to a professional audit firm. Mulally Associates reviews 2% of all claims processed daily. HealthSCOPE Benefits receives weekly and monthly reports regarding overall performance, as well as the performance of individual processors. All claims exceeding $25,000 prior to payment are reviewed by 3 internal staff; this is in addition to a HealthSCOPE Benefits Claim Supervisor reviews of all claims exceeding $50,000 for post-payment review. All claims over $50,000 are reviewed in detail by the President of HealthSCOPE Benefits.

3.1.5.9 Explain how your organization will measure and track quality control for the department managing the PEBP account.

We would use Mulally to review 2% of each analyst's claims and 2% of all PEBP claims. We would receive weekly and monthly report sand we are happy to share these with PEBP.

Please attach a copy of your organization's most recent internal audit report(s), with each labeled and explained clearly.

Please refer to Exhibit 11 to review these reports.

3.1.5.11 PEBP contracts with an independent third party to perform external quarterly claims audits of PEBP's TPA. These audits are done on-site at the TPA office responsible for processing PEBP's medical, dental and vision claims. Please describe your organization's experience with independent auditors. Please confirm that your organization will cooperate with PEBP and PEBP's health plan auditor. Does your organization charge for cooperating and providing information to PEBP's auditor during a claim audit? If yes, what is the fee per audit?

We believe independent auditors only make us better. We welcome such a process and we will do all we can to assist them in their audits. There is no charge. We welcome many client specific audits per year, and PEBP will receive nothing but our full cooperation.

3.1.5.12 Please attach a copy of your organization's most recent external claims processing audit report. This question is not referring to your organization's SAS70 report.

Please refer to Exhibit 12 to review our most recent external claims processing audit report from one of our clients, the County of El Paso, TX.

3.1.5.13 Complete the following for the office that will process the PEBP's claims:

Claim Processing Accuracy Objectives	Financial Payment Accuracy	Payment Accuracy Rate	Procedural Accuracy Rate	Overall Accuracy Rate
2008 Objectives	**99%**	**98%**	**98%**	**N/A**
2008 Results	**99.2%**	**99.7%**	**99.36%**	**N/A**
2009 Objectives	**99%**	**98%**	**98%**	**N/A**
2009 Results	**99.4%**	**99.66%**	**99.46%**	**N/A**
2010 Objectives	**99%**	**98%**	**98%**	**N/A**
2010 Results YTD	**99.5%**	**99.66%**	**99.42%**	**N/A**

3.1.6 Coordination of Benefits, Subrogation and Workers Compensation Claims Identification

3.1.6.1 Describe your organization's system controls regarding Coordination of Benefits (COB) administration. Can analysts override these controls? Please furnish a sample of any reports that are generated by your system in the event of such an override. Who reviews the report and what guidelines are used in the review?

COB updates are handled by our eligibility unit. COB is updated in various ways. For some clients, we do annual letters requesting COB information; others supply this information to us through our website for updates or they collect during annual enrollment. At any time we identify other insurance either by notification on a claim or an attached EOB and the screens where we capture COB information is not current, that information is forwarded to the eligibility unit for research and updating. They will obtain effective date and other carrier information to update the claims system. Analysts are able to override these controls. We have plans that cover items that Medicare or a primary carrier does not cover.

Reports are reviewed by client-specific supervisor and researched for valid overrides on a daily basis

Please refer to Exhibit 13 to review sample report.

3.1.6.2 Do all claim analysts have responsibility for identifying and pursuing COB, or is there a special unit? If specialized, describe the interface and communication between your organization's divisions/units responsible for the PEBP account.

All of our analysts have responsibility for identifying and pursuing COB.

At the time of enrollment, employment by the spouse is reviewed along with any indication of other insurance. If there is an indication of another insurance serving as primary on the spouse, an indicator in the system is

activated. That indicator will not allow a claim to be processed until information from the primary carrier EOB is entered. If children are covered by both plans, the Birthday Rule is used to determine primary/secondary responsibility for the plans. If the other plan is primary, the COB indicator is activated.

During the year, any indication on a claim form that other insurance may have paid primary, results in the claim being pended while an investigation is completed by our enrollment unit. This generally includes a letter requesting coverage information being sent to the family. The claim is not released until the investigation is completed. Once per year, a coverage survey is sent to all families covered by the plan to verify that no other insurance has been put in place requiring the COB indicator to be activated.

We maintain a complete history for each participant (employee and all dependents), including all changed records. This includes demographic and coverage information. Each transaction is "tagged" with a date, time and user so a complete audit trail is maintained. An additional function is the linkage of all enrollment-related documentation (e.g., HIPAA Certificates, Letters, full-time student verification, COB investigation, proof of dependent status, etc.) to the group and participant. The system allows for programming of edits related to Plan Document provisions, such as an annual COB review or semi-annual full-time student review. HealthSCOPE Benefits maintains all eligibility data in our system for as long as the client is active (including run-out periods).

3.1.6.3 Are COB savings tracked online?

Yes, the system tracks them automatically.

3.1.6.4 PEBP requires the TPA to provide a weekly COB update file to PEBP's PBM. The COB file contains information regarding PEBP participants who have primary health insurance coverage (other than Medicare). Please confirm your organization's willingness to continue and possibly improve this process.

Confirmed, we would welcome the opportunity to work with PEBP on improving the process.

3.1.6.5 Explain your organization's standard subrogation policy and procedures; include the criteria used to identify potential subrogation claims.

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group:

"Chase & Pay" Approach

A claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third

party. The case is then passed on to our vendor for tracking and recovery.

"Pay & Chase" Approach

The claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan of Columbus, Ohio, for pursuit of a recovery agreement, tracking and recovery.

The cost of subrogation services is 25% of recoveries gained through intervention. LNL keeps 13% and HSB is paid 12% for its administrative work on the claim.

Because of our experience, we were able to develop highly efficient and effective software that allows us to maximize recoveries. Our claims review process allows us to quickly and accurately identify potential subrogation situations. Once a subrogation file is opened, our software and practice methods allow us to spend time on an exceptionally high volume of cases, including those with low total paid claim amounts. Our experience with subrogation recovery has shown that a high number of low dollar cases will result in a dramatic increase in savings for the health plans. Others in our industry have adopted the belief that only high dollar cases should be reviewed, and our research and experience has concluded to the contrary.

Our attorneys use their legal experience and negotiation/litigation knowledge to maximize recoveries, but perhaps even more importantly, to limit the liability of customers and groups, thus avoiding unnecessary risk and expensive legal fees.

Our superior subrogation computer program and subrogation practice methods allow for intricate investigations on a high volume of cases while maximizing recoveries for our clients. Our experienced lawyers and our dedicated staff provide high quality service which translates into increased savings to our clients.

As noted above, potential Subrogation claims are identified through a claims mining process. Our Claims Review program will filter out the appropriate ICD-9 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident or 'slip and fall' cases.

A more detailed description of our subrogation services' processes is provided below.

3.1.6.6 How do you investigate for potential subrogation or other third party liability claims?

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase & pay" or "pay & chase" approach, depending on the preference of the group. In the "chase & pay" approach, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is requested to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our

vendor for tracking and recovery. In the "pay & chase" approach, the claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan, for pursuit of a recovery agreement, tracking and recovery.

Review and Identification of Potential Claims
The process begins by receiving the paid or denied claims from the client, and importing these claims into our Claims Review system via an electronic data transfer. Our Claims Review program will filter out the appropriate ICD-9 codes and target the claims that individually or collectively may possibly give rise to a right of recovery in addition to those that are coded as definite auto accident or 'slip and fall' cases. Once imported, theses claims are appropriately categorized by the program.

Our staff will then begin the process of pulling up the member's claims records and reviewing the information and at this point make a decision to investigate further or not. Claims that are targeted (they appear with a check mark next to them) will be reviewed first because these targeted codes are most likely subrogation situations. If the claims appear as though they will not yield the potential for subrogation, the member is sent into a 90 day follow up. In 90 days, the member's record will be re-opened if new claims have been received since the date the diary was started. The staff member will be able to review any claims that have been imported since the last 90 day diary and again make a decision as to whether or not a letter should be sent.

If the decision has been made to send a letter and questionnaire, a letter will be sent that day.

There are two different types of letters that are sent. There are letters for definite auto accidents and letters for more general medical treatments. Each letter has different language and a different questionnaire so that it is more specific to the situation.

If the member does not respond to the first letter, a second follow up letter and questionnaire will be automatically sent in 20 days. If the member does not respond to the 2nd letter, they will appear on a Non-Response report, which can be sent to the client if they wish. The staff will review this report at the end of each month and pull the members that have high dollar amount claims. Additional research and attempts to contact the members will be made if it appears that the potential for subrogation is high.

During this process, if a member receives a letter and has a question, they may respond to an online questionnaire or call a toll free number to contact a staff member for direction. Our staff will also follow up with a phone call to members that have questions or have not responded.

If a letter is sent and the individual responds and indicates there was no accident, and this is consistent with our experience and any other investigation information, the member's records will be appropriately noted that a response was received, and they will be sent into the 90 day follow up process once again.

If a response to a letter indicates that the potential for subrogation exists, a subrogation file will be opened and an investigation will begin.

Investigation

Once a response is received and there appears be an opportunity for subrogation, our staff will begin the research to identify all of the appropriate parties that are involved. Our questionnaires have proven to be very effective in obtaining the information we require to proceed, although there are instances where we must research further.

One valuable feature of our subrogation program is that it contains an extensive database of attorney names and addresses, insurance company names and addresses, and insurance adjuster names and phone/fax numbers. We can search by insurance company name, by the adjuster's name, or by attorney name and find the information quickly. Our program also contains numerous other search methods. This has proven to be a valuable tool and has allowed us to quickly proceed with all necessary action. This database is constantly updated as new insurance adjusters or attorneys are added. Basically, if we are provided with only a name, we can search within our database to attempt to locate the adjuster or attorney. This allows us to focus our time and energy on presenting the lien quickly, therefore protecting the health plan's recovery rights.

Sometimes additional research may be necessary and phone calls will be made by our experienced staff members to gather all of the information required. We exhaust all efforts in gathering information. This includes but is not limited to using the internet, contacting the plan member via phone, contacting the liable third party for insurance information, calling insurance companies to locate the appropriate file handler, searching for police reports, and researching court records. If the member has not set up a claim for an accident, we will contact the responsible insurance company and set up a claim for the health plan.

In addition, our program contains a series of standard forms for different types of incidents that we use to obtain additional information. These forms are specific to the situation that occurred and have yielded positive results in obtaining the required information. For example, we have a separate form for each of the following: slip and falls; boat accidents; dog bite incidents; assaults; ATV accidents; one car accidents; and multiple vehicle accidents.

We continue to investigate until answers are received, while others may choose to terminate the investigation and close the file.

Once all of the information is received, all of the involved parties are placed on notice of the subrogation lien.

Working and Tracking Open Files/Cases
Once a file has been opened and all of the appropriate parties have been placed on notice, the file will go into our maintenance and follow-up stage. Typically, once the parties have been placed on notice, they will request the amount of our client's lien or copies of additional documents. Our staff members will update the files by researching our client's claims database and obtain all of the required and/or requested information (strictly following HIPAA guidelines). We provide this information upon request and often numerous times within the life of one file.

Our subrogation program allows us to update the lien amounts easily. Our program is highly efficient and allows for quick turn-around.

Our program utilizes "Reminders" for file follow up. Basically, once a file is opened and the initial notice letters are sent, a reminder will automatically be placed on the file. No file will ever "fall through the cracks" because there will always be a reminder on the file. Every letter that is sent from our subrogation program is associated with a reminder. Therefore, once a letter is printed, a reminder will be placed on the file for later follow up.

If the designated time expires and a response has not been received from the other party, these reminders will re-open in a "Reminder" Database. The Reminders are reviewed daily by our staff members. Each reminder is very specific and will let the staff member know exactly what needs to be done next. When a member opens a Reminder, they will be taken into the related file record. The staff member will have all of the pertinent information available to them and will evaluate the file appropriately.

We obtain status updates on a regular basis for every file that is opened. We request the status from the member's attorney and insurance adjusters, among others. If we do not receive a response to our first status request, we will follow up with phone calls until a response is received. We feel it is extremely important to call the other parties if there is no response.

When we receive a response to one of our letters, all of the pertinent information is entered into the file history. A new reminder will be placed on the file that tells us to follow up in the specified number of days.

The file history is where we keep track of the history of the file from beginning to end. We keep a physical file that contains important documents, but we also use the file history in the subrogation program to keep detailed records. This is much like a journal and it contains a historically sorted and dated written record of the following: All letters that have been sent, staff member journal entries, synopsis of phone conversations, copies of emails, faxes, written description of all letters received, and lists any recoveries that have been received.

Once again, all of our files are carefully and skillfully tracked to their conclusion.

Attorney Involvement / Legal Expertise

When there are legal questions such as assertions of state law "made whole" or other statutes, ERISA queries, excess carrier, issues of contributory negligence, priority of coverages based upon contract language, and numerous others, one of our attorneys is immediately involved to respond, educate or explain to opposing parties, negotiate or contest up to and threatening or commencing litigation.

File Resolution and Settlement

Once a subrogation file has reached the point of conclusion, our educated and experienced staff will work to resolve the matter.

Customized Reporting

The deposits that have been made within a given month are listed on the Subrogation Recovery Report. We break down each reimbursement that has been received and list the associated claim number to which the recovery applies. This is very important because it allows the client to accurately and easily update their records to reflect the correct information. We are also able to create customized reports for depending on the client's specific needs

3.1.6.7 Does your organization utilize the services of a subrogation recovery company? If yes, please indicate the name of the company, their fee for recovery services, their criteria that triggers a recovery action, and their average rate of return for 2008 and 2009.

Confirmed, Luper, Neidenthal & Logan of Columbus, Ohio, provides our subrogation recovery services. Their fee is 25% of Recoveries gained through intervention with LNL keeping 13%

Average rate of return for 2008 /2009
IMPORTANT: Many of the files that were opened in any given year are still active in following year(s) and therefore recovery has not yet been obtained. As people continue to treat under the health plan, the amount paid by the plan will continue to increase. Settling some cases too quickly would result in the plan being unable to collect reimbursement on claims that are paid after the settlement date. It is important to note that subrogation files sometimes take years to conclude and therefore it is difficult to provide an accurate number of recoveries obtained when only reviewing one specific year. Also, not all of the total dollars identified for subrogation are actually subrogation opportunities. Many times we will learn through the process of our investigations that no other insurance exists, so there is nothing to subrogate. These dollars are included in the "total dollars identified for possible subrogation" number, even though they are not actually subrogation dollars.

Total dollars identified for possible subrogation in 2008 = $11,442,993.70

Total dollars recovered in 2008 = $2,100,802.31

Luper Neidenthal & Logan recovered 18% of all total possible dollars identified in 2008

Total dollars indentified for subrogation in 2009 = $8,971,570.16
Total dollars recovered in 2009 = $2,404,757.52
LNL recovered 27% of all total possible dollars identified in 2009

3.1.6.8 List in detail the fees your organization charges for subrogation. Are these fees based on a percentage of recovered funds? Be as specific as possible. Include this information in your cost proposal.

Subrogation is charged at 25% of Recoveries gained through

Customized Reporting

The deposits that have been made within a given month are listed on the Subrogation Recovery Report. We break down each reimbursement that has been received and list the associated claim number to which the recovery applies. This is very important because it allows the client to accurately and easily update their records to reflect the correct information. We are also able to create customized reports for depending on the client's specific needs

3.1.6.7 Does your organization utilize the services of a subrogation recovery company? If yes, please indicate the name of the company, their fee for recovery services, their criteria that triggers a recovery action, and their average rate of return for 2008 and 2009.

Confirmed, Luper, Neidenthal & Logan of Columbus, Ohio, provides our subrogation recovery services. Their fee is 25% of Recoveries gained through intervention with LNL keeping 17%

Average rate of return for 2008 /2009
IMPORTANT: Many of the files that were opened in any given year are still active in following year(s) and therefore recovery has not yet been obtained. As people continue to treat under the health plan, the amount paid by the plan will continue to increase. Settling some cases too quickly would result in the plan being unable to collect reimbursement on claims that are paid after the settlement date. It is important to note that subrogation files sometimes take years to conclude and therefore it is difficult to provide an accurate number of recoveries obtained when only reviewing one specific year. Also, not all of the total dollars identified for subrogation are actually subrogation opportunities. Many times we will learn through the process of our investigations that no other insurance exists, so there is nothing to subrogate. These dollars are included in the "total dollars identified for possible subrogation" number, even though they are not actually subrogation dollars.

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3.1.6.8 List in detail the fees your organization charges for subrogation. Are these fees based on a percentage of recovered funds? Be as specific as possible. Include this information in your cost proposal.

Subrogation is charged at 25% of Recoveries gained through

intervention.

We charge 50% if we have to hire an attorney. I've pasted the language below from our usual contracts.

In the event TPA collects a subrogation claim of Plan Sponsor without retaining an attorney to represent the interests of Plan Sponsor, Plan Sponsor will pay TPA a fee for its services under this Agreement equal to twenty-five percent (25%) of the gross amount recovered for such claim.

In the event TPA collects a subrogation claim of Plan Sponsor but such collection requires retaining an attorney to represent the interests of Plan Sponsor, Plan Sponsor will pay TPA a fee for its services not to exceed fifty percent (50%) of the gross amount recovered for such claim, which includes all litigation expenses, if any, and attorneys' fees.

3.1.6.9 Please describe in detail, how your organization investigates potential workers' compensation claims?

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system. We are able to handle a "chase and pay" or "pay and chase" approach depending on the preference of the PEBP. In the "chase and pay" approach, a claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is requested to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed to our vendor for tracking and recovery. In the "pay and chase" approach, the claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal and Logan for pursuit of a recovery agreement, tracking and recovery.

3.1.7 Financial Management

3.1.7.1 Describe how the claims processing system will be reconciled with the Bank of America account and provide sample reports that would be submitted to PEBP. Please provide a reconciliation schedule with your proposal.

HealthSCOPE Benefits utilizes positive pay and full reconciliation services with Bank of America. A file is sent from our claims system to Bank of America for any check issued, voided or stopped. We receive a monthly reconciliation reports from Bank of America. We reconcile the information from our systems monthly check register against the Bank of America reports. Any variances are then researched and resolved.

Please refer to Exhibit 14 to reference our sample reconciliation schedule.

3.1.7.2 Describe what type, if any, of self-audits are performed to review compliance with internal financial controls and reconciliation of the claims account. Include how often any self-audits are completed.

A detailed review of all monthly bank reconciliations is performed by the Supervisor of Financial Operations. The Director of Financial Operations does a quarterly review of the approved reconciliations. In addition, HealthSCOPE Benefits has an annual SAS 70 audit in which all of our controls are reviewed and tested.

4. PRIVACY and SECURITY

4.1 Does your organization certify that it is in full compliance with HIPAA's administrative simplification standards relating to electronic data interchange (EDI)?

Confirmed

4.2 If applicable, does your organization certify that it reports to the national Healthcare Integrity and Protection Databank (HIPDB) as required and, as may be necessary, submits inquiries to the HIPDB to determine whether any final adverse legal actions have been taken against its member providers?

Yes

4.3 Does your organization certify that it will not require that enrollment and eligibility information and eligibility information electronically transmitted by Client to Vendor comply with EDI?

Confirmed

4.4 Does your organization certify that it is in full compliance with HIPAA's regulation protecting the privacy of individually identifiable health information (the Privacy Rule)?

Confirmed

4.5 Please provide a copy of your organization's HIPAA privacy procedures and any certification you have with respect to HIPAA compliance.

HealthSCOPE Benefits is fully compliant with HIPAA's transaction, privacy and security standards. Our compliance department, Privacy Officers and Security Officers have completed intensive HIPAA training. In addition to ongoing monitoring, we also complete testing of procedures as part of our SAS-70 certification.

Our legal/compliance department is responsible for drafting and implementing policies concerning privacy/confidentiality with regards to protected client information. From a privacy perspective, we have completed significant training of our entire staff and all subcontractors/external vendors as well as implemented several procedural and system controls. All vendor relationships are tightly controlled and audited on an ongoing basis.

For security, we have implemented tight controls on data exchanges and the storage of data. For transmitted data that contains HIPAA/PHI, we utilize file transfer protocol (ftp) and PGP encryption. We also utilize ANSI for claims and eligibility received. In addition,

our client's HR/benefit staff is able to interact with HealthSCOPE Benefits personnel via encrypted e-mail per HIPAA security standards.

All HealthSCOPE Benefits employees adhere to strict HIPAA regulations and guidelines. Benefit Analysts/Claim Examiners complete ongoing training that includes weekly "round table" discussions of procedures, as well as formalized monthly training on topics such as HIPAA privacy and security, fraud, clinical editing, and new procedures. A final element of training includes a briefing on the plans and special requirements of all new clients.

To help you comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), HealthSCOPE provides complete HIPAA Certification Administration. These services include identifying employees and dependents whose coverage has terminated and generating corresponding HIPAA Certificates of Creditable Coverage from their previous plan, and calculating the amount of creditable coverage each person should have.

Please refer to Exhibit 15 to reference our HIPAA Certification.

4.6 Does your organization agree to provide PEBP's Actuary/Consultant access to protected health information under the employer's health plan (PEBP) if the Consultant/Actuary executes a Business Associate Agreement with PEBP?

Confirmed

4.7 Has your organization reviewed the American Recovery and Reinvestment Act (ARRA) of 2009 and performed an analysis to determine changes needed within your organization? Do you have an action plan to address these changes and how they would affect PEBP?

Yes, we have reviewed ARRA, we have implemented its changes, and we have action plans in place to address changes and how it affects PEBP.

4.8 Has your organization reviewed Health Care Reform (PPACA) of 2010 and performed an analysis to determine changes needed within your organization? Do you have an action plan to address these changes and how they would affect PEBP?

Yes, we have reviewed PRACA. We are working with each of our clients individually to address the changes, and we would work with PEBP to review options and determine implementation steps.

4.9 PEBP requires all its vendors to sign a Business Associates Agreement (Attachment F), please confirm that your organization agrees to the provisions in PEBP's Business Associates Agreement and will return the executed document to PEBP within the stated timelines upon issuance.

Confirmed

5. IMPLEMENTATION REQUIREMENTS

5.1 Assuming the contract is effective upon Board of Examiner's approval (anticipated to be April 13, 2011), please provide a detailed implementation schedule, which outlines the transition process, critical deadlines, key staff, and coordination with the Eligibility and

Enrollment Information System, to include Open Enrollment deadlines for plan year 2011. Open Enrollment is tentatively scheduled for May 2011 with July 1, 2011 effective date of change.

Please refer to Exhibit 16 to review our detailed implementation schedule.

6. PERFORMANCE STANDARDS/GUARANTEES and PERFORMANCE PENALTIES

6.1 The requirements as indicated in Attachment F are areas where the awarded vendor will guarantee performance. Failure to meet the required standards will result in the assessment of liquidated damages in the amount of the penalties stated in Attachment F. PEBP will reduce future payment of administrative fees to the vendor by the amount of the liquidated damages. If future payments are less than the amount of liquidated damages, vendor will pay the amount of liquidated damages to PEBP immediately. Prompt resolution of problems or issues is expected, but will not reduce or eliminate any liquidated damages imposed due to failure to meet the performance standards outlined.

PEBP will determine compliance with service performance standards and guarantees through quarterly audits performed by the PEBP's health plan auditor. If vendor fails to meet the required standard, liquidated damages will be assessed per failed standard for each period audited. For example, if the Third Party Administrator is found to be in non-compliance for TAT (turnaround time) for July through September – a penalty of 2.5% of the administrative fees paid for July through September will be assessed. If the Third Party Administrator is found to be in non-compliance in all five performance standard areas, the maximum penalty assessed shall not exceed 25% of the administrative fee for the quarter audited.

Please note the awarded vendor will have the opportunity to dispute any findings by PEBP's health plan auditor. The final outcome of the dispute, however, will be decided by PEBP.

Assessment of the liquidated damages does not preclude declaration of breach of assessment of other damages that the State may be entitled to recover.

Confirmed

While PEBP is adamant that Performance Guarantees and Penalties remain part of the TPA contract, PEBP encourages proposing vendors to propose an alternate method for possible consideration.

Confirmed, please refer to Section III to reference alternate performance guarantees.

7. INSURANCE SCHEDULE/BOND REQUIREMENTS

Vendor must meet and provide proof of all insurance schedule requirements outlined in the attached State of Nevada Insurance Requirement Schedule (contained in Attachment C) before a contract shall be awarded. These documents must be included with your RFP response.

Please refer to Section III review all HSB proof of insurance certificates.

8. COMPANY BACKGROUND AND REFERENCES

8.1 PRIMARY VENDOR INFORMATION

Vendors must provide a company profile. Information provided shall include:

8.1.1 Company ownership (sole proprietor, partnership, etc).

HealthSCOPE Benefits is a privately held corporation.

8.1.1.1 Incorporated companies must identify the state in which the company is incorporated and the date of incorporation. **Please be advised**, pursuant to NRS §80.010, incorporated companies must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS §80.015.

State in which company incorporated – Deleware

Date of Incorporation – October 26, 2000

8.1.1.2 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the Office of the Secretary of State pursuant to NRS §76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us. Vendors must provide the following:

- Nevada Business License Number
- **NV20011223201**
- Legal Entity Name
- **HealthSCOPE Benefits**
- Is "Legal Entity Name" the same name as vendor is doing business as?
  [√] Yes [ ] No
  If "No," provide explanation.

8.1.2 Disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigation pending which involves the vendor or in which the vendor has been judged guilty or liable.

Please refer to Exhibit 17 to reference current pending cases. Please note all of these cases are very typical cases for a TPA. We many have included more than you would want here, but we in no way believe we had any significant contract failures or breaches.

8.1.3 Location(s) of the company offices and location of the office that will provide the services described in this RFP.

HealthSCOPE Benefits' Office Locations:

Headquarters:

HealthSCOPE Benefits
27 Corporate Hill Drive
Little Rock, AR 72205

HealthSCOPE Benefits
8800 Lyra Drive, Suite 650
Columbus, Ohio 43240

HealthSCOPE Benefits
2731 Sutton Blvd., Suite 110
St. Louis, MO 63143

HealthSCOPE Benefits
2630 Elm Hill Pike, #203
Nashville, TN 37214

HealthSCOPE Benefits
9045 E. 59th Street
Indianapolis, IN 46216

HealthSCOPE Benefits
7430 Remcon, Building C
El Paso, TX 79912

HealthSCOPE Benefits
815 Colorado Blvd., 4th Floor
Los Angeles, CA 90041

HealthSCOPE Benefits will provide services to the PEBP at our Little Rock, Arkansas and Columbus, Ohio offices.

8.1.4 Number of employees both locally and nationally.

315

8.1.5 Location(s) from which employees will be assigned.

HealthSCOPE Benefits
27 Corporate Hill Drive
Little Rock, AR 72205

HealthSCOPE Benefits
8800 Lyra Drive, Suite 650
Columbus, Ohio 43240

8.1.6 Name, address and telephone number of the vendor's point of contact for a contract resulting from this RFP.

Mary Catherine Person, President
27 Corporate Hill Drive
Little Rock, AR 72205
Phone: 501-218-7513
Email: mary.person@heatlhscopebenefits.com

8.1.7 Company background/history and why vendor is qualified to provide the services described in this RFP.

Founded in 1985, our company was originally incorporated as Burgett Dietrich (B&D) and specialized in developing and managing "non-metropolitan area" managed care networks, mainly for Fortune 500 manufacturing companies. Since our inception, we have developed over 130 custom Point-of-Service (POS) gatekeeper and PPO networks in more than 30 states.

In 1992, B&D was acquired by CoreSource, then the third largest Third Party Administrator (TPA) in the country. This acquisition and our client's needs spurred the development of a complete portfolio of employee benefit services, including claims and other administrative support services to accommodate large, national accounts.

In 1996, the former B&D was spun off from CoreSource and became a wholly owned subsidiary of CNA (Chicago, IL) and was re-named, CNA Health Partners, Inc. (CNAHP). Our expansion of services and growth continued as CNAHP added supplemental services such as COBRA, Flexible Benefits Administration, Short-Term Disability, HIPAA and Retiree Administration to meet the needs of our clients.

On March 1, 2001 our company became a freestanding company with a commitment to technology to support our clients, with a new name – HealthSCOPE Benefits, Inc. (HSB). In August 1, 2002, HSB was acquired by and was a wholly owned subsidiary of Central Benefits Mutual Insurance Company (which also included Central Benefits Administrators, Morris Associates, and The Plan Handlers).

On December 31, 2007, all TPAs were merged into HealthSCOPE Benefits, and purchased through a management buyout to become a freestanding independent company. Our independence and flexibility will allow us to provide the services described. Since becoming and independent entity, HSB has seen significant business growth, high client satisfaction and excellent cost trends.

All TPAs are not the same. HSB is different. We back up our claims, guarantee results and maintain long-lasting relationships with our clients. HSB's partnership with you is founded on three tenets. It is our pledge to work with you to develop an attractive, affordable and customer-friendly benefits plan for your employees.

Healthy People
Unlike an insurance company, we are not simply accepting risk on behalf of our clients. Unlike a traditional TPA, we are not simply adjudicating and paying claims for the self-insured. Rather, our company empowers clients to proactively monitor and manage the health of their employee populations.

Healthy Business
It's well documented that a healthier workforce is a more productive workforce. But HealthSCOPE Benefits goes beyond the basics to help deliver a healthier bottom line – by assertively controlling healthcare costs through networks, discounts and utilization management. Furthermore, HealthSCOPE's flexible, customized plan design means our client companies are delivering exactly the benefit structure they want.

Healthy Futures
HealthSCOPE Benefits is a partner for the long term; the real value of our partnership is unlocked over time. HealthSCOPE creates sustainable benefit programs. By enabling cost trend management dramatically below the industry's average, HealthSCOPE helps its clients create healthier futures. HSB has been

able to manage it's clients cost trends aggressively while our customers have made limited benefit changes. Our average trend over the last 6 years is 3.5%

8.1.8 Length of time vendor has been providing services described in this RFP to the **public and/or private sector**. Please provide a brief description.

We have been providing claims administration services since 1992 when our clients asked us to get begin processing claims. Our first client is still a client, showing our commitment to service and innovation.

8.1.9 Has the vendor ever been engaged under contract by any State of Nevada agency?
[ ] Yes [√] No If "Yes," specify when, for what duties, and for which agency.

8.1.10 Is the vendor or any of the vendor's employees employed by the State of Nevada, any of its political subdivisions or by any other government?
[ ] Yes [√] No If "Yes," is that employee planning to render services while on annual leave, compensatory time, sick leave, or on his own time?

8.1.11 Is the vendor currently involved in litigation with the State of Nevada or any other entity?
[√] Yes [ ] No If "Yes," list details.

Like all TPAs, we are pulled into disputes based on client plan design or other entities failure to execute their duties.

- Baylor University Medical Center, Baylor Medical Center at Grapevine v. James Hardie Building Products Inc.; HealthSCOPE Benefits, Inc. Case No.: CC-10-05503-A. The County Court of Dallas, Texas. Plaintiff alleged breach of contract in regard to the client's plan taking certain discounts for provider services. Settlement negotiations are underway as of 8/31/10.
- Hot Springs National Park Hospital Holdings, LLC v. Sheryl Pitchford, Employers' Health Coalition, Triumph Airborne Structures, Inc. and HealthSCOPE Benefits, Inc. Case No. CV 2008-468. The Circuit Court of Garland County, Arkansas. Plaintiff alleged breach of contract for discounts taken by the client's plan. The case is pending in trial court.
- Irma Contreras v. Clint Independent School District and Access Administrators. Case No: 2009-041. District Court of El Paso County 448th District, Texas. Plaintiff alleged breach of contract related to the plan's decision to deny a procedure the plan found to be cosmetic. Plaintiff is currently appealing a trial court's decision in favor of the defendants.
- James Hardie Building Products, Inc. v. Best Life and Health Insurance Co. Best Re, Inc.; Plan Handlers, Inc.; and HealthSCOPE Benefits, Inc. Case No: 37-2010-00086933-CU-BC-CTL. San Diego Superior Court, California. Plaintiff alleged negligence and breach of contract related to the stop loss carrier's decision to deny certain claims of Plaintiff's. The case is pending in trial court.
- Tri-City Medical Center, administered by Tri-City Healthcare District v. North County Ford, Inc.; HealthSCOPE Benefits, Inc. Case No.: 37-2010-00058039-CU-BC-NC. Superior Court of California, County of San Diego. Plaintiff alleged breach of contract for discounts taken by the client's plan. Defendants are preparing their response. The case is pending in trial court.

8.1.12 Resumes for key staff to be responsible for performance of any contract resulting from this RFP.

Please refer to Exhibit 18 to review all resumes for key staff to be responsible for performance of any contract resulting from this RFP.

8.1.13 ***Financial information and documentation to be included in Part III of your response in accordance with the Submittal Instructions.***

8.1.13.1 Dun and Bradstreet number - **94-555-7239**

8.1.13.2 Federal Tax Identification Number - **710847266**

8.1.13.3 The last two - (2) years and current year interim: **Included**
Profit and Loss Statement
Balance Statement

8.2 REFERENCES

Vendors should provide a minimum of three (3) references from similar projects performed for private, state and/or large local government clients within the last three years. **Vendors are required to submit Attachment D, Reference Form to the business references they list. The business references must submit the Reference Form directly to the Purchasing Division.** It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the proposal submission deadline for inclusion in the evaluation process. Business References not received, or not complete, may adversely affect the vendor's score in the evaluation process. The Purchasing Division may contact any or all business references for validation of information submitted.

8.2.1 Client name;
8.2.2 Project description;
8.2.3 Project dates (starting and ending);
8.2.4 Technical environment; (i.e., Software applications, Internet capabilities, Data communications, Network, Hardware)
8.2.5 Staff assigned to reference engagement that will be designated for work per this RFP;
8.2.6 Client project manager name, telephone number, fax number and e-mail address.

Confirmed, we have sent Attachment D, Reference Form, to three references including: Whirlpool, CONSOL Energy, and Toledo Public Schools. We included Whirlpool and CONSOL because their size is similar to PEBP and their complexity is similar. We includes TPS because we wanted you to have the options of a public entity, as well.

Whirlpool
Judy Locatis, Benefits Manager
2000 M-63 North
Benton Harbor, MI 49022
Phone: 269-923-7291
Client since 1989

CONSOL Energy
Vanessa Davis
1000 Consol Energy Drive

Canonsburg, PA 15317
Phone: 724-485-4290
Client since 2004

Toledo Public Schools
Mike Coutuier
420 E. Manhattan Boulevard
Toledo, OH 43608
Phone: 419-671-8349
Client since 2007

8.3 SUBCONTRACTOR INFORMATION

8.3.1 Does this proposal include the use of subcontractors?

Yes __√__ No _____ Unknown _____

If "Yes", vendor must:

8.3.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

Client Name:

Mulally Insurance Services

Contact:

Mary Jean Mullally, President
MIS, Inc.
16017 North Florida Ave.
Suite 132
Lutz, Florida 33549
Office 813.973.8700
Direct Line 813.994.6353
Cell 813-787-5191
Fax 832.550.0401

Project Dates: 01/01/97 to Present

Description:

Provides claims auditing services based on industry standards and client specific benefits as outlined in client's summary plan document.

The rising cost of medical care is forcing more employers and their consultants to become involved in their own employee benefit programs. That involvement is changing both the patterns of obtaining benefits and the methods of funding them.

The employer is now finding it necessary to assume a larger portion of the risk. Myriads of managed care health products have emerged to help the employer and their consultants control their health care expenditures.

Information has become the most powerful weapon in the war on escalating medical costs. Utilization review programs, catastrophic case management, and data analysis packages all attempt to generate reports to help identify and analyze utilization patterns.

Employers and their consultants are relying on these reports to make crucial decisions about plan designs and cost containment measures. The astonishing truth is that most of these decisions are made without ever questioning the integrity of the basic information used to generate the reports Millions of dollars are spent each year for the purchase of managed care programs. Nothing is spent on auditing the credibility of the most basic source of information

If your insurance company or third party administrator is not adjudicating claims accurately and according to the plan design, all other information that follows is useless.

MULLALLY INSURANCE SERVICES, INC. emerged from the experience of professionals with both health insurance and claims administration backgrounds. They realized that the accuracy of claims administration increased dramatically when the claims examiners are subject to independent audits.

Client Name:

Empowered Benefits

Contact:

John Gage
Vice President
Empowered Benefits
124 N. McDowell Ct.
Charlotte NC 28204
704-369-0190 ext. 110
jgage@empoweredbenefits.com

www.empoweredbenefits.com

Project Dates: 01/01/2006 - Present

Description:

Based in Charlotte, NC, Empowered Benefits is a 10-year-old technology company that creates personalized and secure web platforms to allow TPAs, Health Plans , and large employers to communicate, deliver and enroll employees in benefits programs.

Empowered Benefits has developed a rules-based online benefits and communication platform that we've adapted, customized and installed for large and multi-locational companies that require complex business rules and eligibility rules and who require integration with multiple vendors and technology platforms.

We've grown our business by solving real-world problems the hard way — through careful listening, analysis, project management, follow-through and delivery. We've never stopped refining our core product.

Client Name:

Luper, Neidenthal and Logan

Contact:

Matthew Anderson, Esq.
Luper Neidenthal & Logan
A Legal Professional Association
50 West Broad Street, Suite 1200
Columbus, OH 43215-3374
Telephone: (614) 229-4473
Fax: (866) 345-4948
E-mail: manderson@lnlattorneys.com
Website: www.lnlattorneys.com

Project Dates: 2007 to Present

Description:

We use the latest in Microsoft technology, in addition to a proprietary software application that we have developed over the years. So whether it is downloading status reports directly into our volume clients' websites or uploading subrogation claims directly into our system, we are able to remain flexible and responsive to the needs of our clients.

Back-ups are performed daily and stored off-site to protect our clients' valuable data. In case of a catastrophic event, our downtime is minimized by the use of virtualization technology for our servers, which will enable us to quickly restore client data.

LNL was the first and is one of the few Ohio firms certified as a "Climate Challenge Partner" by the American Bar Association/Environmental Protection Agency's Law Office Climate Challenge. We are sensitive to environmental issues. As that relates to technology, we have designed a scanning program which has allowed many of our practice areas to become paperless. Wherever possible, our incoming documents are scanned and converted to a digital format, and our outgoing documents are generated and stored electronically. We have virtually eliminated all paper faxing. We send all faxes electronically, and all incoming faxes are delivered electronically directly to the recipient's desktop, eliminating the need for paper. When printing can't be avoided, we use high post-consumer content recycled paper.

Historically a Legal Technology Leader

Almost from the beginning, Luper Neidenthal and Logan has been a leader in law firm technology. Our efforts to stay ahead of the technological curve date back to the days of the IBM System 3X and Wang systems which provided some of the original functionality that is commonly found in law firms today. Our continued investment in the evolution of this type of technology afforded us unmatched client service, operational efficiency and decision support. Among the most notable effects on our firm and clients is the fact that we have enjoyed, over the last decade, exceptional integration of key data through a custom developed system now known as TotumWare (see more about this below). The benefits that we realized, and continue to realize, from the TotumWare initiative are profound. They include:

- **Unification of Time, Billing & Accounting Data in one system.**

- Integration of documents, journals, tasks and workflows with client and matter records providing a 360 degree view of our clients and the related work effort.

- Business Intelligence capabilities allowing us to analyze our practice across what are normally unrelated dimensions, including the correlation of such things as time, realization, profit, costs, client and matter count, type of law, attorney, originator and more.

- The integration of production law data from such areas as foreclosure, collection and subrogation with our core client system eliminating the need for multiple software systems and redundant data entry.

- Automation of bi-directional, secure data feeds between us and our partners and clients reducing overhead on all sides and improving data quality.

- Much more planned for release soon.

All claims are edited in our system for the potential of third-party liability based on diagnosis codes programmed into the system through our subcontractor, Luper, Neidenthal and Logan. We are able to handle a "chase and pay" or "pay and chase" approach, depending on the preference of the group:

"Chase & Pay" Approach

A claim is flagged and a letter sent to the participant requesting information on the injury and liability by a third party. If a third party is involved, the participant is asked to sign a subrogation agreement calling for repayment to the plan from any proceeds from the third party. The case is then passed on to our vendor for tracking and recovery.

"Pay & Chase" Approach

The claims are processed and the case forwarded to our vendor, the law firm of Luper, Neidenthal & Logan of Columbus, Ohio, for pursuit of a recovery agreement, tracking and recovery.

The cost of subrogation services is25% of recoveries gained through intervention.

Client Name:

AIM Healthcare (Nashville, TN)
Review hospital credit balances and DRGs.

Contact:

Clay Gregory
Client Management Director
1021 Windcross Court
Franklin, TN 37067
cgregory@aimhealth.com
Phone- 615-503-1268

Project Dates: 2005 to Present

Description:

AIM Traditional Credit Balance Resolution: identifies and validates overpayments on patient accounts in healthcare provider environments utilizing AIM's Account

Managers located on-site at over 1,700 Hospitals and Health Systems across the country;

AIM Overpayment Recovery Solutions: strategic recovery and resolution programs that maximize recoveries while maintaining and enhancing provider relationships; AIM Medicare Advantage Solutions: comprehensive revenue management services that provide the

Medical Bill Audit (MBA):MBA provides line-by-line, peer-to-peer review by registered nurses trained in recognizing overpayments, unsupported billing and errant coding practices. The registered nurse auditors in AIM's nationwide network are highly experienced RNs who have existing relationships with the providers in their local markets.

By comparing bills with medical records, MBA equips payers to repair gaps that allow inappropriate billing. Common errors uncovered include billing for medications that were never administered and charges for services that were not provided. In addition to delivering direct cost savings, MBA equips our clients to reach the root causes of costly billing issues.

DRG Validation

Ingenix DRG Validation delivers deep reductions of overpayments through the expertise of detail-oriented, certified coders.

Core Capabilities

- Good Audit Potential analysis provides concentrated focus on claims most likely to be overpaid
- Expert assessment of DRGs used throughout the country
- Identification of billing inconsistencies and errors in DRG coding
- Recovery of overpaid dollars

Audit Complete

Ingenix Audit Complete brings together the final solution to the service offerings to verify that all other coding and compliance areas are audited through a systematic and skilled approach.

Core Capabilities

- Coding audits using medical records to verify proper coding involving CPT codes
- Highly analytical approach to determine Good Audit Potential
- Ancillary, physician, and facility claims reviewed during audit process
- Clinical and Compliance audits using industry standard, and customized based on our client's processing guidelines

Client Name:

Dialysis Cost Containment, Inc. (DCC) (Sandpoint, ID)
Negotiate reasonable and customary charges on dialysis services.

Contact:

Kea Crotty
Program Director
DCC, Inc.
P.O. Box 718
Sandpoint, Idaho 83864
Office: 208-265-1719 ext. 112

Fax: 208-263-0824

Project Dates: 2007 to Present

Description:

HealthSCOPE Benefits, Inc. has partnered with Dialysis Cost Containment, Inc. ("DCC"), a member of the PRN Family of Companies. DCC offers an array of unique programs specifically designed to significantly reduce costs while safeguarding the patient from balance billing. These programs are described below:

- UCR Program. This program allows DCC to apply its own UCR payment methodology to the dialysis claim. This UCR methodology is based on the average revenue received by the providers per treatments. Under this program, a health plan can realize an average savings of over 80%.

- Home Health Dialysis Program. This program features use of a portable or transportable machine that significantly reduces the side effects seen in center or facility dialysis, extends life expectancy, improves the transplant success rate, and reduces or eliminates dietary restrictions typically necessitated by ESRD. The patient's participation in the program not only enhances the quality of the patient's life, but is also results in a reduction of the patient's medical costs.

- Epogen Carve Out Program. This program is designed for those patients who are receiving Epogen treatments (often the highest cost of dialysis) in connection with their ESRD. Under this program, DCC acquires the Epogen and coordinates the dispensation of the drug by working directly with the patient and patient's physician. Under this program, the patient is permitted to self-inject the Epogen in a home setting and DCC is able to arrange the purchase and delivery of the drug at less than the average wholesale price. A patient's participation in this program can result in a reduction of Epogen treatment costs by an average of 90% while, at the same time, giving the patients more control over their treatment and enhanced quality of life.

- Negotiated Discounts and Repricing. Under this program, DCC will negotiate directly with networks and providers for purposes of securing a better discount than that which would normally be available under a traditional network arrangement. Through our partnership with DCC, we are pleased to offer the services described above. For more information concerning the DCC programs, contact your HealthSCOPE Benefits, Inc. account executive.

The statistics on the price tag for cancer health care are staggering. A recent study conducted by IMS Health indicates that cancer care accounts for about 15% of a health plan's health care costs. With this in mind,

Client Name: Biologics

Contact:

Shayne A. Malone
Vice President of Sales
Biologics, Inc.
120 Weston Oaks Court
Cary, NC 27513

Project Dates: July 2009 to Present

Description:

Biologics - Oncology Management
HealthSCOPE Benefits, Inc. has partnered with Biologics, Incorporated ("Biologics"), in order to bring its customers a world-class cancer management process, known as the Oncology Management Solution ("OMS Program").

Biologics is a company with over 30 years of experience in the manufacturing of laboratory and medical instrumentation for the clinical, research, chemical, environmental, industrial and pharmaceutical laboratories throughout the world.

Biologic's OMS Program will minimize the plan's vulnerability to excessive financial risks in connection with the payment for chemotherapy charges associated with cancer care. In fact, Biologics has demonstrated that self-funded plans who access the OMS Program can realize cost savings of as much as 30% or more while providing members access to specialized cancer clinical support and education in between visits to their oncologist's office.

Under the OMS Program, participating employers will be provided with a comprehensive oncology-specific strategy for patient management, medication management, provider management and claims management that results in:

- **Intense clinical support to help members have a safe and successful therapy cycle, resulting in improved patient outcomes.**
- **Side effect mitigation through early intervention that could otherwise result in costly emergency and inpatient care.**
- **Cost avoidance for unnecessary and inappropriate chemotherapy treatment through proactive medication management.**

When a member is referred to the OMS Program, a certified oncology nurse coordinator and pharmacist are assigned as the key resource to both the member and treating physician during the course of the treatment. The nurse coordinator and pharmacist will be responsible for guiding members through the entire treatment process as they maintain ongoing communication with the patient's physician concerning the patient's therapy compliance, side effects management and general well-being.

Statistics show that the cost of cancer treatment and chemotherapy will only continue to rise; therefore, Biologics and HealthSCOPE Benefits, Inc. are pleased to make this cancer management program available to help defer these escalating costs.

Client Name: PHX

Contact:

Lori Sempervine
2 Crossroads Drive, Suite 101-B
Bedminster, NJ 07921
lsempervive@phx-online.com

Project Dates: April 12, 2010 to Present

Description:

Since 2003, PHX has been the industry leader in advanced cost management solutions for health plans. Our results-driven, innovative, customized, integrated solutions allow you to effectively gain control of rapidly increasing healthcare costs and reduce costs at every step of the claims process, from claims routing to data analytics. Using a personalized approach and sophisticated technological tools we can maximize your savings in both the near and long term – while dramatically reducing errors and turnaround time.

Our team includes highly skilled cost management experts, medical professionals, and IT specialists who understand the complexities of data analytics, PPO network management, clinical billing and coding, and claims editing. That experience enables us to develop end-to-end solutions tailored to meet your specific needs – and deliver real value and significant cost savings.

Every claim, every day.

Key benefits:
About Us

- **With nearly a decade of leadership and research in cost management for health plans, PHX has a thorough understanding of the complexities of PPO network management, clinical billing and coding requirements, claims editing and reporting issues, and the importance of an integrated approach to data analytics that drives meaningful insight for informed business decisions.**
- **We provide comprehensive solutions that contain costs at every step of the claims process – and seamlessly integrate into your organization.**
- **Our unique collaborative process helps us become a true long-term partner to your business – so we can understand your evolving needs and deliver the fastest, most cost-effective ways to meet your objectives.**
- **PHX offers significant IT infrastructure and data warehousing capabilities, sophisticated claims editing software, and robust yet user-friendly reporting tools.**
- **Our services save you money – at a very competitive price.**

Client Name: Devon Health Services, Inc.

Contact:

Trisha Leh
VP, Business Services
Devon Health Services, Inc.
1100 First Avenue, Suite 100
King of Prussia, PA 19406
P: 610-757-4127
F: 800-221-0002
tleh@devonhealth.com

Project Dates: February 2008 to Present

Description:

Devon Health's Consilium solution provides both out-of-network claim negotiations and the use of secondary network repricing.

Our claim negotiation model uses techniques that provide our clients with discounts that are well above the industry average. A typical claim negotiation process will start at the billed charge on a claim, which is extremely flawed and yields sub-par discounts. With the Consilium solution, Devon Health negotiators have access to a proprietary database containing over $40 billion in paid claims data. This database contains benchmark data from national, regional, and local payers, as well as Medicare, to determine fair market value for reimbursement on services rendered. The focus in our model is shifted from the billed charges to what is considered fair reimbursement. The Consilium solution produces average savings that are up to double the national standard and it mitigates the risks associated with UCR repricing and legacy cost-containment methods. Our negotiators also receive 100% sign off from the providers, which eliminates provider appeals and discount reversals.

Although Devon strongly believes that direct negotiation is the most effective method of receiving higher discounts on out-of-network claims, there is also value in using non-logo secondary networks in some situations. These partners allow non-logo network access, and have contractual arrangements in place with providers to accept the discount.

Devon uses a proprietary algorithm, programmed into its IMPACT claims database, to determine which claims are best suited for negotiations and which would be best to send onto one of its secondary networks. While our primary focus is on leveraging our negotiations program, we have developed a sophisticated program for routing claims to secondary networks as well. We call this "Intelligent Routing". Devon has been able to develop a process whereby we are able to ascertain which is the best network to send each claim to on the *provider level*, rather than regionally or traditionally tiered like most secondary network vendors. Devon also does not own its own secondary non-logo network so it does not have an incentive to push one network over another – Devon will simply pick which network will attain the greatest level of savings to the client.

Devon uses the IMPACT claims system, developed by MCSI. We are fully EDI capable and technologically flexible for our clients. Each client also has the capability to view our Client Portal online, for real-time reporting and to access statistics at any time.

Devon has been working with HealthSCOPE on claims negotiations since February 2008.

8.3.1.2 Provide the same information for any proposed subcontractors as requested in the Primary Vendor Information section.

Confirmed

8.3.1.3 References as specified above must be provided for any proposed subcontractors.

Confirmed

8.3.1.4 The State may require that the awarded vendor provide proof of payment to any subcontractors used for this project. Proposals should include a plan by which, at the State's request, the State will be notified of such payments.

We will provide the amount on a monthly invoice or any other way that the State would like.

8.3.1.5 Primary vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the using agency.

Confirmed

8.3.1.6 Primary vendor must notify the using agency of the intended use of any subcontractors not identified within their response and receive agency approval prior to subcontractor commencing work.

Confirmed

8.3.1.7 Failure to notify PEBP of the use of subcontractors prior to subcontractor commencing work will result in a penalty of five percent (5%) of the previous twelve (12) months' administrative fees per occurrence. Should subsequent billed charges not be sufficient to cover the penalty in full, the balance will be billed by PEBP and considered due upon receipt. You must indicate your organization's acceptance of this requirement.

Confirmed

8.3.1.8 Failure to notify PEBP of any data exchange relationship with any vendor, subcontractor or other entity, either disclosed or undisclosed will result in a penalty of five percent (5%) of the previous twelve (12) months' administrative fees per occurrence. Should subsequent billed charges not be sufficient to cover the penalty in full, the balance will be billed by PEBP and considered due upon receipt. You must indicate your organization's acceptance of this requirement.

Confirmed

8.4 ORGANIZATIONAL STABILITY AND EXPERIENCE

8.4.1. Provide the latest annual report or other financial report(s) that indicates the financial position of your organization. At minimum, provide: a) current ratio, b) days cash on hand, c) debt to equity ratio. Please provide your last two years of *audited* financial statements with your proposal.

Confirmed, this information will be provided as Part III – Confidential Information of our proposal.

8.4.2. Indicate if there are any outstanding legal actions pending against your organization. If so, please explain the number, nature and current status of the

action(s). Can you assure these actions will not disrupt business operations? Please provide State, Court and case number of any such action.

Please refer to Exhibit 17 to reference a current case log. Confirmed, these actions will not disrupt business operations in any way. These are typical cases for a TPA of our size.

8.4.3. Have you acquired or sold any organizations in the last twenty-four (24) months? If so, explain. Has your organization been acquired, purchased or merged with another organization in the last twenty-four (24) months. If so, explain.

Yes, we acquired Foresight TPA of El Paso, Texas on January 1, 2009. We have no other acquisition plans.

8.4.4. Have you relocated staff, changed computer or telephone systems in the last twelve (12) months? Do you anticipate any major changes to your organization or structure in the next twelve to twenty-four (12-24) months? Do you anticipate any changes to your telephone or computer systems in the next twelve to twenty-four (12-24) months? If so, elaborate.

No, we have had no relocations or system changes in the last 24 months, and we do not anticipate any.

8.4.5. For the team that will be handling PEBP's claims, indicate the number of employees for each of the following:

Position	Number
Medical Claims Examiners	13
Dental Claims Examiners	0 (Included in Medical)
Quality Control Staff	N/A Outsourced
Customer Service Representatives	20
Auditors	N/A Outsourced
Administrative Staff	0
Claims Manager	1
Provider Relations Representatives	1
Claims Supervisor	2
Information Technology Staff	1
Other - Account Management	2
TOTAL	40

8.4.6. For the following individuals, indicate the exact or average number of years experience with TPA management at your firm. For positions with an asterisk (*) indicated, please provide a copy of the individual's resume. If other key positions are listed by your organization, please provide a copy of the resumes for those individuals as well.

Years Experience	Years with Firm
Account Manager assigned to this contract * Darren Ashby	8.5 years
CEO * Joe Edwards	19 years, 6 mos.
Claims Director * Cathleen Armstrong	16 years
Claims Manager * Paula Williams	5 years, 10 mos.
Claims Supervisor * Cathy Gantt	14 years
Claim Examiners	6 years
Customer Service Manager * Wanda Elmore	4 years
Auditor Supervisor*	N/A
Customer Service Supervisor * Betina	1 month
Provider Relations Supervisor* Sanda Inglis	21 years
Customer Service Representatives	3 years
Quality Control Manager *	n/a
Quality Control Staff	n/a
Information Technology Manager * Ross Johnston	8.5 years
Other - President – Mary Catherine Person Client Relations Manager – Rhonda Huckaby Director of Business Systems – Ed Grooms	20 years 12 years
TOTAL	139 years

9. COST

All Cost Proposals shall be submitted to the State as a separate, sealed package and clearly marked: "Cost Proposal in Response to RFP No. 1893", please refer to the Submittal Instructions for further instruction.

Confirmed

All services covered under the vendors cost proposal should be listed. The State reserves the right to renegotiate price terms as market conditions warrant.

Confirmed

The State prefers to pay the administrative fee on a per participant per month basis (PPPM). PPPM is defined as Per Participant Per Month (primary insured [employee] or primary retiree). Does not include covered dependents.

Confirmed

The vendor shall bill all fees on the first of each month and no penalties and/or late charges shall be assessed. Complete the following table for all requested plan years. **All Fees are assumed guaranteed unless otherwise noted**. Costs submitted in different format other than what has been provided in this RFP could be refused.

Cost Table

All costs/fees must be disclosed to PEBP. Any costs/fees not disclosed in the vendor's proposal will not be accepted by PEBP.

Confirmed, please refer to Part II – Cost Proposal to reference all pricing.

10. PAYMENT

10.1 PEBP will pay the per participant per month (PPPM) costs based on a "snap shot" of PEBP enrollment generated by PEBP's eligibility and enrollment system on the 1st of each month. It is not necessary that the vendor provide an invoice on a monthly basis. PEBP will generate and provide an invoice with each monthly payment. Vendor shall provide PEBP with any information required to be on the invoice prior to initial payment.

Confirmed

10.2 PEBP will process payment by the fifteenth (15th) of each month and no interest or penalties shall be assessed for late payments.

Confirmed

10.3 Vendors may propose an alternative payment option. Alternative payment options will be considered if deemed in the best interest of the State, project or service solicited herein. The State does not issue payment prior to receipt of goods or services. The alternative options must be described in detail in the exception form provided on Attachment B of this RFP.

We are not suggesting any alternative payment options.

11. SUBMITTAL INSTRUCTIONS

11.1 In lieu of a pre-proposal conference, the Purchasing Division will accept questions and/or comments in writing regarding this RFP.

The RFP Question Submittal Form is located on the Services RFP/RFQ Opportunities webpage at http://purchasing.state.nv.us/services/sdocs.htm. Select this RFP number and the "Question" link.

The deadline for submitting questions is September 28, 2010 at 2:00 p.m., Pacific Time. All questions and/or comments will be addressed in writing and responses e-mailed or faxed to prospective vendors on or about October 1, 2010.

11.2 RFP Timeline

TASK	*DATE/TIME*
Deadline for submitting questions	09/28/10 @ 2:00 p.m.
Answers to all questions submitted available on or about	10/01/10
Deadline for submittal of Reference Questionnaires	10/22/10
Deadline for submission and opening of proposals	**10/26/10 @ 2:00 p.m.**
Evaluation period	10/28/10 – 11/05/10
Selection of finalist vendor(s)	11/08/10
Health Plan Audit of finalist vendor(s)	11/08/10 – 11/19/10
Interviews of finalist vendor(s)	12/01/10
Final Selection of successful vendor	12/02/10
Anticipated approval by Board of Examiners on or about	04/13/11
Contract start date	Upon BOE Approval

NOTE: These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective vendors. The State may invite finalist vendor(s) in for interview(s); however, the State reserves the right to waive any interviews and select a vendor based solely on proposals.

11.3 Proposal submission requirements:

11.3.1 Vendors shall submit their response in three (3) parts as designated below:

Part I: Technical Proposal

One (1) original marked "MASTER"
Eight (8) identical copies
One (1) identical copy on CD (**Note**: CD must be labeled accordingly and in a case.)

THE TECHNICAL PROPOSAL MUST INCLUDE A SEPARATE TAB/SECTION LABELED "**STATE DOCUMENTS**" WHICH SHALL INCLUDE:

- Page 1 of RFP
- All Amendments to the RFP
- All Attachments requiring signature
- Certificate of Insurance

Technical Proposal must not include cost or confidential information.

Technical Proposal shall be submitted to the State in a sealed package and be clearly marked:

"Technical Proposal in Response to RFP No. 1893"

Part II: Cost Proposal:

One (1) original marked "MASTER"
Eight (8) identical copies
One (1) identical copy on CD (**Note**: CD must be labeled accordingly and in a case.)

Cost Proposal shall be submitted to the State in a sealed package and be clearly marked:

"Cost Proposal in Response to RFP No. 1893"

Part III: Confidential Information:

One (1) original marked "MASTER"
Three (3) identical copies
One (1) identical copy on CD (**Note**: CD must be labeled accordingly and in a case.)

Confidential Information shall be submitted to the State in a sealed package and be clearly marked:

"Confidential Information in Response to RFP No. 1893"

If the separately sealed proposal, marked as required above, are enclosed in another container for mailing purposes, the outermost container must fully describe the contents of the package and be clearly marked:

REQUEST FOR PROPOSAL NO.: 1893
PROPOSAL OPENING DATE: October 26, 2010 @ 2:00 p.m.
FOR: Third Party Administration Services

11.3.2 **Proposal must be received at the address referenced below no later than 2:00 p.m. Pacific Time, October 26, 2010.** Proposals that do not arrive by proposal opening time and date WILL NOT BE ACCEPTED. Vendors may submit their proposal any time prior to the above stated deadline.

11.3.3 **Proposal shall be submitted to**:

State of Nevada, Purchasing Division
Colleen Janes, Purchasing Officer
515 E. Musser Street, Suite 300
Carson City, NV 89701

11.4 The State will not be held responsible for proposal envelopes mishandled as a result of the envelope not being properly prepared. Facsimile, e-mail or telephone proposals will **NOT** be considered; however, at the State's discretion, the proposal may be submitted all or in part on electronic media, as requested within the RFP document. Proposal may be

modified by facsimile, e-mail or written notice provided such notice is received prior to the opening of the proposals.

Confirmed

11.5 Although it is a public opening, only the names of the vendors submitting proposals will be announced NRS §333.335(6). Technical and cost details about proposals submitted will not be disclosed. Assistance for handicapped, blind or hearing-impaired persons who wish to attend the RFP opening is available. If special arrangements are necessary, please notify the Purchasing Division designee as soon as possible and at least two days in advance of the opening.

Confirmed

11.6 If discrepancies are found between two or more copies of the proposal, the master copy will provide the basis for resolving such discrepancies. If one copy of the proposal is not clearly marked "MASTER," the State may reject the proposal. However, the State may at its sole option, select one copy to be used as the master.

Confirmed

11.7 For ease of evaluation, the proposal should be presented in a format that corresponds to and references sections outlined within this RFP and should be presented in the same order. Responses to each section and subsection should be labeled so as to indicate which item is being addressed. Exceptions to this will be considered during the evaluation process.

Confirmed

11.8 If complete responses cannot be provided without referencing confidential information, such confidential information must be provided in accordance with submittal instructions and specific references made to the tab, page, section and/or paragraph where the confidential information can be located.

Confirmed

11.9 Proposals are to be prepared in such a way as to provide a straightforward, concise delineation of capabilities to satisfy the requirements of this RFP. Expensive bindings, colored displays, promotional materials, etc., are not necessary or desired. Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to the RFP requirements, and on completeness and clarity of content.

Confirmed

11.10 Descriptions on how any and all equipment and/or services will be used to meet the requirements of this RFP shall be given, in detail, along with any additional information documents that are appropriately marked.

Confirmed

11.11 The proposal must be signed by the individual(s) legally authorized to bind the vendor, see NRS §333.337.

Confirmed

11.12 For ease of responding to the RFP, vendors are encouraged, but not required, to request an electronic copy of the RFP. Electronic copies are available in the following formats: Word 2003 via e-mail, CD, or on the State Purchasing Division's website in PDF or Word format at http://purchasing.state.nv.us. When requesting an RFP via e-mail or CD, vendors should contact the Purchasing Division for assistance. In the event vendors choose to receive the RFP on CD, the vendor will be responsible for providing a blank CD; unless vendors provide a Federal Express, DHL, etc. account number and appropriate return materials, the CD will be returned by first class U.S. mail.

Confirmed

11.13 Vendors utilizing an electronic copy of the RFP in order to prepare their proposal should place their written response in ***an easily distinguishable font*** immediately following the applicable question.

Confirmed

11.14 ***For purposes of addressing questions concerning this RFP, the sole contact will be the Purchasing Division. Upon issuance of this RFP, other employees and representatives of the agencies identified in the RFP will not answer questions or otherwise discuss the contents of this RFP with any prospective vendors or their representatives. Failure to observe this restriction may result in disqualification of any subsequent proposal NAC §333.155(3).*** This restriction does not preclude discussions between affected parties for the purpose of conducting business unrelated to this procurement.

Confirmed

11.15 Vendor who believes proposal requirements or specifications are unnecessarily restrictive or limit competition may submit a request for administrative review, in writing, to the Purchasing Division. To be considered, a request for review must be **received** no later than the deadline for submission of questions.

Confirmed

The Purchasing Division shall promptly respond in writing to each written review request, and where appropriate, issue all revisions, substitutions or clarifications through a written amendment to the RFP.

Confirmed

Administrative review of technical or contractual requirements shall include the reason for the request, supported by factual information, and any proposed changes to the requirements.

Confirmed

11.16 If a vendor changes any material RFP language, vendor's response may be deemed non-responsive. NRS §333.311.

Confirmed

11.17 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals, which do not contain the requisite licensure, may be deemed non-responsive. However, this does not negate any applicable Nevada Revised Statute (NRS) requirements.

Confirmed

12. PROPOSAL EVALUATION AND AWARD PROCESS

12.1 Proposals shall be consistently evaluated and scored in accordance with NRS §333.335(3) based upon the following criteria:

- Demonstrated competence and experience in performance of comparable engagements
- Expertise and availability of key personnel
- Conformance with the terms of this RFP
- Implementation
- Reasonableness of cost
- References

  - **Note: Financial stability will be scored on a pass/fail basis**
  - **Vendors are advised that Aon Consulting is a contracted consultant/actuary to PEBP, but will not score the proposals in the evaluation process.**
  - **Proposals shall be kept confidential until a contract is awarded.**

As part of the evaluation process, the evaluation committee may invite top-scoring vendors to formally interview. Final selection would be made following the interviews.

Confirmed

12.2 The evaluation committee may also contact the references provided in response to the Section identified as Company Background and References; contact any vendor to clarify any response; contact any current users of a vendor's services; solicit information from any available source concerning any aspect of a proposal; and seek and review any other information deemed pertinent to the evaluation process. The evaluation committee shall not be obligated to accept the lowest priced proposal, but shall make an award in the best interests of the State of Nevada NRS § 333.335(5)

Confirmed

12.3 Immediately following the evaluation committee's selection of the finalist vendors, PEBP's health plan auditor will perform an on-site review of each TPA's claims system. The reviews are scheduled for November 8- 19, 2010.

Confirmed

12.4 Each vendor must include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the vendor or in which the vendor has been judged guilty or liable. Failure to comply with the terms of this provision may disqualify any proposal. The State reserves the right to reject any proposal based upon the vendor's prior history with the State or with any other party, which documents, without limitation, unsatisfactory performance, adversarial or contentious demeanor, significant failure(s) to meet contract milestones or other contractual failures. See generally, NRS §333.335.

Confirmed

12.5 Clarification discussions may, at the State's sole option, be conducted with vendors who submit proposals determined to be acceptable and competitive NAC §333.165. Vendors shall be accorded fair and equal treatment with respect to any opportunity for discussion and/or written revisions of proposals. Such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by competing vendors.

Confirmed

12.6 A Notification of Intent to Award shall be issued in accordance with NAC §333.170. Any award is contingent upon the successful negotiation of final contract terms and upon approval of the Board of Examiners and the State of Nevada Division of Insurance, when required. Negotiations shall be confidential and not subject to disclosure to competing vendors unless and until an agreement is reached. If contract negotiations cannot be

concluded successfully, the State upon written notice to all vendors may negotiate a contract with the next highest scoring vendor or withdraw the RFP.

Confirmed

12.7 Any contract resulting from this RFP shall not be effective unless and until approved by the Nevada State Board of Examiners (NRS 333.700).

Confirmed

13. TERMS, CONDITIONS AND EXCEPTIONS

13.1 Performance of vendor will be rated quarterly by PEBP's health plan auditor. The Vendor will be notified in writing of their rating.

Confirmed

13.2 This procurement is being conducted in accordance with NRS chapter 333 and NAC chapter 333.

Confirmed

13.3 The State reserves the right to alter, amend, or modify any provisions of this RFP, or to withdraw this RFP, at any time prior to the award of a contract pursuant hereto, if it is in the best interest of the State to do so.

Confirmed

13.4 The State reserves the right to waive informalities and minor irregularities in proposals received.

Confirmed

13.5 The State reserves the right to reject any or all proposals received prior to contract award (NRS 333.350).

Confirmed

13.6 The State shall not be obligated to accept the lowest priced proposal, but will make an award in the best interests of the State of Nevada after all factors have been evaluated (NRS 333.335).

Confirmed

13.7 Any irregularities or lack of clarity in the RFP should be brought to the Purchasing Division designee's attention as soon as possible so that corrective addenda may be furnished to prospective vendors.

Confirmed

13.8 Proposals must include any and all proposed terms and conditions, including, without limitation, written warranties, maintenance/service agreements, license agreements, lease purchase agreements and the vendor's standard contract language. The omission of these documents renders a proposal non-responsive.

Confirmed

13.9 Alterations, modifications or variations to a proposal may not be considered unless authorized by the RFP or by addendum or amendment.

Confirmed

13.10 Proposals, which appear unrealistic in the terms of technical commitments, lack of technical competence, or are indicative of failure to comprehend the complexity and risk of this contract, may be rejected.

Confirmed

13.11 Proposals from employees of the State of Nevada will NOT be considered.

Confirmed

13.12 Proposals may be withdrawn by written or facsimile notice received prior to the proposal opening time. Withdrawals received after the proposal opening time will not be considered except as authorized by NRS 333.350.

Confirmed

13.13 The price and amount of this proposal must have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or prospective vendor. Complementary proposals are illegal and prohibited.

Confirmed

13.14 No attempt may be made at any time to induce any firm or person to refrain from submitting a proposal or to submit any intentionally high or noncompetitive proposal. All proposals must be made in good faith and without collusion.

Confirmed

13.15 Prices offered by vendors in their proposals are an irrevocable offer for the term of the contract and any contract extensions. The awarded vendor agrees to provide the purchased services at the costs, rates and fees as set forth in their proposal in response to this RFP. No other costs, rates or fees shall be payable to the awarded vendor for implementation of their proposal.

Confirmed

13.16 The State is not liable for any costs incurred by vendors prior to entering into a formal contract. Costs of developing the proposals or any other such expenses incurred by the vendor in responding to the RFP, are entirely the responsibility of the vendor, and shall not be reimbursed in any manner by the State.

Confirmed

13.18 The master copy of each proposal shall be retained for official files and will become public record after the award of a contract unless the proposal or specific parts of the proposal can be shown to be exempt by law (NRS 333.333). Only specific parts of the proposal may be labeled a "trade secret," provided that the vendor thereby agrees to indemnify and defend the State for honoring such a designation. The failure to so label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by any release of the information.

Confirmed

13.17 A proposal submitted in response to this RFP must identify any subcontractors, and outline the contractual relationship between the awarded vendor and each subcontractor. An official of each proposed subcontractor must sign, and include as part of the proposal submitted in response to this RFP, a statement to the effect that the subcontractor has read and will agree to abide by the awarded vendor's obligations.

Confirmed

13.18 The awarded vendor will be the sole point of contract responsibility. The State will look solely to the awarded vendor for the performance of all contractual obligations, which may result from an award based on this RFP, and the awarded vendor shall not be relieved for the non-performance of any or all subcontractors.

Confirmed

13.19 The awarded vendor must maintain, for the duration of its contract, insurance coverages as set forth in the Insurance Schedule of the contract form appended to this RFP. Work on the contract shall not begin until after the awarded vendor has submitted acceptable evidence of the required insurance coverages.

Confirmed

Notwithstanding any other requirement of this section, the State reserves the right to consider reasonable alternative methods of insuring the contract in lieu of the insurance policies required by the above-stated Insurance Schedule. It will be the awarded vendor's responsibility to recommend to the State alternative methods of insuring the contract. Any alternatives proposed by a vendor should be accompanied by a detailed explanation regarding the vendor's inability to obtain insurance coverage as described above. The State shall be the sole and final judge as to the adequacy of any substitute form of insurance coverage.

Confirmed

13.20 Each vendor must disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented, as a conflict should be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. PEBP will determine whether a conflict of interest exists and whether it may reflect negatively on the PEBP's selection of a vendor. PEBP reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

Confirmed

13.21 Each vendor must include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, any civil or criminal litigation or investigation pending which involves the vendor or in which the vendor has been judged guilty or liable. Failure to comply with the terms of this provision will disqualify any proposal. The State reserves the right to reject any proposal based upon the vendor's prior history with the State or with any other party, which documents, without limitation, unsatisfactory performance, adversarial or contentious demeanor, significant failure(s) to meet contract milestones or other contractual failures.

Confirmed

13.22 The State will not be liable for Federal, State, or Local excise taxes.

Confirmed

13.23 Execution of Attachment A of this RFP shall constitute an agreement to all terms and conditions specified in the RFP, including, without limitation, the Attachment B contract form and all terms and conditions therein, except such terms and conditions that the vendor expressly excludes. Exceptions will be taken into consideration as part of the evaluation process.

Confirmed

13.24 PEBP reserves the right to negotiate final contract terms with any vendor selected. The contract between the parties will consist of the RFP together with any modifications thereto, and the awarded vendor's proposal, together with any modifications and clarifications thereto that are submitted at the request of PEBP during the evaluation and negotiation process. In the event of any conflict or contradiction between or among these documents, the documents shall control in the following order of precedence: the final executed contract, the RFP, any modifications and clarifications to the awarded vendor's proposal, and the awarded vendor's proposal. Specific exceptions to this general rule may be noted in the final executed contract.

Confirmed

13.25 Vendor understands and acknowledges that the representations above are material and important, and will be relied on by PEBP in evaluation of the proposal. Any vendor misrepresentation shall be treated as fraudulent concealment from PEBP of the true facts relating to the proposal.

Confirmed

13.26 No announcement concerning the award of a contract as a result of this RFP can be made without the prior written approval of PEBP.

Confirmed

13.27 The Nevada Attorney General will not render any type of legal opinion regarding this transaction.

Confirmed

13.28 Any unsuccessful vendor may file an appeal in strict compliance with NRS 333.370.

Confirmed

13.29 Local governments (as defined in NRS 332.015) are intended third party beneficiaries of any contract resulting from this RFP and any local government may join or use any contract resulting from this RFP subject to all terms and conditions thereof. The State is not liable for the obligations of any local government, which joins or uses any contract resulting from this RFP.

Confirmed

13.30 The awarded vendor must agree, whether expressly prohibited by federal, state or local law, or otherwise, that no funding associated with this contract will be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose including the following:

(a) any federal, state, county or local agency, legislature, commission, counsel, or board;

(b) any federal, state, county or local legislator, commission member, counsel member, board member, or other elected official; or

(c) any officer or employee of any federal, state, county or local agency, legislature, commission, counsel or board.

Confirmed

13.31 The vendor agrees to accept any specified eligibility rules established by the State. Proposals received will be considered to be in strict compliance with the specifications. The awarded vendor will be responsible for compliance.

Confirmed

13.32 All claims data shall be the property of PEBP and must be made available upon request.

Confirmed

13.33 Upon termination of this contract, all claims data shall be returned to PEBP or purged from all data systems. PEBP and PEBP's health plan auditor will verify that data is returned or purged to PEBP's satisfaction.

Confirmed

13.34 All vendors agree to extend to the State the right to an independent and/or agency audit with ten (10) days of written notice.

Confirmed

13.35 Vendor shall process and pay all claims received after the proposed effective date of July 1, 2011.

Confirmed

13.36 Vendor agrees that during the duration of the contract, and for 12 months after termination, that any direct contact, direct marketing, educational material, and other communication made to plan participants, other than responses to individual member inquiries regarding individual claims or member services issues, are strictly prohibited without the authorization and approval of PEBP

Confirmed

13.37 Vendor shall provide all usual services incident to the settlement of claims in accordance with plan provisions, including but not limited to providing appropriate forms, adjudication, records retention, check and EOB issuance, overpayment recovery, resolution of claimant inquiries and payment discrepancies, claim appeal procedures and eligibility requirements as reported by PEBP. Vendor shall provide plan participants with claim forms and EOBs that are easy to read and understand and have been pre-approved by PEBP.

Confirmed

13.38 Vendor shall specify in proposal submitted which city (or cities) claims processing office(s) will be located.

Confirmed

13.39 Vendor shall have a Nevada business license prior to contract approval by the Board of Examiners.

Confirmed

13.40 Vendor shall have a Certificate of Registration issued by the Nevada Division of Insurance as required by NRS 683.085 prior to approval of the Board of Examiners. Vendor will be required to provide a copy of their approved Certificate of Registration before commencement of services.

Confirmed

13.41 Vendor shall have a Nevada Third Party Administrator's bond at an amount required by the Risk Management Division and/or Division of Insurance.

Confirmed

13.42 Vendor shall provide insurance with liability limits and terms as set forth in Attachment C to this RFP.

Confirmed

13.43 Vendor shall provide a Commercial Crime Insurance policy in the name of the State and which does not exclude acts by principals in vendor's firm.

Confirmed

13.44 Vendor shall provide the State a performance bond in an amount identified by the State of Nevada, Risk Management division, within ten (10) working days of the final contract award.

Confirmed

13.45 Vendor shall give the State 180 days notice of contract cancellation.

Confirmed

13.46 The vendor's customer service representatives shall be available at a minimum, Monday through Friday (with the exception of National holidays) via a toll-free, national telephone number, between the hours of 8:00 a.m. and 5:00 p.m. Pacific time.

Confirmed

13.47 Vendor's system must store eligibility information online and have the capability to store historical data for a minimum of five years. The vendor's system must also have the capability to interface with PEBP's Eligibility and Enrollment Information System so that eligibility is automatically maintained and updated within both systems.

Confirmed

13.48 The vendor must reimburse PEBP for any recovered overpayments as a result of provider billing errors, incorrect claim processing or any other reason associated with claim administration. In the event the vendor is responsible for an overpayment that cannot be recovered, the vendor must agree to indemnify the State for the full amount of the

overpayment. The Vendor or PEBP will not pursue individual overpayments in the amount of $25.00 or less.

Confirmed

13.49 The following requirements apply to incorrect payment correction:

- Underpayments will be adjusted or reimbursed to the appropriate payee in a reasonable time after discovery.
- The successful vendor's overpayment log shall include all collection history, including phone collection efforts.
- Within 10 days after discovery, the successful vendor shall provide the payee with a written notice of overpayment and request for reimbursement.
- After 30 days of non-payment after the first notice, the successful vendor shall provide the payee a second written notice of request for reimbursement.
- After 45 days of non-payment after the first notice, the successful vendor shall provide the payee a third written notice of request for reimbursement or the claim will be referred for collection.
- After 60 days of non-payment after the first notice, the successful vendor may use the services of its contracted collection agency unless the anticipated cost of collection exceeds the anticipated recovery.
- The successful vendor's collection agency must comply with Nevada and federal debt collection laws, and its fees shall not exceed 20% of the amount collected without prior approval from PEBP.
- The successful vendor shall require regular reporting by its collection agency that will be shared with PEBP if requested.
- Neither the successful vendor nor its collection agency may bring legal action against a plan participant or provider to collect an overpayment.
- Any unsuccessful collection matter that requires legal action shall be referred to the PEBP for assessment and consultation with the Office of the Attorney General.
- The successful vendor shall internally audit the payment logs, and make both the logs and any internal audit report available to PEBP upon request.

Confirmed

13.50 Vendor shall submit with the proposal a disaster recovery plan in the event of a major disaster that disables most or all of the vendor's processing capabilities for the State of Nevada. A major disaster includes, but is not limited to:

- A hardware system failure/collapse
- A software system failure/collapse
- Any natural disaster or ACT of GOD
- Total loss of electrical/backup power

Please explain the anticipated time frames to restore normal operations once the disaster situation has been resolved.

Confirmed, please refer to Exhibit 19 to reference our disaster recovery plan.

Vendor shall submit with the proposal a plan for regularly scheduled backups for PEBP data for the day-to-day computer-related processing operations and where the backups will be stored.

The off-site backups are stored in the Branchburg, New Jersey, location that is referenced in Exhibit 19. Backups are done on a nightly basis.

13.51 Vendor shall provide to PEBP's actuary consultant monthly and/or quarterly data electronically, and any other data as requested by PEBP or PEBP's actuary consultant, in electronic format. The data must contain at least the following fields:

- Claim ID number
- Employee Social Security number (scrambled or unscrambled) or PEBP assigned ID number (as determined by PEBP)
- Date of birth
- Relation
- State employee indicator (State/non-State PEBP)
- Active/Retiree indicator
- Date of service
- Received date
- Paid date
- Billed amount
- Excluded amounts
  - Ineligible
  - Over maximum
  - Other excluded categories
- Deductible
- Coinsurance
- Co-payment
- COB
- Net paid amount
- Service identifier (CPT or DRG)
- Place of service
- Date of admission (for hospital claims)
- Date of discharge (for hospital claims)
- Number of units (for non-hospital claims)
- Provider network status

Confirmed

13.52 Vendor's system shall be fully compliant with HIPAA requirements for administrative simplification and electronic transmission of health information.

Confirmed

13.53 Vendor shall report COB savings to PEBP and PEBP's actuary consultant.

Confirmed

13.54 Vendor shall provide a report at least quarterly that includes Medicare, Workers' Compensation and third party liability/subrogation savings.

Confirmed

13.55 Vendor shall provide the financial reports within ten days of the close of the month and/ or quarter including:

- Monthly check registers of checks issued and cleared
- Monthly administrative statements that will allow the State to reconcile fees by covered employees (actives, retirees, non-state agencies)

Confirmed

13.56 Vendor shall apply Usual, Customary and Reasonable profiles based on current industry standard percentages or as determined by PEBP.

Confirmed

13.57 The vendor shall provide an eligibility exception report with each electronic download. These must be reconciled weekly with PEBP.

Confirmed

13.58 Vendor will be required to comply with any future regulations passed by the Nevada State Legislature, related to Third Party Administration.

Confirmed

14. SUBMISSION CHECKLIST

This checklist is provided for vendor's convenience only and identifies documents that must be submitted with each package in order to be considered responsive. Any proposals received without these requisite documents may be deemed non-responsive and not considered for contract award.

Part I:	**Completed**
1. Required number of Technical proposals (per Submittal Instructions)	√
2. **Required Forms to be submitted with technical proposal under section/tab labeled "State Documents";**	√
a. Page 1 of the RFP completed	√
b. All Amendments completed and signed	√
c. Primary Vendor Attachments A & B signed	√
d. Subcontractor Attachment A & B signed (if applicable)	√
e. Primary Vendor Information provided	√
f. Subcontractor Information provided (if applicable)	√
g. Certificate of Insurance	√
h. (other)_____	_____

Part II:	
1. Required number of Cost proposals (per Submittal Instructions)	√
2. (other)_____	_____

Part III:	
1. Required number of Confidential Information (per Submittal Instructions and defined in Acronyms/Definitions)	√
2. Financial Information	√

REMINDERS:

1. Send out Reference forms for Primary Vendor (with Part A completed)	√
2. Send out Reference forms for Subcontractors (with Part A completed) (if applicable)	√

Attachment A
CONFIDENTIALITY OF PROPOSALS AND CERTIFICATION OF INDEMNIFICATION
PRIMARY VENDOR

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS §333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS §600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information. In accordance with the Submittal Instructions of this document, vendors are requested to submit confidential information in a separate envelope or binder marked "**confidential**."

The State will not be responsible for any information contained within the proposal should vendors not comply with the labeling and packing requirements, proposals will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains either Confidential Information, Trade Secrets and/or Proprietary information as defined in Section 2 "ACRONYMS/DEFINITIONS."

YES √

NO

SIGNATURE _____ October 18, 2010
Primary Vendor Date

PRINT NAME HealthSCOPE Benefits
Primary Vendor

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
PRIMARY VENDOR

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

Checking "YES" indicates acceptance of all terms and conditions, while checking "NO" denotes non-acceptance and vendor's exceptions should be detailed below. In order for any exceptions to be considered they **MUST** be documented.

YES _____ I agree. NO ___√___ Exceptions below:

SIGNATURE Mary Catherine Person October 13, 2010

Primary Vendor Date

PRINT NAME Mary Catherine Person, President
Primary Vendor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)
Section 4, Contract For Services Of Independent Contractor	Page 102	Contractor proposes that unless otherwise specified, termination shall not be effective until thirty (30) calendar days after a party has served written notice of default, or without cause upon the other party.
Section 8, Contract For Services Of Independent Contractor	Page 102	Contractor proposes replacing the current language of Section 8 with the following language: "TIMELINESS OF BILLING SUBMISSION. The parties recognize that the State is on a fiscal year. Further, the parties agree that the State shall maintain its own contracts with providers and/or provider networks. The State agrees that because the Contractor will not be a party to any contract with providers and/or provider networks, and consequently has no ability to control, or any interaction whatsoever with, claims submissions from providers and/or via provider networks, the Contractor shall not be subject to any administrative fee in the event that a provider and/or a provider network submits a claim on behalf of a provider after the first Friday in August, which would force the State to process the billing as a stale claim pursuant to NRS 353.097."
Section 14, Contract For Services Of Independent	Page 104	Contractor proposes replacing the current text of Section 14 with the following text:

Contractor		"Each party agrees to indemnify and hold harmless the non-indemnifying party, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the indemnifying party's gross negligence, willful misconduct or fraud in carrying out its duties pursuant to this Agreement. The State agrees that in no event shall the indemnification obligations of this Section apply to that portion of any liability, settlement, and related expenses caused by the acts or omissions of any healthcare providers with respect to Participants. In addition, the State agrees to indemnify the Contractor, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the State's failure to timely fund its claims obligations, unless such claim, liability, cost, loss, expense or damage results from Contractor's gross negligence, willful misconduct or fraud."
Section 20, Contract For Services Of Independent Contractor	Page 106	Contractor proposes replacing the final sentence of Section 20 with the following text: "Contractor shall neither assign, transfer nor delegate any rights, obligations nor duties under this Contract without the prior written consent of the State, such consent not to be unreasonably withheld."
Indemnification Clause, Attachment BB, Insurance Schedule	Page 110	Contractor proposes replacing the current text of the Indemnification Clause with the following text: "Each party agrees to indemnify and hold harmless the non-indemnifying party, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the indemnifying party's gross negligence, willful misconduct or fraud in carrying out its duties pursuant to this Agreement. The State agrees that in no event shall the indemnification obligations of this Section apply to that portion of any liability, settlement, and related expenses caused by the acts or omissions of any healthcare providers with respect to Participants. In addition, the State agrees to indemnify the Contractor, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the State's failure to timely fund its claims obligations, unless such claim, liability, cost, loss, expense or damage results from Contractor's gross negligence, willful misconduct or fraud."
Section 2.05, Attachment E, Business Associate Addendum	Page 6 of Business Associate Addendum	Contractor proposes changing the line "... but no later than <u>five (5) days</u> after discovery of the Breach" to state "but no later than <u>fifteen (15) days</u> after discovery of the Breach."

Attach additional sheets if necessary. Please use this format.

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment A
CONFIDENTIALITY OF PROPOSALS AND CERTIFICATION OF INDEMNIFICATION
SUBCONTRACTOR

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS §333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS §600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information. In accordance with the Submittal Instructions of this document, vendors are requested to submit confidential information in a separate envelope or binder marked "**confidential**."

The State will not be responsible for any information contained within the proposal should vendors not comply with the labeling and packaging submission requirements, proposal will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposal that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains either Confidential Information, Trade Secrets and/or Proprietary information as defined in Section 2 "ACRONYMS/DEFINITIONS."

YES_____

NO ✓

SIGNATURE _____ Date 10/13/10
Subcontractor

PRINT NAME Steve Battenschlag
Subcontractor

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

Checking "YES" indicates acceptance of all terms and conditions, while checking "NO" denotes non-acceptance and vendor's exceptions should be detailed below. In order for any exceptions to be considered they **MUST** be documented.

YES _____ I agree. NO ✓ Exceptions below:

SIGNATURE Steve Bottenschlag
Subcontractor

10/13/10
Date

PRINT NAME Steve Bottenschlag
Subcontractor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)
BB	25	Subcontractor to be covered by contractors insurance and not provide seperate insurance pursuant to section F. Subcontractor will not obtain seperate insurance.

Attach additional sheets if necessary. Please use this format.

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

Checking "YES" indicates acceptance of all terms and conditions, while checking "NO" denotes non-acceptance and vendor's exceptions should be detailed below. In order for any exceptions to be considered they **MUST** be documented.

YES X I agree. NO _____ Exceptions below:

SIGNATURE _____ Subcontractor

Oct 14, 2010
Date

PRINT NAME John Gage
Subcontractor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)

Attach additional sheets if necessary. Please use this format.

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment A
CONFIDENTIALITY OF PROPOSALS AND CERTIFICATION OF INDEMNIFICATION
SUBCONTRACTOR

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS §333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS §600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information. In accordance with the Submittal Instructions of this document, vendors are requested to submit confidential information in a separate envelope or binder marked "**confidential**."

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By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains either Confidential Information, Trade Secrets and/or Proprietary information as defined in Section 2 "ACRONYMS/DEFINITIONS."

YES_____

NO X

SIGNATURE _____
Empowered Benefits
Subcontractor

Date

PRINT NAME John Gage
Subcontractor

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

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SIGNATURE _____ Subcontractor

Oct 14, 2010
Date

PRINT NAME John Gage
Subcontractor

EXCEPTION SUMMARY FORM

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YES_____

NO_____✓_____

SIGNATURE _____

Subcontractor

Date 10/11/10.

PRINT NAME BRIAN ATKINSON - DEVON HEALTH SERVICES, INC.

Subcontractor

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment B
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SUBCONTRACTOR

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YES ✓ I agree. NO _____ Exceptions below:

SIGNATURE _____ 10/11/10
Subcontractor Date

PRINT NAME Brian Atkinson - Devon Health Services, Inc.
Subcontractor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)

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YES X

NO_____

SIGNATURE Luper Neidenthal Logan by [signature] VP
Subcontractor

Date 10/13/2010

PRINT NAME Luper Neidenthal Logan a legal professional association by K. Wallace Neidenthal Vice President
Subcontractor

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

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YES __X__ I agree. NO _____ Exceptions below:

SIGNATURE [signature], Vice Pres. _____ 10/13/2010
Subcontractor Date

PRINT NAME Luper Neidenthal & Logan, a legal professional association
Subcontractor
K. Wallace Neidenthal Vice President

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)

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YES_____

NO X

SIGNATURE [signature]
PHX, INC
Subcontractor

Date 10-13-10

PRINT NAME ROBERT M. HEMMER CFO
Subcontractor

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

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YES X I agree. NO ____ Exceptions below:

SIGNATURE [signature] Subcontractor PHX, INC. 10-13-10 Date

PRINT NAME ROBERT M. HEMMER CFO Subcontractor PHX, INC.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)

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This proposal contains either Confidential Information, Trade Secrets and/or Proprietary information as defined in Section 2 "ACRONYMS/DEFINITIONS."

YES ✓

NO _____

SIGNATURE Mary Jean Mullally
Mullally Insurance Services, Inc.
Subcontractor

Date 10/18/2010

PRINT NAME Mary Jean Mullally, Pres.
Subcontractor

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

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YES ✓ I agree. NO _____ Exceptions below:

SIGNATURE Mary Jean Mullally, Pres. 10/18/2010
Subcontractor Date

PRINT NAME Mary Jean Mullally
Subcontractor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)

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This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

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YES_____

NO____X____

SIGNATURE Shelby Solomon
Subcontractor

10/20/2010
Date

PRINT NAME Shelby Solomon
Subcontractor

AIM Healthcare Services, Inc.
Company Name of Subcontractor

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment B
CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP
SUBCONTRACTOR

AIM Healthcare Services, Inc. ("AIM") has read, understands and agrees to comply with the terms and conditions specified in this Request for Proposal that are applicable to the services AIM will be performing as a subcontractor to HealthScope Benefits via a mutually agreed upon subcontract.

Checking "YES" indicates acceptance of all terms and conditions, while checking "NO" denotes non-acceptance and vendor's exceptions should be detailed below. In order for any exceptions to be considered they **MUST** be documented.

YES _____ I agree. NO __X__ Exceptions below:

SIGNATURE _____ Subcontractor 10/20/2010 Date

PRINT NAME Shelby Solomon Subcontractor Aim Healthcare Services, Inc. Company Name of Subcontractor

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (PROVIDE A DETAILED EXPLANATION)
N/A	N/A	As a subcontractor to HealthScope, AIM agrees to comply with the terms and conditions in the Request for Proposal that are applicable to the scope of work AIM will perform as a subcontractor via a mutually agreed upon subcontract. AIM does not agree to terms in the RFP that are not applicable to AIM or are between HealthScope and the State.

Attach additional sheets if necessary. Please use this format.

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal

Attachment C

CONTRACT FORM

The following State Contract Form is provided as a courtesy to vendors interested in responding to this RFP. Please review the terms and conditions in this form, as this is the standard contract used by the State for all services of independent contractors. It is not necessary for vendors to complete the Contract Form with their proposal responses.

All vendors are required to submit a Certificate of Insurance in the "State Documents tab/section of their technical proposal identifying the coverages and minimum limits currently in effect.

Please pay particular attention to the insurance requirements, as specified in paragraph 16 and Attachment BB of the attached contract.

As with all other requirements of this RFP, vendors may take exception to any of the terms in the Contract Form, including the required insurance limits. Exceptions will be considered during the evaluation process.

Unless specified as above, the insurance minimum limits will be negotiated at the time the State issues a Letter of Intent to Award.

For Purchasing Use Only:
RFP/CONTRACT #

CONTRACT FOR SERVICES OF INDEPENDENT CONTRACTOR

A Contract Between the State of Nevada
Acting By and Through Its

(NAME, ADDRESS, PHONE AND FACSIMILE NUMBER OF CONTRACTING AGENCY)

and

HealthSCOPE Benefits' changes highlighted in yellow.

(NAME, CONTACT PERSON, ADDRESS, PHONE, FACSIMILE NUMBER OF INDEPENDENT CONTRACTOR)

WHEREAS, NRS 333.700 authorizes elective officers, heads of departments, boards, commissions or institutions to engage, subject to the approval of the Board of Examiners, services of persons as independent contractors; and

WHEREAS, it is deemed that the service of Contractor is both necessary and in the best interests of the State of Nevada;

NOW, THEREFORE, in consideration of the aforesaid premises, the parties mutually agree as follows:

1. REQUIRED APPROVAL. This Contract shall not become effective until and unless approved by the Nevada State Board of Examiners.

2. DEFINITIONS. "State" means the State of Nevada and any state agency identified herein, its officers, employees and immune contractors as defined in NRS 41.0307. "Independent Contractor" means a person or entity that performs services and/or provides goods for the State under the terms and conditions set forth in this Contract. "Fiscal Year" is defined as the period beginning July 1 and ending June 30 of the following year.

3. CONTRACT TERM. This Contract shall be effective from _____ subject to Board of Examiners' approval (anticipated to be _____) to _____, unless sooner terminated by either party as specified in paragraph ten (10).

4. NOTICE. Unless otherwise specified, termination shall not be effective until 30 calendar days after a party has served written notice of default, or without cause upon the other party. All notices or other communications required or permitted to be given under this Contract shall be in writing and shall be deemed to have been duly given if delivered personally in hand, by telephonic facsimile with simultaneous regular mail, or mailed certified mail, return receipt requested, postage prepaid on the date posted, and addressed to the other party at the address specified above.

5. INCORPORATED DOCUMENTS. The parties agree that the scope of work shall be specifically described. This Contract incorporates the following attachments in descending order of constructive precedence:

ATTACHMENT AA: STATE SOLICITATION RFP #_____ and AMENDMENT(S) #___;
ATTACHMENT BB: INSURANCE SCHEDULE; AND
ATTACHMENT CC: CONTRACTOR'S RESPONSE

A Contractor's Attachment shall not contradict or supersede any State specifications, terms or conditions without written evidence of mutual assent to such change appearing in this Contract.

6. CONSIDERATION. The parties agree that Contractor will provide the services specified in paragraph five (5). The State does not agree to reimburse Contractor for expenses unless otherwise specified in the incorporated attachments. Any intervening end to a biennial appropriation period shall be deemed an automatic renewal (not changing the overall Contract term) or a termination as the results of legislative appropriation may require.

7. ASSENT. The parties agree that the terms and conditions listed on incorporated attachments of this Contract are also specifically a part of this Contract and are limited only by their respective order of precedence and any limitations specified.

8. TIMELINESS OF BILLING SUBMISSION. The parties recognize that the State is on a fiscal year. Further, the parties agree that the State shall maintain its own contracts with providers and/or provider networks. The State agrees that because the Contractor will not be a party to any contract with providers and/or provider networks, and consequently has no ability to

control, or any interaction whatsoever with, claims submissions from providers and/or via provider networks, the Contractor shall not be subject to any administrative fee in the event that a provider and/or a provider network submits a claim on behalf of a provider after the first Friday in August, which would force the State to process the billing as a stale claim pursuant to NRS 353.097.

9. INSPECTION & AUDIT.

a. Books and Records. Contractor agrees to keep and maintain under generally accepted accounting principles (GAAP) full, true and complete records, contracts, books, and documents as are necessary to fully disclose to the State or United States Government, or their authorized representatives, upon audits or reviews, sufficient information to determine compliance with all state and federal regulations and statutes.

b. Inspection & Audit. Contractor agrees that the relevant books, records (written, electronic, computer related or otherwise), including, without limitation, relevant accounting procedures and practices of Contractor or its subcontractors, financial statements and supporting documentation, and documentation related to the work product shall be subject, at any reasonable time, to inspection, examination, review, audit, and copying at any office or location of Contractor where such records may be found, with or without notice by the State Auditor, the relevant state agency or its contracted examiners, the Department of Administration, Budget Division, the Nevada State Attorney General's Office or its Fraud Control Units, the State Legislative Auditor, and with regard to any federal funding, the relevant federal agency, the Comptroller General, the General Accounting Office, the Office of the Inspector General, or any of their authorized representatives. All subcontracts shall reflect requirements of this paragraph.

c. Period of Retention. All books, records, reports, and statements relevant to this Contract must be retained a minimum three (3) years, and for five (5) years if any federal funds are used pursuant to the Contract. The retention period runs from the date of payment for the relevant goods or services by the State, or from the date of termination of the Contract, whichever is later. Retention time shall be extended when an audit is scheduled or in progress for a period reasonably necessary to complete an audit and/or to complete any administrative and judicial litigation which may ensue.

10. CONTRACT TERMINATION.

a. Termination Without Cause. Any discretionary or vested right of renewal notwithstanding, this Contract may be terminated upon written notice by mutual consent of both parties, or unilaterally by either party without cause.

b. State Termination for Non-appropriation. The continuation of this Contract beyond the current biennium is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. The State may terminate this Contract, and Contractor waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Contracting Agency's funding from State and/or federal sources is not appropriated or is withdrawn, limited, or impaired.

c. Cause Termination for Default or Breach. A default or breach may be declared with or without termination. This Contract may be terminated by either party upon written notice of default or breach to the other party as follows:

i. If Contractor fails to provide or satisfactorily perform any of the conditions, work, deliverables, goods, or services called for by this Contract within the time requirements specified in this Contract or within any granted extension of those time requirements; or

ii. If any state, county, city or federal license, authorization, waiver, permit, qualification or certification required by statute, ordinance, law, or regulation to be held by Contractor to provide the goods or services required by this Contract is for any reason denied, revoked, debarred, excluded, terminated, suspended, lapsed, or not renewed; or

iii. If Contractor becomes insolvent, subject to receivership, or becomes voluntarily or involuntarily subject to the jurisdiction of the bankruptcy court; or

iv. If the State materially breaches any material duty under this Contract and any such breach impairs Contractor's ability to perform; or

v. If it is found by the State that any quid pro quo or gratuities in the form of money, services, entertainment, gifts, or otherwise were offered or given by Contractor, or any agent or representative of Contractor, to any officer or employee of the State of Nevada with a view toward securing a contract or securing favorable treatment with respect to awarding, extending, amending, or making any determination with respect to the performing of such contract; or

vi. If it is found by the State that Contractor has failed to disclose any material conflict of interest relative to the performance of this Contract.

d. Time to Correct. Termination upon a declared default or breach may be exercised only after service of formal written notice as specified in paragraph four (4), and the subsequent failure of the defaulting party within fifteen (15) calendar days of receipt of that notice to provide evidence, satisfactory to the aggrieved party, showing that the declared default or breach has been corrected.

e. Winding Up Affairs Upon Termination. In the event of termination of this Contract for any reason, the parties agree that the provisions of this paragraph survive termination:

i. The parties shall account for and properly present to each other all claims for fees and expenses and pay those which are undisputed and otherwise not subject to set off under this Contract. Neither party may withhold performance of winding up provisions solely based on nonpayment of fees or expenses accrued up to the time of termination;

ii. Contractor shall satisfactorily complete work in progress at the agreed rate (or a pro rata basis if necessary) if so requested by the Contracting Agency;
iii. Contractor shall execute any documents and take any actions necessary to effectuate an assignment of this Contract if so requested by the Contracting Agency;
iv. Contractor shall preserve, protect and promptly deliver into State possession all proprietary information in accordance with paragraph twenty-one (21).

11. REMEDIES. Except as otherwise provided for by law or this Contract, the rights and remedies of the parties shall not be exclusive and are in addition to any other rights and remedies provided by law or equity, including, without limitation, actual damages, and to a prevailing party reasonable attorneys' fees and costs. It is specifically agreed that reasonable attorneys' fees shall include without limitation one hundred and twenty-five dollars ($125.00) per hour for State-employed attorneys. The State may set off consideration against any unpaid obligation of Contractor to any State agency in accordance with NRS 353C.190.

12. LIMITED LIABILITY. The State will not waive and intends to assert available NRS chapter 41 liability limitations in all cases. Contract liability of both parties shall not be subject to punitive damages. Liquidated damages shall not apply unless otherwise specified in the incorporated attachments. Damages for any State breach shall never exceed the amount of funds appropriated for payment under this Contract, but not yet paid to Contractor, for the fiscal year budget in existence at the time of the breach. Damages for any Contractor breach shall not exceed one hundred and fifty percent (150%) of the contract maximum "not to exceed" value. Contractor's tort liability shall not be limited.

13. FORCE MAJEURE. Neither party shall be deemed to be in violation of this Contract if it is prevented from performing any of its obligations hereunder due to strikes, failure of public transportation, civil or military authority, act of public enemy, accidents, fires, explosions, or acts of God, including without limitation, earthquakes, floods, winds, or storms. In such an event the intervening cause must not be through the fault of the party asserting such an excuse, and the excused party is obligated to promptly perform in accordance with the terms of the Contract after the intervening cause ceases.

14. INDEMNIFICATION. Each party agrees to indemnify and hold harmless the non-indemnifying party, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the indemnifying party's gross negligence, willful misconduct or fraud in carrying out its duties pursuant to this Agreement. The State agrees that in no event shall the indemnification obligations of this Section apply to that portion of any liability, settlement, and related expenses caused by the acts or omissions of any healthcare providers with respect to Participants. In addition, the State agrees to indemnify the Contractor, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the State's failure to timely fund its claims obligations, unless such claim, liability, cost, loss, expense or damage results from Contractor's gross negligence, will misconduct or fraud.

15. INDEPENDENT CONTRACTOR. Contractor is associated with the State only for the purposes and to the extent specified in this Contract, and in respect to performance of the contracted services pursuant to this Contract, Contractor is and shall be an independent contractor and, subject only to the terms of this Contract, shall have the sole right to supervise, manage, operate, control, and direct performance of the details incident to its duties under this Contract. Nothing contained in this Contract shall be deemed or construed to create a partnership or joint venture, to create relationships of an employer-employee or principal-agent, or to otherwise create any liability for the State whatsoever with respect to the indebtedness, liabilities, and obligations of Contractor or any other party. Contractor shall be solely responsible for, and the State shall have no obligation with respect to: (1) withholding of income taxes, FICA or any other taxes or fees; (2) industrial insurance coverage; (3) participation in any group insurance plans available to employees of the State; (4) participation or contributions by either Contractor or the State to the Public Employees Retirement System; (5) accumulation of vacation leave or sick leave; or (6) unemployment compensation coverage provided by the State. Contractor shall indemnify and hold State harmless from, and defend State against, any and all losses, damages, claims, costs, penalties, liabilities, and expenses arising or incurred because of, incident to, or otherwise with respect to any such taxes or fees. Neither Contractor nor its employees, agents, nor representatives shall be considered employees, agents, or representatives of the State. The State and Contractor shall evaluate the nature of services and the term of the Contract negotiated in order to determine "independent contractor" status, and shall monitor the work relationship throughout the term of the Contract to ensure that the independent contractor relationship remains as such. To assist in determining the appropriate status (employee or independent contractor), Contractor represents as follows:

		Contractor's Initials	
		YES	**NO**
1.	Does the Contracting Agency have the right to require control of when, where and how the independent contractor is to work?	_____	MCP _____

2.	Will the Contracting Agency be providing training to the independent contractor?	_____	MCP _____
3.	Will the Contracting Agency be furnishing the independent contractor with worker's space, equipment, tools, supplies or travel expenses?	_____	MCP _____
4.	Are any of the workers who assist the independent contractor in performance of his/her duties employees of the State of Nevada?	_____	MCP _____
5.	Does the arrangement with the independent contractor contemplate continuing or recurring work (even if the services are seasonal, part-time, or of short duration)?	_____	MCP _____
6.	Will the State of Nevada incur an employment liability if the independent contractor is terminated for failure to perform?	_____	MCP _____
7.	Is the independent contractor restricted from offering his/her services to the general public while engaged in this work relationship with the State?	_____	MCP _____

16. INSURANCE SCHEDULE. Unless expressly waived in writing by the State, Contractor, as an independent contractor and not an employee of the State, must carry policies of insurance and pay all taxes and fees incident hereunto. Policies shall meet the terms and conditions as specified within this Contract along with the additional limits and provisions as described in Attachment BB, incorporated hereto by attachment. The State shall have no liability except as specifically provided in the Contract.

The Contractor shall not commence work before:

1) Contractor has provided the required evidence of insurance to the Contracting Agency of the State, and
2) The State has approved the insurance policies provided by the Contractor.

Prior approval of the insurance policies by the State shall be a condition precedent to any payment of consideration under this Contract and the State's approval of any changes to insurance coverage during the course of performance shall constitute an ongoing condition subsequent this Contract. Any failure of the State to timely approve shall not constitute a waiver of the condition.

Insurance Coverage: The Contractor shall, at the Contractor's sole expense, procure, maintain and keep in force for the duration of the Contract insurance conforming to the minimum limits as specified in Attachment BB, incorporated hereto by attachment. Unless specifically stated herein or otherwise agreed to by the State, the required insurance shall be in effect prior to the commencement of work by the Contractor and shall continue in force as appropriate until:

1. Final acceptance by the State of the completion of this Contract; or
2. Such time as the insurance is no longer required by the State under the terms of this Contract;

Whichever occurs later.

Any insurance or self-insurance available to the State shall be in excess of, and non-contributing with, any insurance required from Contractor. Contractor's insurance policies shall apply on a primary basis. Until such time as the insurance is no longer required by the State, Contractor shall provide the State with renewal or replacement evidence of insurance no less than thirty (30) days before the expiration or replacement of the required insurance. If at any time during the period when insurance is required by the Contract, an insurer or surety shall fail to comply with the requirements of this Contract, as soon as Contractor has knowledge of any such failure, Contractor shall immediately notify the State and immediately replace such insurance or bond with an insurer meeting the requirements.

General Requirements:

a. Additional Insured: By endorsement to the general liability insurance policy evidenced by Contractor, the State of Nevada, its officers, employees and immune contractors as defined in NRS 41.0307 shall be named as additional insureds for all liability arising from the Contract.
b. Waiver of Subrogation: Each insurance policy shall provide for a waiver of subrogation against the State of Nevada, its officers, employees and immune contractors as defined in NRS 41.0307 for losses arising from work/materials/equipment performed or provided by or on behalf of the Contractor.
c. Cross-Liability: All required liability policies shall provide cross-liability coverage as would be achieved under the standard ISO separation of insureds clause.
d. Deductibles and Self-Insured Retentions: Insurance maintained by Contractor shall apply on a first dollar basis without application of a deductible or self-insured retention unless otherwise specifically agreed to by the State. Such approval shall not relieve Contractor from the obligation to pay any deductible or self-insured retention. Any deductible or self-insured retention shall not exceed fifty thousand dollars ($50,000.00) per occurrence, unless otherwise approved by the Risk Management Division.
e. Policy Cancellation: Except for ten (10) days notice for non-payment of premium, each insurance policy shall be endorsed to state that without thirty (30) days prior written notice to the State of Nevada, c/o Contracting Agency, the

policy shall not be canceled, non-renewed or coverage and /or limits reduced or materially altered, and shall provide that notices required by this paragraph shall be sent by certified mailed to the address shown on page one (1) of this contract:

f. Approved Insurer: Each insurance policy shall be:
1) Issued by insurance companies authorized to do business in the State of Nevada or eligible surplus lines insurers acceptable to the State and having agents in Nevada upon whom service of process may be made; and
2) Currently rated by A.M. Best as "A-VII" or better.

Evidence of Insurance:

Prior to the start of any Work, Contractor must provide the following documents to the contracting State agency:

1) Certificate of Insurance: The Acord 25 Certificate of Insurance form or a form substantially similar must be submitted to the State to evidence the insurance policies and coverages required of Contractor. The certificate must name the State of Nevada, its officers, employees and immune contractors as defined in NRS 41.0307 as the certificate holder. The certificate should be signed by a person authorized insurer to bind coverage on its behalf. The state project/contract number; description and contract effective dates shall be noted on the certificate, and upon renewal of the policies listed Contractor shall furnish the State with replacement certificates as described within Insurance Coverage, section noted above.

Mail all required insurance documents to the State Contracting Agency identified on page one of the contract.

2) Additional Insured Endorsement: An Additional Insured Endorsement (CG 20 10 11 85 or CG 20 26 11 85) , signed by an authorized insurance company representative, must be submitted to the State to evidence the endorsement of the State as an additional insured per General Requirements, subsection a above.
3) Schedule of Underlying Insurance Policies: If Umbrella or Excess policy is evidenced to comply with minimum limits, a copy of the Underlyer Schedule from the Umbrella or Excess insurance policy may be required.

Review and Approval: Documents specified above must be submitted for review and approval by the State prior to the commencement of work by Contractor. Neither approval by the State nor failure to disapprove the insurance furnished by Contractor shall relieve Contractor of Contractor's full responsibility to provide the insurance required by this Contract. Compliance with the insurance requirements of this Contract shall not limit the liability of Contractor or its sub-contractors, employees or agents to the State or others, and shall be in addition to and not in lieu of any other remedy available to the State under this Contract or otherwise. The State reserves the right to request and review a copy of any required insurance policy or endorsement to assure compliance with these requirements.

17. COMPLIANCE WITH LEGAL OBLIGATIONS. Contractor shall procure and maintain for the duration of this Contract any state, county, city or federal license, authorization, waiver, permit, qualification or certification required by statute, ordinance, law, or regulation to be held by Contractor to provide the goods or services required by this Contract. Contractor will be responsible to pay all taxes, assessments, fees, premiums, permits, and licenses required by law. Real property and personal property taxes are the responsibility of Contractor in accordance with NRS 361.157 and NRS 361.159. Contractor agrees to be responsible for payment of any such government obligations not paid by its subcontractors during performance of this Contract. The State may set-off against consideration due any delinquent government obligation in accordance with NRS 353C.190.

18. WAIVER OF BREACH. Failure to declare a breach or the actual waiver of any particular breach of the Contract or its material or nonmaterial terms by either party shall not operate as a waiver by such party of any of its rights or remedies as to any other breach.

19. SEVERABILITY. If any provision contained in this Contract is held to be unenforceable by a court of law or equity, this Contract shall be construed as if such provision did not exist and the non-enforceability of such provision shall not be held to render any other provision or provisions of this Contract unenforceable.

20. ASSIGNMENT/DELEGATION. To the extent that any assignment of any right under this Contract changes the duty of either party, increases the burden or risk involved, impairs the chances of obtaining the performance of this Contract, attempts to operate as a novation, or includes a waiver or abrogation of any defense to payment by State, such offending portion of the assignment shall be void, and shall be a breach of this Contract. Contractor shall neither assign, transfer nor delegate any rights, obligations nor duties under this Contract without the prior written consent of the State, such consent not to be unreasonably withheld.

21. STATE OWNERSHIP OF PROPRIETARY INFORMATION. Any reports, histories, studies, tests, manuals, instructions, photographs, negatives, blue prints, plans, maps, data, system designs, computer code (which is intended to be consideration

under the Contract), or any other documents or drawings, prepared or in the course of preparation by Contractor (or its subcontractors) in performance of its obligations under this Contract shall be the exclusive property of the State and all such materials shall be delivered into State possession by Contractor upon completion, termination, or cancellation of this Contract. Contractor shall not use, willingly allow, or cause to have such materials used for any purpose other than performance of Contractor's obligations under this Contract without the prior written consent of the State. Notwithstanding the foregoing, the State shall have no proprietary interest in any materials licensed for use by the State that are subject to patent, trademark or copyright protection.

22. PUBLIC RECORDS. Pursuant to NRS 239.010, information or documents received from Contractor may be open to public inspection and copying. The State has a legal obligation to disclose such information unless a particular record is made confidential by law or a common law balancing of interests. Contractor may label specific parts of an individual document as a "trade secret" or "confidential" in accordance with NRS 333.333, provided that Contractor thereby agrees to indemnify and defend the State for honoring such a designation. The failure to so label any document that is released by the State shall constitute a complete waiver of any and all claims for damages caused by any release of the records.

23. CONFIDENTIALITY. Contractor shall keep confidential all information, in whatever form, produced, prepared, observed or received by Contractor to the extent that such information is confidential by law or otherwise required by this Contract.

24. FEDERAL FUNDING. In the event federal funds are used for payment of all or part of this Contract:

a. Contractor certifies, by signing this Contract, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to the regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pt. 67, § 67.510, as published as pt. VII of the May 26, 1988, Federal Register (pp. 19160-19211), and any relevant program-specific regulations. This provision shall be required of every subcontractor receiving any payment in whole or in part from federal funds.

b. Contractor and its subcontractors shall comply with all terms, conditions, and requirements of the Americans with Disabilities Act of 1990 (P.L. 101-136), 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999, inclusive, and any relevant program-specific regulations.

c. Contractor and its subcontractors shall comply with the requirements of the Civil Rights Act of 1964, as amended, the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offeror for employment because of race, national origin, creed, color, sex, religion, age, disability or handicap condition (including AIDS and AIDS-related conditions.)

25. LOBBYING. The parties agree, whether expressly prohibited by federal law, or otherwise, that no funding associated with this contract will be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:

a. Any federal, state, county or local agency, legislature, commission, counsel or board;

b. Any federal, state, county or local legislator, commission member, counsel member, board member, or other elected official; or

c. Any officer or employee of any federal, state, county or local agency; legislature, commission, counsel or board.

26. WARRANTIES.

a. General Warranty. Contractor warrants that all services, deliverables, and/or work product under this Contract shall be completed in a workmanlike manner consistent with standards in the trade, profession, or industry; shall conform to or exceed the specifications set forth in the incorporated attachments; and shall be fit for ordinary use, of good quality, with no material defects.

b. System Compliance. Contractor warrants that any information system application(s) shall not experience abnormally ending and/or invalid and/or incorrect results from the application(s) in the operating and testing of the business of the State. This warranty includes, without limitation, century recognition, calculations that accommodate same century and multi-century formulas and data values and date data interface values that reflect the century.

27. PROPER AUTHORITY. The parties hereto represent and warrant that the person executing this Contract on behalf of each party has full power and authority to enter into this Contract. Contractor acknowledges that as required by statute or regulation this Contract is effective only after approval by the State Board of Examiners and only for the period of time specified in the Contract. Any services performed by Contractor before this Contract is effective or after it ceases to be effective are performed at the sole risk of Contractor.

28. GOVERNING LAW; JURISDICTION. This Contract and the rights and obligations of the parties hereto shall be governed by, and construed according to, the laws of the State of Nevada, without giving effect to any principle of conflict-of-law that

would require the application of the law of any other jurisdiction. The parties consent to the exclusive jurisdiction of the First Judicial District Court, Carson City, Nevada for enforcement of this Contract.

29. ENTIRE CONTRACT AND MODIFICATION. This Contract and its integrated attachment(s) constitute the entire agreement of the parties and as such are intended to be the complete and exclusive statement of the promises, representations, negotiations, discussions, and other agreements that may have been made in connection with the subject matter hereof. Unless an integrated attachment to this Contract specifically displays a mutual intent to amend a particular part of this Contract, general conflicts in language between any such attachment and this Contract shall be construed consistent with the terms of this Contract. Unless otherwise expressly authorized by the terms of this Contract, no modification or amendment to this Contract shall be binding upon the parties unless the same is in writing and signed by the respective parties hereto and approved by the Office of the Attorney General and the State Board of Examiners.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be signed and intend to be legally bound thereby.

Independent Contractor's Signature Date	Independent's Contractor's Title
Signature Date	Title
Signature Date	Title
Signature Date	Title
Signature - Board of Examiners	APPROVED BY BOARD OF EXAMINERS
Approved as to form by:	On _____ (Date)
Deputy Attorney General for Attorney General	On _____ (Date)

ATTACHMENT BB
INSURANCE SCHEDULE

INDEMNIFICATION CLAUSE:

INDEMNIFICATION. Each party agrees to indemnify and hold harmless the non-indemnifying party, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the indemnifying party's gross negligence, willful misconduct or fraud in carrying out its duties pursuant to this Agreement. The State agrees that in no event shall the indemnification obligations of this Section apply to that portion of any liability, settlement, and related expenses caused by the acts or omissions of any healthcare providers with respect to Participants. In addition, the State agrees to indemnify the Contractor, its officers, directors, agents, and employees from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from the State's failure to timely fund its claims obligations, unless such claim, liability, cost, loss, expense or damage results from Contractor's gross negligence, will misconduct or fraud.

INSURANCE REQUIREMENTS:

Contractor and subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, his agents, representatives, employees or subcontractors and Contractor is free to purchase additional insurance as may be determined necessary.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below. An excess liability policy or umbrella liability policy may be used to meet the minimum liability requirements provided that the coverage is written on a "following form" basis.

1. **Commercial General Liability – Occurrence Form**

Policy shall include bodily injury, property damage and broad form contractual liability coverage.

- General Aggregate $10,000,000
- Products – Completed Operations Aggregate $10,000,000
- Personal and Advertising Injury $5,000,000
- Each Occurrence $5,000,000

a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor".

2. **Automobile Liability - can be waived if contract does not involves use of motor vehicle.**

Bodily Injury and Property Damage for any owned, hired, and non-owned vehicles used in the performance of this Contract.
Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor".

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$500,000

a. Policy shall contain a waiver of subrogation against the State of Nevada.
b. This requirement shall not apply when a contractor or subcontractor is exempt under N.R.S., **AND** when such contractor or subcontractor executes the appropriate sole proprietor waiver form.

4. **Professional Liability (Errors and Omissions Liability)**

The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this contract.

Each Claim	$5,000,000
Annual Aggregate	$5,000,000

a. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.

5. **Fidelity Bond or Crime Insurance**
Bond or Policy Limit $5 million
a. The bond or policy shall include coverage for all directors, officers, agents and employees of the Contractor.
b. The bond or policy shall include coverage for third party fidelity and name the State of Nevada as loss payee.
c. The bond or policy shall include coverage for extended theft and mysterious disappearance.
d. The bond or policy shall not contain a condition requiring an arrest and conviction.
e. Policies shall be endorsed to provide coverage for computer crime/fraud.

6. **Performance Bond**
Amount required: Further details will be published in an amendment to the RFP.
1) Security may be in the form of surety bond, Certificate of Deposit or Treasury Note payable to the State of Nevada, only.
2) The security shall be deposited with the contracting State agency no later than ten (10) working days following award of the Contract to Contractor.

3) Upon successful Contract completion, the security and all interest earned, if any, shall be returned to the Contractor.

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. On insurance policies where the State of Nevada is named as an additional insured, the State of Nevada shall be an additional insured to the full limits of liability purchased by the Contractor even if those limits of liability are in excess of those required by this Contract.

2 The Contractor's insurance coverage shall be primary insurance and non-contributory with respect to all other available sources.

C. **NOTICE OF CANCELLATION:** Each insurance policy required by the insurance provisions of this Contract shall provide the required coverage and shall not be suspended, voided or canceled except after thirty (30) days prior written notice has been given to the State, except when cancellation is for non-payment of premium, then ten (10) days prior notice may be given. Such notice shall be sent directly to:

Public Employees' Benefits Program

Attn: Megan Sloan, Management Analyst 2

901 South Stewart Street, Suite 1001
Carson City, Nevada 89701

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with insurers duly licensed or authorized to do business in the state of Nevada and with an "A.M. Best" rating of not less than A- VII. The State in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

As a TPA, we are not rated by A.M. Best.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State with certificates of insurance (ACORD form or equivalent approved by the State) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and any required endorsements are to be received and approved by the State before work commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract or to provide evidence of renewal is a material breach of contract.

All certificates required by this Contract shall be sent directly to:

Public Employees' Benefits Program
Attn: Megan Sloan, Management Analyst 2

901 South Stewart Street, Suite 1001
Carson City, Nevada 89701

The State project/contract number and project description shall be noted on the certificate of insurance. The State reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as additional insureds under its policies **or** Contractor shall furnish to the State separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the insurance requirements in this Contract shall be made by the Attorney General's Office or the Risk Manager, whose decision shall be final. Such action will not require a formal Contract amendment, but may be made by administrative action.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be signed and intend to be legally bound thereby.

Independent Contractor's Signature	Date	Independent's Contractor's Title
Signature- State of Nevada	Date	Title

Attachment BB Page 1 of X

RMIns rev 03/08

Attachment D

REFERENCE QUESTIONNAIRE

The State of Nevada, as a part of the RFP process, requires proposing vendors to submit business references as required within this document. The purpose of these references is to document the experience relevant to the scope of work and provide assistance in the evaluation process.

The proposing vendor or subcontractor is required to complete Part A and send the following reference form to each business reference listed for completion of Part B. The business reference, in turn, is requested to submit the Reference Form directly to the State of Nevada, Purchasing Division by the requested deadline for inclusion in the evaluation process. The business reference may be contacted for validation of the response.

Questions regarding the reference form or process, contact the designee listed on the cover page.

This questionnaire will be sent to you directly by our subcontractors.

State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Room 300
Carson City, NV 89701

Jim Gibbons
Governor

Greg Smith
Administrator

RFP # 1893 REFERENCE QUESTIONNAIRE FOR:

Part A: _____
(Name of company requesting reference)

☐ As Primary Vendor
☐ As Subcontractor of _____
Name of Primary Vendor

Part B:
This form is being submitted to your company for completion as a business reference for the company listed above. This form is to be returned to the State of Nevada, Purchasing Division, via e-mail at srvpurch@purchasing.state.nv.us Attn: Chris McElroy or facsimile at (775) 684-0188, Attn: Chris McElroy no later than **October 22, 2010,** and **must not** be returned to the company requesting the reference. When contacting us, please be sure to include the Request for Proposal number listed at the top of this page.

CONFIDENTIAL INFORMATION WHEN COMPLETED

Company providing reference:	
Contact name and title/position	
Contact telephone number	
Contact e-mail address	

QUESTIONS:

1. In what capacity have you worked with this vendor in the past?
   COMMENTS:

2. How would you rate this firm's knowledge and expertise?
   ____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)
   COMMENTS:

3. How would you rate the vendor's flexibility relative to changes in the project scope and timelines?
   ____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)
   COMMENTS:

4. What is your level of satisfaction with hard-copy materials produced by the vendor?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)
COMMENTS:

5. How would you rate the dynamics/interaction between the vendor and your staff?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)
COMMENTS:

6. Who were the vendor's principal representatives involved in your project and how would you rate them individually? Would you comment on the skills, knowledge, behaviors or other factors on which you based the rating?
(3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

Name: _____Rating:

Name: _____Rating:

Name: _____Rating:

Name: _____Rating:

COMMENTS:

7. How satisfied are you with the products developed by the vendor?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)
COMMENTS:

8. With which aspect(s) of this vendor's services are you most satisfied?
COMMENTS:

9. With which aspect(s) of this vendor's services are you least satisfied?
COMMENTS:

10. Would you recommend this vendor's services to your organization again?
COMMENTS:

Attachment E
BUSINESS ASSOCIATES ADDENDUM

Attach E

If you are unable to access the above inserted file, please contact Nevada State Purchasing at srvpurch@purchasing.state.nv.us for an emailed copy.

For a list of changes, please see the attached Exhibit 20.

Attachment F

SERVICE PERFORMANCE STANDARDS AND FINANCIAL GUARANTEES

Attach F

If you are unable to access the above inserted file, please contact Nevada State Purchasing at srvpurch@purchasing.state.nv.us for an emailed copy.

Please refer to Section II to reference our Performance Guarantees.