STATE OF CONNECTICUT

Request for Proposal
Medicare Advantage and Prescription Drug Services

January 20, 2017

1 PURPOSE/ INTRODUCTION

1.1 **INTRODUCTION**

The State of Connecticut Office of the State Comptroller (OSC) is conducting an active search of the marketplace for a service provider(s) that can partner with OSC to provide Medicare Advantage and Prescription Drug (MA-PD) services to its Medicare-eligible retirees and their Medicare-eligible dependents, effective January 1, 2018. OSC may contract for Medicare Advantage benefits only or for Medicare Advantage plus prescription drug benefits. An award will not be made for prescription drug benefits only.

Through the issuance of this Request for Proposal (RFP), OSC is soliciting proposals from qualified vendors that can provide the services listed above. If interested and able to meet the requirements described in this RFP, OSC appreciates and welcomes your offer.

The contract term is for a three-year period beginning January 1, 2018 with Implementation to begin at contract award. The contact term will include a clause that gives the OSC the right to extend the contract for up to two additional one-year periods.

OSC reserves the right to award any service in whole or in part, if proposals demonstrate that doing so would be in OSC's best interest. OSC also reserves the right to issue multiple awards, no award, cancel, or alter the procurement at any time. In addition, OSC reserves the right to extend the proposed RFP period, if needed. Proposals containing the lowest cost will not necessarily be awarded as OSC recognizes that factors other than costs are important to the ultimate selection of the provider or providers. Proposals provided in response to this RFP must comply with the submittal requirements set forth in later sections, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein. Based upon the results of the evaluation, OSC will award the contract(s) to the most advantageous Bidder(s), based on cost and the technical evaluation factors in the RFP. Any contract awarded hereunder shall be subject to the approval of the Office of the Attorney General in accordance with applicable state laws and regulations.

This RFP is only for the procurement of MA-PD services. Responses and pricing information provided in this RFP should apply to MA-PD only. Any information provided by respondents, which pertains to other coverages, (unless explicitly requested within the RFP), will not be considered in evaluation of this RFP. This includes attempts by Bidders to provide MA-PD premiums that are contingent upon the additional award or renewal of business in connection with other benefits coverages.

Please read the entire solicitation package and submit an offer in accordance with the instructions. All forms contained in the solicitation package must be completed in full and submitted along with the Technical Response and Price Proposal Worksheet, which combined, will constitute the offer. **This RFP and your response, including all subsequent documents provided during this RFP process will become part of the contract terms and policy between the parties.**

Submission of your proposal will acknowledge acceptance of these requirements. The financial requirements include initial and renewal pricing and projection controls.

OSC has retained Segal Consulting to assist in the evaluation of the proposals. Each proposal shall be evaluated in accordance the factors listed below:

- Value of the benefit plans and services, taking into consideration the requirements of the RFP, proposed services and any "value-added" terms, conditions and service levels
- Cost of the proposed benefits and/or services
- Programs provided by the firm designed and proven to maximize CMS funding through risk adjustment strategies and minimize claim cost through medical management strategies
- Qualifications of the firm including financial capacity and staffing, and availability of staff to work with OSC during Open Enrollment and continue to support OSC after the program's "go-live" date
- Contractor's experience with MA-PD Plans, commitment to such plans, and experience offering such plans to public sector employers, which includes quality of references
- Network access and network management (medical and pharmacy)
- Demonstrated experience with Eligibility Management, Payment and Billing Systems, Customer Service, Flexibility, Reporting Capability, Member Services, and Quality Assurance Programs
- Contractor's ability to educate and communicate with retirees
- Contractor's ability to minimize enrollee disruption
- Proven strategies to maximize Star Ratings and receive bonus subsidies from CMS
- Contractor's compliance with state contracting requirements and willingness to enter into Comptroller's standard contract terms and conditions
- Information Services and Reporting: Ability to exchange Health Enhancement Program (HEP) related claims data with State's data warehouse vendor and availability of standard reports and ad hoc reporting functionality
- Demonstration of Contractor's commitment to affirmative action by full compliance with the regulations of the Commission on Human Rights and Opportunities
- At the option of the review committee, Contractor's Finalist interview

All Bidders must meet the Qualifications of the Firm (outlined in Section 5) and the General Proposal Conditions (outlined in Section 6) set forth in this RFP. Bidders are asked to respond only to the specific questions asked.

2 GENERAL INFORMATION

2.1 **BACKGROUND**

The State Comptroller is empowered by Connecticut General Statutes Section 5-259 to arrange and procure "a group hospitalization and medical and surgical insurance plan" for State employees and retirees with approval of the Attorney General." The Healthcare Policy & Benefits Services Division (HPBSD) of the OSC administers the State healthcare coverage program for employees and retirees. The Comptroller also procures health coverage under the Connecticut Partnership Plan (http://www.osc.ct.gov/ctpartner/index.html) for non-state public employers under Public Act 15-93.

OSC offers coverage through a number of self-insured hospital-medical plans and a self-insured prescription drug plan to its actively employed members and early retirees. The hospital-medical plans are currently administered by Anthem and United Healthcare (UHC)/Oxford. The prescription drug plan is administered by

CVS Caremark. OSC provides the same hospital-medical plan options for its Medicare-eligible retirees and Medicare-eligible dependents as secondary to Medicare Parts A and B. This coverage, as well as the coverage for enrollees of the Connecticut Partnership Plan is available to approximately 48,000 members including Medicare-eligible retirees and Medicare-eligible dependents of retirees.

The hospital-medical benefits for all medical plans are in alignment and remain unchanged from the prior coverage year. UHC/Oxford and Anthem both offer Point of Service (POS), Point of Enrollment (POE) and Point of Enrollment-Gatekeeper (POE-G) plans to retirees, although the benefits and member cost share may differ based upon retirement date.

- Point of Service Plans (POS)—health care services are available both within and outside a defined network of providers; no referrals are necessary to receive care from participating providers. Health care services obtained outside the defined network may require pre- authorization and are reimbursed at the rate of 80% of the plan's allowable cost after the annual deductible has been met. Approximately 92 percent of claims are in-network.
- Point of Enrollment Plans (POE)—health care services are available only from a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may not be covered.
- Point of Enrollment Gatekeeper Plans (POE-G)—health care services are available only from a defined network of providers; a primary care physician (PCP) must be chosen to coordinate all care; referrals are required from the PCP for all specialist services.

Out of state employees, whose permanent residence is outside of Connecticut, may select from two Out of Area Plans: the United Healthcare/Oxford USA Plan and the Anthem Out-of-Area Plan.

Under the Connecticut Partnership Plan hospital-medical benefits are provided under the UHC/Oxford POS plan only and the CVS Caremark plan for prescription drug coverage.

OSC provides self-insured prescription drug coverage to its Medicare-eligible retirees and their Medicare-eligible dependents through a Medicare Generation Rx Part D Employer Group Waiver Plan (EGWP). The EGWP is administered by SilverScript Insurance Company, a subsidiary of CVS/Caremark. Medicare-eligible retirees in the Connecticut Partnership Plan do not participate in the EGWP.

Also, the State of Connecticut has mandated coverage for hearing aids. The benefit provides for one hearing aid for 24 months for those of all ages. The Connecticut Insurance Department has required carriers to remove the age limits on hearing aid benefits for policies issued or renewed on or after January 1, 2016.

OSC anticipates that all Medicare-eligible retirees, their Medicare-eligible dependents, and qualifying Medicare-eligible primary ESRD beneficiaries will automatically be enrolled in the MA-PD plan unless they choose to opt out. If a member/beneficiary opts out, he/she will lose their OSC hospital-medical coverage and prescription drug coverage altogether and will not be permitted to re-enroll until the next Open Enrollment period. If the member has family coverage, opting out will disenroll the entire family from both medical and prescription drug coverage.

Retirees and covered dependents that age into Medicare will automatically be enrolled into the MA-PD Plan, effective on their Medicare eligibility date. There shall be no gap in coverage for those aging into MA-PD. Workers over the age of 65 shall be automatically enrolled into the MA-PD Plan effective on their date of retirement. Retirees and their dependents who are enrolled in the MA-PD Plan and subsequently drop, terminate, or otherwise lose their Medicare Part B coverage will lose their State of Connecticut hospital-medical and prescription drug coverage and will not be permitted to re-enroll in coverage until the following Open Enrollment.

2.2 HEALTH ENHANCEMENT PROGRAM

In 2011, in response to a collective bargaining agreement, the State implemented the Health Enhancement Program (HEP), a value based insurance design (VBID) program. State employees, certain retirees, and their dependents that enroll in the HEP program are required to obtain age and gender specific preventive services. Medicare Retirees who retired after 2011 also participate in this program. Enrollees who are identified with one of five medical conditions (diabetes types I and II, asthma and Chronic Obstructive Pulmonary Disease (COPD), coronary artery disease, hypertension, and hyperlipidemia) must also adhere to certain condition-specific education requirements. The enhanced benefit design reduces copays for certain services to remove barriers to care. The State has contracted with Care Management Solutions, Inc. (CMSI) to provide compliance monitoring and chronic condition counseling services in connection with HEP. CMSI has contracted with Conifer Health Solutions to provide data warehousing services.

The State is requiring that detailed claims data be provided to the State's data warehouse vendor, Conifer, and the State's health care consultant.

2.3 HEALTH CARE COST CONTAINMENT COMMITTEE

The Health Care Cost Containment Committee (HCCCC) is joint a labor-management committee whose goal is to implement health care programs (including health promotion and wellness activities) that reduce the rate of increase in the cost of providing in medical, pharmacy and dental coverage to state employees and retirees while at the same time improving quality of care.

2.4 COLLECTIVE BARGAINING

Medical and pharmacy benefits for employees and retirees are subject to a Collective Bargaining Agreement (CBA). OSC will only award an MA-PD contract that provides retiree health benefits consistent with the CBA as currently written, or as it may be modified by mutual agreement of the parties.

2.5 **CONTRIBUTION INFORMATION**

Medicare-eligible retirees and Medicare-eligible dependents of retirees pay no monthly premiums for medical and prescription drug coverage. Please review both **Retirees Health Care Options Planners** (Attachment A) - for those with a retirement date of October 1, 2011 or earlier and those with a retirement date of October 2, 2011 or later for a description of the coverage.

2.6 **OBJECTIVES**

OSC seeks to provide high quality, cost-effective benefits to its retirees and their families. OSC is soliciting offers on a fully-insured, national passive MA-PD PPO plan, with the same benefits for services rendered in or out-of-network. The proposed MA-PD PPO plan should mirror the plan described in the summary of benefits portion of the attached Retiree Healthcare Planners, within CMS guidelines. Proposers are encouraged to identify and offer features or enhancements that provide additional value without adding cost as well as any creative solutions that will achieve OSC's goals. Of particular interest are programs that focus on wellness, medical management, maximization of CMS funding and minimization of claims cost.

2.7 **SCOPE OF WORK**

Provide MA-PD PPO services with respect to such group insurance coverages, plans and programs as listed in this RFP.

The following services are required:

- Member Services
- Claims Adjudication
- Data Reporting
- Member Enrollment and Eligibility Maintenance
- Revenue Maximization
- Medical Management
- Network Access and Network Management
- Medicare Advantage and Part D Administrative Assistance
- Effective Member Communications
- Patient and Provider Education

2.8 **CONTRACT TERM**

The contract term will be for three years starting January 1, 2018, and ending December 31, 2020, [with two optional one-year extensions at the option of OSC.]

3 RESPONSE INSTRUCTIONS

3.1 INSTRUCTIONS FOR SUBMITTING INTENT TO BID REPLY AND NON-DISCLOSURE AGREEMENT

If your company intends to submit a proposal for MA-PD, you must submit an Intent to Bid reply by **2:30 p.m. EST on Friday, January 27, 2017.** Also, to access the Reference Documents (i.e., claims data, census, etc.), Bidders must complete the Non-Disclosure Agreement (NDA). Both forms can be sent to the following email address: osc.rfp@ct.gov. The Intent to Bid (Attachment B) and NDA documents (Attachment C) are included in this RFP. **Reference Documents will only be provided to Bidders that have submitted a completed and signed NDA.** Once the NDA is finalized, the Bidder will receive a copy of all Reference Documents via Secure File Transfer (SFT) from Segal.

3.2 INSTRUCTIONS FOR SUBMITTING TECHNICAL PROPOSALS

This document constitutes your invitation to bid. All Technical Proposals must be received by 2:30 P.M. (EST), March 6, 2017 in order to be considered. Proposals received later than the time and date specified will not be accepted. If you choose not to offer a proposal, please confirm this in writing with the specific reasons for your decision in the Intent to Bid document. All proposals received shall become the property of OSC, and may, without compensation to the Bidder, be used or disposed of as OSC may see fit.

Proposals should limit the amount of materials submitted in paper form. Large bulky printouts, such as geo-access reports, marketing materials, provider lists, etc., should be included on the CD-ROM accompanying your response but not included as paper copies. Written materials should be printed double-sided where possible.

3.3 INSTRUCTIONS FOR SUBMITTING PRICE PROPOSALS

This document constitutes your invitation to bid. We request that Bidders submit an Initial Price Proposal and a Final Price Proposal. Initial Price Proposals must be received by 2:30 P.M. (EST), March 6, 2017, in order to be considered. Final Price Proposals must be received by 2:30 P.M. (EST), April 17, 2017, in order to be considered. Initial and Final Price Proposals received later than the time and date specified will not be considered. If you choose not to offer a proposal, please confirm this in writing with the specific reasons for your decision. All proposals received shall become the property of OSC, and may, without compensation to the Bidder, be used or disposed of as OSC may see fit.

Proposals should limit the amount of materials submitted in paper form. Large bulky printouts, such as geo-access reports, marketing materials, provider lists, etc., should be included on the CD-ROM accompanying your response but need not be included as paper copies. Written materials should be printed double-sided where possible.

3.4 REFERENCE DOCUMENTS

Reference Documents (i.e., claims data, census, etc.) will **only** be provided to Bidders that have submitted a completed and signed Non-Disclosure Agreement (NDA). The NDA is included in the RFP (Attachment C). Completed and signed NDA's should be emailed to osc.rfp@ct.gov.

3.5 QUESTIONNAIRE INSTRUCTIONS

All sections and questions must be answered completely and as outlined in the RFP. Many questions within the RFP do not require lengthy responses. When a question does require a more robust response, please provide a response that is clear and concise. DO NOT answer any of the questions by referring to a prior answer or by referring to an attachment. It is not acceptable to use the term "See Attached" as a response to any of the questions, fee quotation forms, or plan or network comparisons. Such answers will not be considered and will constitute sufficient grounds for rejecting a proposal.

ANSWERS TO THE QUESTIONS SHOULD BE AS SHORT AND CONCISE AS POSSIBLE TO FACILITATE OUR ANALYSIS AND TO AVOID CONFUSION.

3.5 BIDDER CONFERENCE

There will not be a Bidder Conference regarding this RFP.

3.6 BIDDER QUESTIONS

OSC intends to answer questions from any Bidder that is considering a response to this RFP. All questions must be submitted by email to osc.rfp@ct.gov by the deadline of 2:30 P.M. (EST) on January 30, 2017. Questions will not be accepted over the telephone or after the question submission deadline. The State reserves the right to provide a combined answer to similar questions. Any and all questions and answers to this RFP will be posted by February 13, 2017 on the OSC website at http://www.osc.ct.gov/vendor/index.html.

3.7 PROPOSAL DELIVERY

Bidder must provide copies of its proposal submission as follows:

A. Technical Proposal:

The Technical Proposal **must be labeled and packaged separately from the Price Proposal**. All documents and attachments in the RFP must remain in their native format (e.g., Excel documents should remain in Excel formats) in the Bidder's response.

The Bidder shall submit one (1) original and ten (10) paper copies and four (4) CD-ROM-based electronic copies of the entire Technical Proposal in a sealed envelope, bearing the name and address of the Bidder. Any Bidder that submits matter that the Bidder in good faith determines to contain trade secrets or confidential commercial or financial information must provide two redacted copies of its RFP response in a CD or DVD (an original and one copy), which may be disclosed without objection in the event that the State receives a Freedom of Information Act (FOIA) request for its proposal.

The envelope containing the complete Technical Proposal package must be clearly marked with the words, MA-PD and submitted to:

Office of the State Comptroller
Business Services Office
State of Connecticut
55 Elm Street, Room 301
Hartford, CT 06106
ATTN: RFP – MA-PD

B. Price Proposal

The Price Proposal **must be labeled and packaged separately from the Technical Proposal**. All documents and attachments in the RFP must remain in their native format (e.g., Excel documents should remain in Excel formats) in the Bidder's response.

The Bidder shall submit one (1) original and ten (10) paper copies and four (4) CD-ROM-based electronic copies of the entire Price Proposal in a sealed envelope, bearing the name and address of the Respondent. Any Bidder that submits matter that the Bidder in good faith determines to contain trade secrets or confidential commercial or financial information must provide two redacted copies of its RFP response in a CD or DVD (an original and one copy), which may be disclosed without objection in the event that the State receives a Freedom of Information Act (FOIA) request for its proposal.

The envelope containing the complete Price Proposal package must be clearly marked with the words, MA-PD and submitted to:

Office of the State Comptroller
Business Services Office
State of Connecticut
55 Elm Street, Room 301
Hartford, CT 06106
ATTN: RFP – MA-PD

3.8 KEY DATES

Based upon expected timing for the release of the CMS 2018 Final Call Letter and benchmarks, Bidders are being asked to submit two Price Proposals. The Initial Price Proposal (before the release of the Final Call Letter) will be due on the same date and time as the Technical Proposal. The complete Technical Proposal and Initial Price Proposal must be submitted by **2:30 P.M. EST on March 6, 2017.** The Final Price Proposal must be submitted by **2:30 P.M. EST on April 17, 2017**. In accordance with the above instructions, the Technical and Initial Price Proposals must be labeled and packaged separately**.**

Proposals will not be accepted after these stated dates and times. OSC reserves the right to reject any and all responses to this RFP.

Event	Due Date
Release of RFP	January 20, 2017
Intent to Bid Reply Due	January 27, 2017
Written Questions from Proposers Due Date (by 5:00 p.m. EST)	January 30, 2017
Response to Questions from Proposers	February 13, 2017
Complete Technical Proposal and Initial Price Proposal Due Date (by 2:30 p.m. EST)	March 6, 2017
Final Price Proposal Due Date (by 2:30 p.m. EST)	April 17, 2017
Notification of Finalist(s)	April 24, 2017
Finalist(s) Presentation(s) in Hartford	Week of May 15, 2017
Anticipated Contract(s) Award Date	May 22, 2017
Implementation Begins	June 1, 2017
Proposed Effective Date	January 1, 2018

3.9 OWNERSHIP OF PROPOSALS

All proposals submitted in response to this RFP are to be the sole property of the State, and are subject to the applicable Freedom of Information provisions of Connecticut General Statutes, Sections 1-200 *et seq*. Any Contractor that includes any information that is proprietary or not readily available to the public from other sources must provide a redacted version of its proposal as set forth above.

3.10 SELECTION OF BIDDER(S)

All responding Bidders will be notified in writing within a reasonable length of time following the selection. Prior to the award, two or more Bidders may be requested to make oral presentations in person to the evaluation committee. The proposal shall become the property of OSC.

3.11 ECONOMY OF PREPARATION

The proposal should be prepared simply and economically and provide a concise description of Bidder's response to the requirements of this RFP. Emphasis should be on clarity. OSC will not be responsible for any costs incurred by Bidder in the preparation, submission, or presentation of a proposal.

4 INFORMATION REQUIRED FROM BIDDERS

A response on each of the following is required. Failure to meet any of the qualifications outlined below may result in disqualification of your proposal.

4.1 QUALIFICATIONS OF THE FIRM - BUSINESS ORGANIZATION

4.1.1 State the full name and address of your organization, and if applicable, the branch office or other subordinate element that will perform or assist in performing the work hereunder.

Unlimited.

4.1.2 Indicate whether you operate as an individual, partnership, limited liability company, or corporation.
Unlimited.

4.1.3 State the name of the state in which you are formed or incorporated.
Unlimited.

4.1.4 State whether you are currently in good standing in the state in which you are formed or incorporated and provide a Certificate of Good Standing from that state.
Unlimited.

4.1.5 State whether you are licensed to operate in the State of Connecticut.
500 words.

4.2 QUALIFICATIONS OF THE FIRM - PRIOR EXPERIENCE

5.2.1 To be considered a viable proposer, the following minimum requirements for prior experience must be met:

- Bidder must be currently providing MA-PD services to at least two group health plans with a minimum of 50,000 lives
- Bidder must have a minimum of five (5) years of MA-PD group experience
- Bidder must not have any bankruptcy filings within the last 5 years; and
- Bidder must have experience working with working with public sector plans of similar size; and
- Bidder's senior officers, board members, or directors must not have any felony convictions.

4.3 QUALIFICATIONS OF THE FIRM - MANPOWER

4.3.1 Identify lead individuals by name and title. Include:

- Proposed staffing for this account
- A resume for each lead team member
- The proposed percent of time each lead team member will be dedicated to this account (based on 40-hour work-week).

4.4 QUALIFICATIONS OF THE FIRM - AUTHORIZED OFFICIALS

4.4.1 Include the names, titles, e-mail addresses, and telephone numbers of personnel of the organization authorized to execute the proposed contract with OSC.
Unlimited.

4.5 REVIEW CRITERIA

4.5.1 The OSC has retained Segal Consulting to assist in the review of the responses. Each response shall be reviewed in accordance with the State's criteria and other relevant factors. Responders are requested to respond only to specific questions asked.

Proposals will be evaluated by an evaluation committee. Selection will be based on all factors listed below and others implicit within the RFP and with a view to obtaining the best performance at reasonable costs for OSC. Oral presentations may be required as part of the evaluation criteria.

- General Information, Capabilities, and Experience with National MA-PD PPO Plans
- Data, Reporting and Performance Measurement
- CMS Revenue Maximization Strategies
- Cost Management Strategies, Wellness and Disease Management
- Network Access and Network Management
- Member Services, Staffing and Plan Administration, Implementation
- Finalist Interviews (optional)
- Total Price Proposal

4.6 OTHER INFORMATION4.6.1 Other documents and information that may be helpful in preparing your proposal may be accessed via the Internet. Bidders are responsible for checking the OSC website for the most up to date information - http://www.osc.ct.gov/benefits/medical.htm

4.7 ADDITIONAL PROCUREMENT DOCUMENTS

4.7.1 The following required forms must be completed and uploaded to "BizNet" in accordance with the following instructions:

Required Forms

Follow instructions for submission of the following:

a) Agency Vendor Form (SP-26NB), available at:

http://das.ct.gov/Purchase/Info/Vendor_Profile_Form_(SP-26NB).pdf

b) W-9 Form, available at: http://www.irs.gov/pub/irs-pdf/fw9.pdf

c) "**BizNet**"

The Connecticut Department of Administrative Services ("DAS") requires that all firms seeking to do business with the State create a business profile on the DAS Business Network ("BizNet") system. Additional required forms as described below must be submitted to or on file with the BizNet system by the deadline for submission of proposals. Paper or electronic copies need not be provided with the submission to the Comptroller's office.

Firms create an account on BizNet by using the following link:

https://www.biznet.ct.gov/AccountMaint/Login.aspx.

Once your firm creates an account, login and select “CT Procurement” and then

“Company Information” for access. If you experience difficulty establishing or otherwise managing your firm's account, please call DAS at 860-713-5095.

DAS has implemented the requirement to create a BizNet account to make doing business with the State of Connecticut more business friendly. One benefit to using BizNet is that it eliminates certain redundancies, such as the former requirement to complete and submit forms even though the forms had been recently submitted in response to another Request for Proposals.

In addition to eliminating redundancy, BizNet has automated the completion and submission of required Ethics Affidavits and Non Discrimination forms. Firms must now upload these forms electronically to their BizNet account and update them on an annual basis, rather than submitting paper copies with each proposal. Firms will have the ability to view, verify and update their information by logging in to their BizNet account, prior to submitting responses to an RFP.

Ethics Certifications

The following Ethics Forms must be signed, dated, notarized, uploaded or updated on BizNet. To obtain these forms, you must login to BizNet and follow the instructions referenced above.

- OPM Ethics Form 1: Gift & Campaign Contribution Certification;
- OPM Ethics Form 5: Consulting Agreement Affidavit:
- OPM Ethics Form 6: Affirmation of Receipt of State Ethics Laws Summary
- OPM Ethics Form 7: Iran Certification

For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:
http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNAV_GID=1806

Non-Discrimination Certification

Choose one (1) of the forms listed below that applies to your business. Complete and upload or update the form on BizNet annually. To obtain a copy of these forms, you must login to BizNet and follow the instructions referenced above.

- Form A: Representation by Individual (Regardless of Value); or
- Form B: Representation by Entity (Valued at $50,000 or less); or
- Form C: Affidavit by Entity (Valued at $50,000 or more); or
- Form D: New Resolution by Entity; or
- Form E: Prior Resolution by Entity

For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:
http://www.ct.gov/opm/cwp/view.asp?a=2982&q=390928&opmNAV_GID=1806

Commission on Human Rights and Opportunities ("CHRO") Workplace Analysis Affirmative Action Report/Employment Information Form.

The CHRO Workplace Analysis Affirmative Action Report/Employment Information must be completed in BizNet and updated as necessary. You must login to BizNet and follow the Instructions referenced above.

For information on how to complete these forms you may contact Diane Comeau at Diane.Comeau@ct.gov for assistance.

For information about how to upload the Ethics Affidavits and Non-Discrimination forms please access the following page. http://das.ct.gov/images/1090/Upload%20Instructions.pdf

4.7.2 Affirmative Action The proposal must include a summary of the Contractor's experience with affirmative action including a summary of the Contractor's affirmative action plan and the Contractor's affirmative action policy statement.

Regulations of Connecticut State Agencies Section 46a-68j-30(10) require agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements:

a. The Contractor's success in implementing an affirmative action plan;

b. The Contractor's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;

c. The Contractor's promise to develop and implement a successful affirmative action plan;

d. The Contractor's submission of employment statistics contained in the "Workforce Analysis Affirmative Action Report," indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and

e. The Contractor's promise to set aside a portion of the contract for legitimate small Contractors and minority business enterprises, where applicable (See C.G.S. §32-9e).

The State of Connecticut's Contract Compliance Forms applicable to State contracts are available at http://www.ct.gov/chro/cwp/view.asp?a=2525&Q=315900, please click on the four forms indicated below to download the pdf files from the CHRO web page:

- ***Notification to Bidders***
  This document gives notice that the contract to be awarded is subject to the contract compliance requirements mandated by State statutes and regulations.

- ***Workforce Analysis Affirmative Action Report-State Contractors***
  This employment information form is used to report the racial and sexual composition of a firm's or corporation's workplace. The form must be completed by the Contractor and submitted with the proposal.

- ***Affidavit for Certification of Subcontractors as Minority Business Enterprises***
  Upon award of a contract, this form is used to document the good faith efforts of a Contractor to include minority business enterprises as subcontractors (including suppliers) on the State contract.

- ***Contract Compliance Notice Poster***
  This notice concerns the prohibition of discrimination in employment practices. Upon award of a State contract, the notice must be posted by the Contractor in conspicuous places accessible to all employees and applicants for employment.

More information about the State of Connecticut's Contract Compliance requirements is available on the Commission on Human Rights and Opportunities' web site at www.state.ct.us/chro under "Contract Compliance."

4.7.3. Please confirm you have downloaded, completed, and submitted all of the procurement documents listed above. If not, please explain.

Confirmed,
Not confirmed, explain:

5 GENERAL PROPOSAL CONDITIONS

Below are the general conditions for submitting a proposal. By checking "Agree", Bidder represents the MA-PD proposal submitted adheres to these conditions, unless otherwise noted in the proposal. Failure to meet any of these conditions may result in disqualification of your proposal. This RFP and your response, including all subsequent documents provided during this RFP process, will become part of the contract terms and policy between the parties.

General Proposal Conditions	Agree	Disagree. Please explain.
5.1 Bidder acknowledges that contract start date is January 1, 2018.		
5.2 Bidder agrees to respond to this RFP in full, including all requirements.		
5.3 Any award will be made to the Bidder(s) whose proposal(s) is/are deemed to be in the best interest of OSC. OSC reserves the right to reject any and all proposals.		
5.4 Any cost incurred by Bidder in preparing or submitting proposals is Bidder's sole responsibility. Proposals will not be returned.		
5.5 Bidder will not be bound by oral explanations or instructions given during the competitive process or after the award of the contract(s). However, OSC reserves the right to request that Bidder put any such oral explanations or instructions into writing and, once in written format, such documentation shall become part of Bidder's proposal for purposes of becoming part of the final agreement.		
5.6 Bidder agrees to be bound by its proposal for a period of at least 180 days, during which time OSC and/or Segal may request clarification or correction of the proposal for the purpose of evaluation. Amendments or clarifications shall not affect the remainder of the proposal, but only the portion as amended or clarified.		
5.7 Any exceptions to terms, conditions, or other requirements in any part of these specifications must be clearly pointed out in the appropriate section of the proposal. Otherwise, it will be considered that all items offered are in strict compliance with the specifications.		
5.8 The proposal must be signed (electronic signature is acceptable) by a legal representative of the bidding firm, who is authorized to bind the firm to a contract in the event of the award. All rates, fees and terms presented will be considered legally binding.		
5.9 All Bidder services must adhere to relevant federal and state laws and regulations.		

5.10 Any early termination provision contained in your contract cannot be tied to financial provisions or penalties. OSC can provide 60 days' notice while you will be required to provide 180 days' notice to OSC.		
5.11 Bidder agrees there will be no initial or ongoing commissions or finder's fees payable on any plan or services as a result of this RFP.		
5.12 There are NO additional fees (beyond those outlined in the Price Proposal Worksheet – Attachment D) required to provide the services outlined in this RFP. Any mandatory fees must be clearly outlined in the Price Proposal Worksheet. Under no circumstances will OSC be liable to Bidder for fees not disclosed in Bidder's written proposal.		
5.13 Bidder agrees that OSC will not indemnify Bidder under the terms of the contract.		
5.14 Bidder acknowledges that OSC is subject to Connecticut open records laws relating to disclosure of public records and may be required, upon request, to disclose certain records and information covered by and not exempted from such laws. Notwithstanding anything to the contrary contained in the Bidder's proposal or in the final Agreement, Bidder acknowledges and agrees that OSC may comply with those laws and any such compliance shall not be deemed a violation with any provision of Bidder's proposal or final Agreement.		
5.15 Bidder agrees that the Agreement shall be governed by and construed in accordance with Connecticut Law, without giving any effect to the conflict of laws provision thereof.		
5.16 Insurance. Bidder shall maintain or obtain (as applicable), with respect to the activities in which Bidder engages pursuant to this Agreement, professional liability (errors and omissions) insurance and general liability insurance in amounts reasonable and customary for the nature and scope of business engaged in by such party. Bidder shall deliver to OSC evidence of such insurance on or before the Effective Date and annually thereafter and name OSC as an additional insured.		
5.17 Bidders must be licensed to do business in the State of Connecticut where such license is required for the services proposed. If you have an application for license pending please provide a copy of the application. Such license must be in effect before October 1, 2017.		
5.18 OSC requires that the contract be signed by no later than two weeks post contract award. Bidder agrees to meet this deadline.		
5.19 Bidder will execute and be in full compliance with the attached Business Associate Agreement (BAA) (Attachment E) with OSC.		

5.20 Bidder must notify OSC within 30 days of purchase, acquisition and any other change in its ownership or partners or control affecting 10% or greater interest, any acquisition by it of 10% or greater interest in any subsidiary, and any new agreement with, by or between any affiliates that is relevant to the contract.		
5.21 Bidder acknowledges and agrees that Bidder has a continuing obligation to disclose any change of circumstances that will affect its qualifications as a Bidder.		
5.22 Bidder agrees to make changes in a timely manner in such instances where the Connecticut Legislature enacts legislation that impacts OSC and requires such changes.		
5.23 Bidder agrees that all reporting submitted by Bidder must be reconciled to the billing.		
5.24 Bidder must provide detailed disclosure of all invoice line items to OSC at each monthly billing cycle in the electronic format prescribed by OSC.		
5.25 Bidder must be able to accept standard, HIPAA-compliant enrollment data electronically.		
5.26 Bidder must have the capability to maintain eligibility files, and transmit and receive a reconciliation file to/from OSC electronically, on a weekly or monthly basis (frequency to be determined), in OSC's eligibility file format. OSC will provide its file format to the Bidder. See also Attachment F Eliigibility File Feed/CORE-CT File Exchange Protocols		
5.27 Bidder agrees that OSC owns its data and that such data will be considered proprietary and will not be shared, except at OSC's request, with full knowledge and express written consent.		
5.28 Bidder must notify OSC, in writing, immediately upon identification of system-related problems, programming problems or data transfer problems. Bidder must make every effort necessary to correct such problems within 48 hours regardless of the time or date in order to minimize any disruption to members.		
5.29 Upon termination of the contract, Bidder must provide historical data to succeeding Bidder or OSC, as directed, at no additional charge. Bidder must provide, at no additional cost to OSC, up to five (5) files of historical data, for the three previous contract years, to any new Bidder selected by OSC. Transition of data will begin immediately following notification of termination and must be complete within 90 days of that notification. Within 14 days of notification, bidder must provide files as of the notification date. Bidder must provide all data on a rolling basis at least once every 30 days thereafter until all OSC data has been provided to the succeeding bidder or to OSC as		

directed.		
5.30 Bidder agrees that all personnel/staff in Bidder's organization have completed HIPAA training. If yes, in the [Explanation] please indicate the frequency, or how often, this occurs (i.e. once annually, only once during new training orientation, etc.)		
5.31 Bidder will attach a copy of its most recently completed HIPAA assessment in the Required Documents section of the RFP.		
5.32 Bidder will supply OSC with the most recent copy of its completed HIPAA assessment every time one is completed.		
5.33 Bidder has attached a copy of its Information Security Policy and Procedures in the Required Documents section of the RFP. These policies must apply to the systems, processes and personnel directly related to the work included in this contract and not for other subcontractors or lines of business.		
5.34 If awarded the contract, OSC or its agent or representative may, at any point during the Agreement, perform an on-site self-assessment of Bidder's organization based on HIPAA requirements.		
5.35 Bidder agrees that all employees at Bidder's organization have been trained on how to report a security incident or potential breach under HIPAA.		
5.36 Bidder must have the ability to accept “warm transfers” from OSC's Retirement Health Insurance Unit to Bidder's call center(s) at no additional cost to OSC.		
5.37 Bidder must provide a dedicated Implementation Manager whose sole account is OSC and who, in coordination with the dedicated Account Manager and OSC Account Management team, will effectively manage the implementation of this program. The dedicated Implementation Manager must continue to support OSC a minimum of 45 days after the implementation date of January 1, 2018 should OSC desire. Such support includes, but is not limited to, weekly calls with OSC and the designated Account Management team, maintenance of issue-tracking logs, and issue resolution. This support must be provided as part of the base administrative fees with no additional cost to OSC.		
5.38 All OSC information disclosed during the proposal and contract term must remain strictly confidential unless disclosure is required by law.		
5.39 Bidder agrees to the specified eligibility rules established by OSC.		
5.40 No covered Medicare-eligible retiree or covered Medicare-eligible dependent of a retiree shall lose or gain coverage as a result of a vendor change. All transition-of-care-related issues and non-confinement provisions		

must be expressly waived for the initial enrollment for covered retirees and covered dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by OSC and/or CMS.		
5.41 Bidder agrees to be audited by OSC or an entity chosen by OSC.		
5.42 Bidder will not render or administer services off-shore, and all work performed will be in the contiguous United States.		
5.43 Bidder will submit required documentation to confirm financial viability in the Required Documents section of the RFP.		
5.44 Bidder must provide operational and system redundancy and disaster recovery procedures to ensure disruption-free service in the Required Documents section of the RFP.		

6 MEDICARE ADVANTAGE (MA) CONFIRMATIONS

6.1 Confirm your current capability to provide each of the following. If your proposal includes subcontractors, confirm that the arrangement you propose is currently operational and will not be first implemented for OSC. **A response on each of the following is required.** Failure to meet any of the qualifications outlined below may result in disqualification of your proposal.

Requirement	**Confirmed/ Not Confirmed**	**Explanation if Not Confirmed**
a. Confirm that you will provide MA-PD PPO coverage on a full replacement basis and/or on a coexisting basis with a separate pharmacy self-insured EGWP plan.		
b. Confirm that you will provide an MA-PD PPO plan with same in-network and out-of-network cost sharing for members.		
c. Confirm that you will provide the requested plan design(s) identically to the State of Connecticut plan members in all states.		
d. Confirm for all benefits that retirees will not lose or have lesser benefits than those benefits currently in force, assuming benefits meet CMS requirements.		
e. Confirm that you will provide the same fully-insured rates to the State of Connecticut plan members throughout the country.		
f. Confirm that you will agree to a three-year contract with OSC based on the effective date of coverage.		
g. Confirm that you are willing to cover members entering your plan that have been diagnosed with End Stage Renal Disease (ESRD).		
h. Confirm that you are willing to cover ESRD members that leave the plan and return to the plan during a subsequent Open Enrollment.		
i. Confirm that you agree that retirees who are disabled and on Medicare, but who are under age 65, are eligible for the MA-PD PPO plan(s) proposed.		

j. Confirm that you agree to provide the MMRs and MORs as detailed in this RFP.		
k. Confirm that your pricing is based on OSC's actual Medicare Allowed claims data (claims line detail will be provided to Bidders) in connection with this RFP.		
l. MA Vendor agrees to send timely notification letters to members and their prescribing physicians of drug formulary changes or other changes where there is a negative impact on the member at no additional fee.		
m. Confirm that you will provide a designated clinical manager to OSC for both medical and pharmacy programs, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered by your organization. Confirm that the clinical managers will have sufficient resources to efficiently and effectively handle the work load.		
n. Confirm there is no additional cost sharing if a retiree uses an out-of-network provider and that any excess charges (balance billing) will be paid by the health plan and not the retiree.		

7 QUESTIONNAIRE - GENERAL INFORMATION, CAPABILITIES, AND EXPERIENCE WITH NATIONAL MA-PD PLANS

7.1 REFERENCES

7.1.1 Provide three (3) current customer group health plan references. For at least two (2) of these references, Bidder should cover at least 50,000 group health plan members. OSC is interested in working with carriers that have experience with and a history of providing MA-PD benefits to public sector plans of similar size. Provide the following for each reference:

	Reference 1	Reference 2	Reference 3
a. Customer name			
b. Length of time serviced			
c. Number of covered members			
d. Description of services (MA-PD)			
e. Name of contact			
f. Contact title			
g. Contact phone number			
h. Contact email			
i. Contact address			

7.1.2 Provide this same information for two (2) recently-terminated customers. Include the reason the engagement was terminated.

	Reference 1	Reference 2

a. Customer name		
b. Length of time serviced		
c. Number of covered members		
d. Description of services (MA-PD)		
e. Name of contact		
f. Contact title		
g. Contact phone number		
h. Contact email		
i. Contact address		
j. Reason for termination		

7.2 COMPANY OVERVIEW

7.2.1 Please provide the following information:

	Your Company	Parent Company
Legal Company Name		
Corporate Office Address		
Telephone Number		
Company URL (web address)		

7.2.2 Provide the location of your office(s) that would be responsible for managing the OSC contract.

7.2.3 Provide the names of all subcontractors along with the type of services they will provide, the number of years your firm has utilized the subcontractor, and the contractual relationship between subcontractor and your company. Please use the table provided below.

	Name and Address	**Type of Service(s)**	**Years Utilizing this Contractor**	**Contractual Relationship**
1.				
2.				
3.				
4.				
5.				

7.2.4 Has your organization experienced recent merger or acquisition activity? If so, please describe. Has your organization recently undergone any workforce realignments? If so, please describe. Are there any anticipated changes in ownership or business developments, including, but not limited to, mergers, stock issues, and the acquisition of new venture capital? If so, please explain.

7.2.5 Does your company have any current or pending litigation? If yes, please explain.

1: Yes, explain
2: No

7.2.6 Has your company been sanctioned by CMS in the past 5 years? If so, please explain.

1: Yes, explain
2: No

7.2.7 Describe any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.

7.2.8 What are the most recent ratings for your company by the following?

	Rating	Date
A.M. Best		
Fitch		
Moody's		
Standard and Poor's		

7.2.9 If your rating has changed within the past 12 months for any of the rating agencies, please explain.

7.2.10 Is your organization:

1: Privately held,
2: Publicly traded,
3: A Mutual Holding Company,
4: Other. Please describe:

7.2.11 What fidelity and surety insurance or bond coverage do you carry or would you recommend to protect OSC? Specifically, describe the type and amount of the fidelity bond insuring your employees, which would protect OSC in the event of a loss.

7.2.12 Confirm that you will provide the most recent 2 years of your firm's audited financial statements. Provide the requested financial statements as an attachment to your proposal.

1: Confirmed,
2: Not confirmed, explain: [Unlimited]

7.3 EXPERIENCE

7.3.1 Describe your organization's experience participating in Medicare with an EGWP option for both Part C and Part D benefits. Include the number of years that your organization has participated in Medicare Advantage and a brief history of key developments over this time., such as when your first group Medicare Advantage plan was offered. Please also include insight on the direction of your program over the next five years.

7.3.2 Provide statistics regarding your MA business for your entire book of business. Break out your MA individual book of business and your MA employer group book of business, further broken out for your public sector group of business. Provide both the number of enrolled members for individual and group and the number of employer group clients for 2013 - 2017.

	Individual Members	Total Group Members	Total Number of Employer Groups	Public Sector Members	Number of Public Sector Groups	Number of Public Sector Groups with 50,000+ lives
2013						
2014						
2015						
2016						
2017						

7.3.3 Provide your organization's year-end Medicare membership for each year that you have participated in the Medicare program.

7.3.4 a. How many new group MA members did your organization add effective January 1, 2016 and January 1, 2017? b. How many new MA groups did your organization add effective January 1, 2016 and January 1, 2017?

7.3.5 What percentage of your 2016 total group MA-PD membership renewed for the 2017 plan year?

7.3.6 Provide your average book of business, fully insured renewal increases, for the last 5 years, for your Medicare Advantage group health plan business as outlined in the table below.

	Average Book of Business Medicare Advantage Group Health Plan Rate Increase	Average Book of Business Medicare Advantage Rate Increase for Public Sector Groups	Average Book of Business Medicare Advantage Rate Increase for Public Sector Groups with 50,000+ Group Health Plan Members
2014			
2015			
2016			
2017			
2018			

7.4 STAFFING

7.4.1 Confirm that all Member Service Representatives (MSR), clinical staff and other applicable team members are appropriately licensed or certified in the state in which they are employed. Describe the licensing requirements for your staff.

1: Confirmed
2: Not confirmed

7.4.2 Confirm that you will be available and participate in the OSC's Open Enrollment communications campaign. Describe your involvement and how you will assist members in learning about their benefit options. Note that Open Enrollment is scheduled to end in June for coverage effective July 1st.

1: Confirmed
2: Not confirmed

7.4.3 Confirm that your organization will conduct on-site, state wide educational sessions for OSC's Medicare-eligible retirees and Medicare-eligible dependents of retirees during the period from May to June 1st for implementation beginning June 1. Confirm that you will conduct at least one meeting in each county plus two or more meetings in the larger populated counties.

1: Confirmed
2: Not confirmed

7.4.4 OSC may be interested in your organization providing on-site staff. The staff may be needed to work in the OSC offices as Member Service representatives for medical and pharmacy issues. These employees may also need to be available to OSC management staff for the purpose of resolving claim and member issues. Please suggest staffing levels for this request. Describe how your organization would train the on-site staff to support the members and OSC staff and whether OSC would be involved in the interview process for this staff.

1: Confirmed
2: Not confirmed

7.4.5 Confirm your understanding and agreement that ALL on-site staff will be subject to a background check.

1: Confirmed
2: Not confirmed

7.4.6 Please provide the following information:

	Response
A statement of whether the Bidder or any of the Bidder's employees, agents, independent contractors, or subcontractors have been convicted of, pled guilty to, or pled nolo contendere to any felony, and if so, an explanation providing relevant details.	
A statement of whether there is any concluded or pending litigation against the Bidder or Bidder's employees related to a contract engagement; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the firms performance in a contract under this RFP.	
A statement of whether the Bidder or any of the Bidder's business associates have reported a HIPAA breach involving 500 or more individuals in a given state or jurisdiction in the last ten	

years.	
A statement on how Bidder vets employees and/or contract personnel to ensure workforce clearance procedures are followed under HIPAA.	
A statement as to whether, in the last ten years, Bidder or any of its subcontractors has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors; and if so, an explanation providing relevant details.	

7.5 MEMBER SERVICES

7.5.1 Please describe the hours and days the Members Services unit will have live representatives available to OSC members.

7.5.2 Is there a Pre-Enrollment information line available during Open Enrollment as well as an Information line available throughout the year? Will the pre-enrollment line be dedicated to OSC? Will the post enrollment line be dedicated to OSC?

7.5.3 How are calls "after hours" of operation handled?

1: Voice mail,
2: No service,
3: Full service – 24/7,
4: Some extended hours for calls,
5: Other, please specify:

7.5.4 Confirm each of the following:

Member Services	Response
a. Bidders will operate a dedicated member services unit with a toll-free dedicated member services telephone line to answer questions from OSC's members.	
b. Bidders will have special telephone features for the hearing impaired.	
c. Resources will be available to assist non-English speaking callers through a translation service.	
d. All calls will be recorded and kept for 24 months and made available for OSC's review upon request.	
e. MSR will warm or soft transfer members to other service areas or Vendors, including OSC, if necessary.	
f. Members will be able to opt out of the Interactive Voice Response (IVR) to speak with a live MSR.	

7.5.5 Please provide the geographic location of the Member Service unit(s) that will be servicing OSC's members. Will this service be outsourced? If so, provide the name of the outsourcer.

7.5.6 How large is your MA Member Service Department? How many employees work exclusively in this department?

7.5.7 Describe your firm's process for providing training to MSRs to serve a senior membership.

7.5.8 Describe how you can provide OSC's staff call monitoring capability for live and/or recorded calls remotely and on-site. If recorded calls, confirm that you will allow OSC to select a sampling on a weekly basis. Please describe if your organization's system is capable of allowing OSC staff to hear a specific call made to your call center if the OSC staff person can provide the date, time, and MSR involved.

7.5.9 Describe the escalation process for Member Service satisfaction and complaints.

7.5.10 Describe the escalation process for urgent drug claim issues where claims are rejecting at the pharmacy and members need immediate assistance and resolution.

7.5.11 Confirm you will handle all initial internal and external appeals in accordance with CMS requirements and guidelines. Describe how you will comply with this requirement.

1: Confirmed
2: Not confirmed

7.5.12 Confirm you will handle any and all grievances in accordance with CMS requirements and guidelines. Describe how you will comply with this requirement.

1: Confirmed
2: Not confirmed

7.5.13 Confirm that you will send via surface mail, a member ID card to all members at least ten (10) business days before the beginning of each plan year. Confirm that you will mail ID cards to newly-enrolled members within ten (10) business days of receiving confirmation from CMS. Confirm that you will re-issue the member ID card within five (5) business days of notice if a member reports a lost card or for any reason that results in a change to the information disclosed on the member ID card.

1: Confirmed
2: Not confirmed

7.5.14 Confirm that you will issue new member ID cards as required by OSC, at your expense.

1: Confirmed
2: Not confirmed

7.5.15 Confirm your ability to provide a member ID card that, at a minimum, includes the following information:

ID Card Information	Response
The member's name;	
Bidder's twenty-four (24) hour, seven (7) day/week toll-free eligibility and pre-certification services telephone number and applicable co-payments and deductibles for services.	
List any elements not currently included.	

7.5.16 Do you use an outside vendor to print ID cards? If yes, what security measures do you have in place to prevent a breach?

1: Confirmed
2: Not confirmed

7.5.17 If your organization has experienced a security breach, describe the breach and how your organization achieved resolution.

7.5.18 Will you issue a combined ID card for medical and PBM services, if applicable? Provide a sample of the ID card.

1: Yes. Sample is attached
2: Yes. Sample is not attached, explain:
3: No, explain:

7.5.19 Confirm the Evidence of Coverage (EOC) will be available prior to Open Enrollment annually in accordance with CMS requirements.

1: Confirmed
2: Not confirmed

7.5.20 Please complete the following table:

Provider Directories	**Response**
Describe the provider directories available to your membership.	
How often are they provided?	
Do you issue hard copies?	
Can the directories be accessed online? If so, how often are they updated?	

7.5.21 Indicate whether your member website captures the following:

Member Website Capabilities	**Response** (Yes/No)
Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers) for Providers that accept Medicare assignment)	
Ability to make a doctor's appointment online	
Ability to review claims payment status online	
Ability to review a history of claims payments (medical and pharmacy), including deductible status, and out-of-pocket maximum status	
Ability to see a summary of OSC's plan design and review the EOC	
Ability to print ID cards and request replacement cards	
Ability to contact Member Services online	
Star Ratings	
Information about diseases and conditions	
Contact information for OSC, its other vendors, and links to their websites	
Online access to forms	

Up to date OSC-specific formularies with tier rankings	

7.5.22 Confirm that you will provide all correspondence to members required by CMS regarding terminations and compliance issues.

1: Confirmed
2: Not confirmed

7.5.23 Confirm that you will provide all CMS required filings related to certification of compliance to all fraud and abuse requirements.

1: Confirmed
2: Not confirmed]

7.5.24 For the PD plan you are proposing, confirm that you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis.

1: Confirmed
2: Not confirmed

7.5.25 Describe your organization's Member Satisfaction Surveys and provide the most recent results.

7.6 ACCOUNT MANAGEMENT/ CLIENT SERVICES

7.6.1 Please provide contact information for the Account Executive that will be assigned to this engagement.

	Response
Company Name	
Contact Name	
Contact Title	
Address	
Office Number	
Mobile Number	
e-Mail Address	
Company URL (web address)	

7.6.2 Identify the key Account Management team you propose to work on this account and provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management. Some positions may be dedicated and others may be designated. Please describe your definitions for “Dedicated” and “Designated” and indicate which positions are Dedicated vs. Designated.

7.6.3 Indicate whether the person who will fill each position is already employed by your firm or whether he/she will be recruited upon Contract Award. If the person(s) are already employed, provide resumes, length of time with your firm and length of time in their current position. At a minimum, the positions below should be included.

1. Account Director – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with OSC, and managing all other Bidder's staff working on this account. The Account Director shall have at least 3 years of experience with your firm as an Account Director in similar engagements.
2. Actuary – Responsible for developing OSC's premiums for MA-PD plan options and projecting future claims costs and CMS reimbursements. Will assist OSC in determining the projected short- and long-term financial impact(s) of prospective programs. The Actuary shall be a Fellow of the Society of Actuaries and have experience in rating MA-PD plans for groups similar to OSC.
3. Medical Director – Responsible for design and clinical effectiveness of medical management and wellness programs to manage the risk of OSC's membership and therefore control future cost/premium increases. Will work pro-actively and collaboratively with OSC to identify health risks in OSC's membership that are behaviorally caused and, as necessary, develop modified or additional programs to target these risks. Will assist OSC in determining the projected short- and long-term clinical and health impact(s) of current and prospective programs.
4. Medicare Director – Responsible for coordinating with CMS to ensure that all MA-PD filings are structured to properly and fully support OSC's requirements. Also develops processes and strategies to maximize CMS funding to minimize premiums. Proactively assists OSC in developing strategic considerations to maximize operational and cost efficiencies. Responsible for communicating CMS and MA-PD program updates and the resulting impact on OSC's program. Must have at least 3 years of experience as a Medicare Director in similar engagements.
5. Pharmacy Director – Responsible for managing the overall pharmacy operation, including all account services directly related to clinical pharmacy including formulary management, clinical plan rules and programs, medication therapy management, and specialty pharmacy. Will provide information and recommendations with respect to new drug/therapy introductions and clinical pharmacy best practices.
6. Clinical Account Director – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design, improving clinical outcomes and cost containment opportunities, overseeing clinical services under the contract with OSC, and managing all other Bidder's clinical staff working on this account.
7. Privacy Officer/Attorney – Responsible for ensuring compliance with all applicable laws and regulations, including HIPAA and ACA. Responsible for maintaining internal controls to protect PHI and insuring that adequate and timely steps are taken in the event of a breach of confidentiality. Responsible for communicating program and policy updates to OSC and coordinating as necessary with OSC's internal counsel and staff.
8. Operations Director – Responsible for overseeing the file transfer process of eligibility data, interfaces between vendors, reporting, and data sharing. Responsible for all Member Services and communications. The Operations Director shall have at least 3 years of experience as an Operations Director in similar engagements.
9. Implementation Manager – Responsible for development and execution of implementation plan. Coordinates with OSC's internal and external resources. The Implementation Manager shall have at least three (3) years of experience as an Implementation Manager covering at least 50,000 group health members and larger.

7.6.4 Please describe your firm's turn-over rate, as it pertains to Account Management staff.

7.6.5 Confirm that you will provide an Account Executive and a backup account staff member that will handle **ALL** service matters related to the operation of the program.

1: Confirmed
2: Not confirmed

7.6.6 Confirm that you will respond to all OSC inquiries within one (1) business day.

1: Confirmed
2: Not confirmed

7.6.7 Describe your firm's process to escalate problems or concerns through the corporate structure to facilitate resolution of issues.

7.6.8 Discuss how your firm will track this requirement and report your findings to OSC.

7.6.9 Confirm that you will provide an annual score card to OSC so that OSC can assess your performance. Please upload a sample of your annual score card.

1: Confirmed, sample attached
2: Confirmed, sample not attached explain:
3: Not confirmed, explain:

7.6.10 Confirm that your team will attend on-site quarterly meetings with OSC to present current plan and service performance, address any recent issues/challenges encountered, suggest potential savings opportunities, and discuss other pertinent topics to be identified prior to each meeting.

1: Confirmed
2: Not confirmed

7.6.11 Confirm that your team will attend OSC's Healthcare Cost Containment Committee Meetings as necessary, and at your expense.

1: Confirmed
2: Not confirmed

7.6.12 Do your services include legislative updates to plan sponsors?

1: Yes – included in Standard Fees,
2: Yes – for Additional Charge,
3: No

7.7 CLAIMS PROCESSING

7.7.1 With regard to the claim office(s) that will be used, provide the following:

	Response
Location	
Average Claims/Processor/Day	
Annual Claim Volume	

Percentage of claims that are auto-adjudicated	
Indicate the average time to pay the following provider type from the receipt of a "clean claim":	
Hospitals	
Physicians	
Pharmacies	
Other types of providers. Please describe.	

7.7.2 Confirm that the claims processing system is integrated with the eligibility and Member Services system.

1: Confirmed
2: Not confirmed

7.7.3 Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims please discuss separately.

7.7.4 Provide the following information regarding internal claims audit(s):

	Response
What are the current standards for internal claim audits?	
How often are claim processors audited?	
When an error is found, what is the time period for correction of the claim?	
Are reports monthly, quarterly, semi-annual, etc.?	
What claims do you consider for high dollar audits?	
Are high dollar audit claims handled internally?	
How are criteria determined for internal audits? What triggers do you utilize?	
What percent of claims are audited internally?	
What is the ratio of quality reviewers to claim processors?	

7.8 REPORTING

7.8.1 Confirm that you will provide and present quarterly reports to OSC.

1: Confirmed
2: Not confirmed

7.8.2 Bidders shall create and generate standard utilization and cost reports. Provide a list of your standard reports. In addition, include a description of each report, a sample, and the frequency of the report.

7.8.3 Are these reports available online currently?

7.8.4 Confirm that you are able to customize reports and this is included in your quoted premium(s).

1: Confirmed
2: Not confirmed

7.8.5 Confirm that your organization will provide claim line detail for ALL claims—medical, wellness, and pharmacy—including, but not limited to, financial and diagnoses information to OSC's data warehouse vendor.

1: Confirmed
2: Not confirmed

7.8.6 Confirm that your organization will provide this data to OSC's data warehouse vendor in a mutually agreed upon format by the 15th day of the month following the subject month.

1: Confirmed
2: Not confirmed

7.8.7 Confirm that your organization will provide detailed claims data to the State's data warehouse vendor and the State's health care consultant.

1: Confirmed
2: Not confirmed

7.8.8 Describe your process of transferring data to OSC's data warehouse vendor and ensuring the data will be HIPAA-compliant and subject to confidentiality and data security policies of OSC. Describe whether software used is capable of analyzing and producing reports for the physician and hospital profiling. In addition, describe whether your data warehouse is capable of producing utilization and pricing information in various categories.

7.8.9 Confirm that you will submit the Part C and Part D Medicare Membership Reports (MMR) monthly, including all fields as received from CMS. The monthly MMR will be submitted by the end of the corresponding month.

1: Confirmed
2: Not confirmed

7.8.10 Confirm that you will submit the Part C and Part D Model Output Reports (MOR) upon request, no more often than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of request.

1: Confirmed
2: Not confirmed

7.8.11 Please list and describe the reports received from CMS, other than the MMR and MOR that will be available for the proposed MA-PD plan, including frequency of the reports.

7.8.12 Describe your standard web portal and Member Services utilization reports (i.e., number of hits and calls and the nature of the members' inquiries) and provide examples.

7.8.13 Confirm that you will provide monthly, quarterly, and annual appeals reports to OSC.

1: Confirmed
2: Not confirmed

7.8.14 Confirm that OSC will be provided sufficient information regarding the previous year's renewals to audit them for accuracy and compare them to actual experience.

1: Confirmed
2: Not confirmed

7.8.15 Is there an additional charge for ad hoc reporting? If so, please provide the average cost per report and the average preparation time.

1: Yes, explain:
2: No, explain:

7.8.16 Confirm that you conform to the file layout requirements of the State of Connecticut Core-CT system outlined in Attachment F.

1: Confirmed
2: Not confirmed

7.8.17 Confirm that you can access the Core-CT portal address from the Production Supplier Portal URL: https://coreps.ct.gov/PSPRD/signon.html and the Test Supplier Portal URL: https://corepstpr.ct.gov/PSTPR/signon.html.

1: Confirmed
2: Not confirmed

7.9 ELIGIBILITY

7.9.1 Describe your enrollment system (including how long it has been in place and whether there are plans to use a new system within the next three years), hardware and software, and detail how updates are made regarding eligibility.

7.9.2 Confirm that you will update eligibility data within 24 hours from receipt of data.

1: Confirmed
2: Not confirmed

7.9.3 OSC will handle all enrollments and cancellations and transmit that data in an 834 file at least weekly to Bidder for processing. Confirm that you will electronically accept and process, on at least a weekly basis, the ASC X12 Benefit Enrollment and 834 Maintenance (834) transaction provided file format sent to you by OSC at least weekly.

1: Confirmed
2: Not confirmed

7.9.4 Confirm that your organization will not enroll or cancel OSC members on its own unless there is a conflict from CMS.

1: Confirmed
2: Not confirmed

7.9.5 If a conflict from CMS is found, confirm that the conflict information will be reported back to OSC within one business day so that OSC can correct and retransmit their records.

1: Confirmed
2: Not confirmed]

7.9.6 Confirm that your present system is capable of handling more than 1 eligibility file in a day if requested by OSC.

1: Confirmed
2: Not confirmed

7.9.7 Confirm that you will be responsible for certifying participant eligibility through your online system.

1: Confirmed
2: Not confirmed

7.9.8 Confirm that your organization will store member-level detail and will include it on any member-level reporting back to OSC.

1: Confirmed
2: Not confirmed

7.9.9 Please confirm that your organization will generate a reconciliation file monthly or on demand and that this file will contain, at a minimum, demographics, enrollment date, and cancel date.

1: Confirmed
2: Not confirmed

7.9.10 Describe the processing procedures to ensure files are received and processed timely. What safeguards are in place to detect missing files?

7.9.11 Confirm that you will stop an eligibility upload in the event that established error thresholds are exceeded.

1: Confirmed
2: Not confirmed

7.9.12 Describe how you propose to notify OSC in the event an eligibility upload is aborted.

7.9.13 Will the previous file be reinstated?

7.9.14 Confirm that you will provide direct same day confirmation that the eligibility file was received, properly loaded, processed, and that this confirmation will include the date of receipt.

1: Confirmed
2: Not confirmed

7.9.15 Explain your process of working error reports generated from the file loads.

7.9.16 Does your system allow for direct and remote access manual data entry and correction of eligibility data by authorized OSC staff?

1: Yes,
2: No, explain:

7.9.17 Describe the process for manual entry and safeguards in place (i.e., authorization to make manual entries, audit tracking of who made changes, etc.).

7.9.18 Describe the address information maintained on your enrollment system.

7.9.19 Does your system have the capability to store more than one address per Enrollee, not including a confidential mailing address?

1: Yes,
2: No, explain:

7.9.20 Describe the procedures in place to accommodate a confidential mailing address as required by Title II of HIPAA.

7.9.21 How much historical eligibility information is maintained on an individual's file? How much is accessible online, real time versus archived?

7.9.22 Describe your ability to manage CMS eligibility issues and how you propose to work with OSC staff on these issues.

7.9.23 Describe the process for resolving CMS eligibility issues for members that only have a P.O. Box address?

7.9.25 Confirm that there will be no minimum participation requirements.

1: Confirmed
2: Not confirmed

7.10 COORDINATION OF BENEFITS (COB)

7.10.1 Confirm that, at a minimum, your organization will accept and use the COB data provided by OSC in the 834 file to process claims.

1: Confirmed
2: Not confirmed

7.10.2 Indicate whether you have any sources of COB information in addition to the information received in OSC's 834 file.

7.11 REVENUE MAXIMIZATION

7.11.1 In the table below, provide your CMS Five-Star Quality Rating **used for pricing** the 2015, 2016 and 2017 national MA-PD PPO plan you will be offering, and comment on the ratings (or lack of ratings, if applicable).

CMS Five-Star Quality Rating	2015	2016	2017	Comments
Staying Healthy: Screenings, Tests and Vaccines				
Managing Chronic (Long-Term) Conditions				
Member Experience with Health Plan				

Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance				
Health Plan Customer Service				
Drug Plan Customer Service				
Member Complaints, Problems Getting Services, and Improvement in the Drug Plan's Performance				
Member Experience with the Drug Plan				
Patient Safety and Accuracy of Drug Pricing				
Total Five-Star Quality Rating				

7.11.2 Describe your plans for CMS Star Rating maximization.

7.11.3 Describe your approaches to risk adjustment. Include in your response any innovative programs you use to improve the accuracy of the risk scores and any increase in scores you have been able to achieve.

7.11.4 Describe your process for reconciling member risk scores with risk scores on file with CMS, tracking member risk scores, and tracking the financial impact of risk-adjusted scores.

7.11.5 How do your risk adjustment strategies impact the pharmacy risk score?

7.11.6 How does your organization work to maximize risk scores for individuals aging into Medicare?

7.11.7 What does your organization do to educate providers on the importance of complete medical record documentation to support the data used for risk adjustment?

7.12 DATA REPORTING TO CMS

7.12.1 What controls does your organization have in place to ensure all required data is sent to CMS for each data collection period?

7.12.2 What does your organization do to audit the quality and completeness of provider claims data?

7.12.3 What controls are in place to ensure that claims data submitted to CMS includes only valid risk adjustment codes?

7.12.4 What controls are in place to ensure that data sent to CMS is from a valid provider type?

7.12.5 What controls are in place to identify duplicate transactions that are ineligible from a CMS perspective?

7.12.6 What process is in place to assess and/or monitor the potential financial impact for instances of noncompliance (particularly as it relates to the submission of duplicate transactions)?

7.12.7 Provide your book of business prescription drug event (PDE) error rate for 2015 and 2016.

7.13 MEDICAL MANAGEMENT

7.13.1 Describe in detail all programs and services, such as wellness programs, disease management programs, case management programs, pharmacy utilization management programs, etc. you will offer with this plan that may in some way control costs.

7.13.2 Describe your medical management experience with retiree groups.

7.13.3 Describe how your program design enhances quality of care, including improvements in health status and clinical outcomes. How does your approach differ between your MA-PD products and. your commercial plans?

7.13.4 Discuss how you engage targeted individuals to participate in your programs.

7.13.5 Describe your outreach to the membership with chronic conditions.

7.13.6 Please respond to the following table:

	Response
a. Describe how members with both medical and behavioral concerns are identified.	
b. Who manages these members?	
c. Does your organization have a process for collaboratively managing members with both medical and behavioral health problems?	

7.13.7 Describe the advantages of a single carrier managing both the medical and pharmacy benefits.

7.13.8 Describe the disadvantages of a single carrier managing both the medical and pharmacy benefits.

7.13.9 How does your organization use pharmacy data to identify high risk, high need populations?

7.13.10 Describe your Rx utilization management programs (Prior Authorizations, Step Therapy, Quantity Level Limitations, age and gender restrictions, Medication Therapy Management programs, high-risk drug programs for the elderly, etc.). In your response, include the process for enrollment, targeting, reporting, and outcomes reporting.

7.13.11 Can the above programs be customized for OSC's membership?

7.13.12 Indicate which of the following Case Management components are offered by your organization:

Case Management	**Offered** (Yes/No)
a. Pre-admission review/Pre-determination	
b. In-patient admission/concurrent review	
c. Discharge planning	
d. High-risk post-discharge outreach	
e. Retrospective review	

f. Outpatient review	
g. Catastrophic/long-term Case Management	
h. Episodic/short-term Case Management	
i. End-of-life program identification and transition	

7.13.13 Describe the circumstances under which prior authorization of a drug is required.

7.13.14 Are Prior Authorizations performed in-house or by a third party?

7.13.15 Describe the non-formulary Prior Authorization process.

7.13.16 Describe the transition process you will utilize for members who are currently using non-formulary prescription drugs, drugs requiring prior authorization, or quantity level limits.

7.14 FINANCE AND BANKING

7.14.1 Please provide a sample detailed invoice.

1: Attached,
2: Not attached, explain:

7.14.2 Currently, OSC can only remit payment for an invoice via ACH transfer. Confirm that you are able to accept this payment format.
1: Confirmed,
2: Not confirmed, explain:

7.14.3 Confirm you will provide invoices/billing on a monthly basis.
1: Confirmed,
2: Not confirmed, explain:

7.14.4 Confirm that your invoices will contain a detailed disclosure of all invoice line items and will be submitted electronically.
1: Confirmed,
2: Not confirmed, explain:

8 NATIONAL MA-PD PPO

8.1 PLAN DESIGN

OSC wishes to procure a fully-insured, national MA-PD PPO plan with the same benefits for services rendered in-network and out-of-network. A summary of current retiree benefits plan you are requested to provide a quote on is attached in **Attachment A.** The MA-PD PPO should function as a passive PPO that provides the same level of benefits for retirees when they see a provider outside the network that accepts Medicare. The national MA-PD PPO plan you propose must meet all CMS requirements, and any benefits not delineated in

the plan design must be covered at least at the minimum requirement set by CMS. **Bidders may not deviate from these plan designs in any manner other than to meet CMS requirements, and the plan design proposed must be at least equal to the current plan.** You may offer alternative, supplemental benefits and/or enhanced benefits, with respect to which costs and return on investment (ROI) projections shall be provided.

8.1.1 Confirm you will be able to replicate the current plan design for the national MA-PD PPO plan, with the same benefits for services whether rendered in-network and out-of-network for medical and Part D prescription drug services. If not, indicate any deviations.

1: Confirmed,
2: Not confirmed, explain:

8.1.2 If you denoted any deviations above, provide the actuarial value of these deviations.

8.1.3 The OSC and the (HCCCC) will compare and evaluate the plan design each Bidder is proposing for the current Medicare Supplemental benefits plus Part D EGWP. Describe in detail the value of the MA-PD plan you are proposing over the current plan of benefits.

8.1.4 Describe all benefits in the current plan that are NOT covered under your proposed MA-PD plan (i.e., OSC covers acupuncture but Medicare does not). Please describe why these benefits are not covered under your proposed MA-PD plan.

8.1.5 Please describe all benefits in your proposed MA-PD plan design that are an enhancement over the current plan's benefits design.

8.1.6 If you are offering alternative, supplemental benefits and/or enhanced benefits, please describe these and provide cost, benefit and ROI projections.

8.1.7 During discussions involving OSC and the HCCCC, which will take place prior to a Bidder being awarded the MA-PD contract, questions about the equivalency of the benefits offered under the current plan versus under the proposed plan may arise. In such instances, confirm that you are willing to address such questions about any possible benefit discrepancies between the current plan and your proposed plan, in order to educate OSC and the HCCCC on the relative equivalency between the benefits in question.

1: Confirmed,
2: Not confirmed, explain:

8.1.8 Are there any CMS filing limitations that would impact benefit coverage levels for any benefit design elements? If yes, please explain and include in your pricing.

8.1.9 Confirm that you are able to provide OSC's current EGWP formulary. OSC's current formulary to be included in the Reference Documents.

8.1.10 Are there any CMS filing limitations that would impact OSC's current formulary? If yes, please explain in detail and include in your pricing.

8.1.11 Please describe how your plan covers emergency services incurred outside of the U. S.

8.3 NETWORK ACCESS AND MANAGEMENT

8.3.1 Perform and provide a GeoAccess analysis based on your contracted MA PPO provider network and the census file to be included in the Reference Documents. Do this by both specific access standards as well as using compound access. Use the access standards in the table below for your analysis. Only providers under contract with the plan should be included. In other words, do not count all providers that accept Medicare if you meet the 51% Rule.

Provider Type	Urban Enrollees	Suburban Enrollees	Rural Enrollees
Primary care physician	4 in 5 miles	4 in 10 miles	2 in 20 miles
Hospital	2 in 5 miles	2 in 10 miles	1 in 20 miles
Cardiologist	2 in 5 miles	2 in 10 miles	1 in 20 miles
Gastroenterologist	2 in 5 miles	2 in 10 miles	1 in 20 miles
Orthopedist	2 in 5 miles	2 in 10 miles	1 in 20 miles
Rheumatologist	2 in 5 miles	2 in 10 miles	1 in 20 miles
Other specialist	4 in 5 miles	4 in 10 miles	2 in 20 miles

1: Attached,
2: Not attached, explain:

8.3.2 Does your organization meet CMS's MA coordinated care network adequacy requirement for OSC's Medicare-eligible retiree membership (the 51% rule)? Discuss how you are able to meet this requirement.

1: Yes,
2: No, explain:

8.3.3 What is your percentage of network adequacy with regard to the 51% rule based on OSC's membership?

8.3.4 Explain your long-term network growth strategy.

8.3.5 Are members restricted in using physicians and hospitals of their choice?

8.3.6 What PBM do you currently use? How long have they been in place? When does your current contract with your PBM expire?

8.3.7 Perform and provide a GeoAccess analysis based on your contracted pharmacy network and the census file to be included in the Reference Documents. Provide this separately for independent pharmacies and chain pharmacies. Use the access standards in the table below for your analysis.

Provider Type	Urban Enrollees	Suburban Enrollees	Rural Enrollees
Pharmacy	2 in 5 miles	2 in 10 miles	2 in 20 miles

1: Attached,
2: Not attached, explain:

8.3.8 Are all major pharmacy chains in-network for the Part D benefit? List any major pharmacy chains excluded from your network.

8.3.9 Please provide a copy of your Hepatitis C treatment policy as an attachment to this RFP.

1: Attached,
2: Not attached, explain:

8.3.10 Please provide a copy of your PCSK9 policy as an attachment to this RFP.

1: Attached,
2: Not attached, explain:

8.3.11 Describe how your organization manages Specialty medications.

8.3.12 Provide your organization's definition and qualification criteria of a specialty drug.

8.3.13 Please describe any existing specialty pharmacy networks your organization currently maintains.

8.3.14 Describe how your organization notifies clients of the pricing terms for new specialty drugs including how far in advance such notice is provided.

8.3.15 Do you currently have a specialty/biotech drug P&T committee? If yes, explain the role, function, and structure and how it differs from your traditional P&T Committee.

8.3.16 Please indicate in which of the 50 states your organization is licensed to offer employer-sponsored, network-based MA-PD solutions.

8.3.17 Please complete the following:

	Response
a. Based upon OSC's provided retiree census data, identify any areas in which you are filed to operate where your provider network and network pharmacies may not have adequate capacity to meet the potential demand.	
b. How is adequacy determined by your organization?	
c. What are your plans for expansion in these areas?	
d. What is your solution to meet the pharmaceutical needs of members who live in areas where pharmacy access is inadequate?	
e. Indicate any areas where your network access does not meet the CMS-standard access requirements.	

8.3.18 Describe your organization's approach for credentialing providers and pharmacies to participate in your network (your recruitment strategy).

8.3.19 Provide your provider and pharmacy turnover percentages for calendar years 2014, 2015 and 2016. Break down your providers by category, physician, hospital, etc., and calculate turnover percentages for each category In order to insure that each Bidder calculates the turnover rate in the same manner, follow these instructions:

a. Provide the number of contracted providers and pharmacies as of the first day of each calendar year for each quarter of 2014, 2015, and 2016. Average the numbers of each year to obtain the average number of providers contracted for the year.

b. Provide the number of providers and pharmacies which were under contract at any point during 2013, 2014, and 2015 and were no longer under contract as of the last day (December 31) of that year, i.e., the total number of separations during 2013, 2014, and 2015.

c. Calculate the turnover rate as the total number of separations for the year divided by the average number of contracted providers and pharmacies for the year

Provider Turnover – 2014	**Provider Turnover – 2015**	**Provider Turnover – 2016**	**Pharmacy Turnover – 2014**	**Pharmacy Turnover - 2015**	**Pharmacy Turnover - 2016**

8.3.20 Describe your organization's MA-PD network growth and development plans. Describe your organization's approach for selecting and recruiting providers and pharmacies to participate in your MA-PD networks.

8.3.21 An Excel file labeled Medical and Rx Providers to be included in the Reference Documents - - is a provider utilization file representative of the medical and Rx utilization experience for OSC's Medicare-eligible retirees and their Medicare-eligible dependents for this plan. For each provider listed, please indicate if the medical provider or pharmacy is in the network (i.e., a participating provider) for the plan(s) you are proposing. Note for pharmacy providers, separate columns will be used to indicate if the pharmacy is a chain or an independent.

Single, Radio group.
1: Attached,
2: Not attached, explain: [Unlimited]

8.3.22 Describe how your organization will target and educate providers that are considered out-of-network in the analysis above.

8.4 PLAN ADMINISTRATION

8.4.1 Describe your process to support OSC in handling split-family contracts in which some members are Medicare-eligible and some members are not.

8.4.2 Explain how the following processes will be managed by your organization. Describe any typical issues and your approach for resolution.

1. Initial enrollment process for January 1, 2018
2. Opt in and Opt out processes
3. Age in process
4. The 21-day rule and retro enrollments/ cancellations

8.4.3 Describe what happens to medical and prescription drug coverage for members who:

1. Have Part A but do not have Part B
2. Drop Part B after enrollment in the MA-PD plan
3. Enroll in another Part D plan
4. Enroll in Medicare late and fail to enroll when that member turns 65. Who is responsible for paying any associated late penalties?

8.4.4 Describe your process for applying a member's Late Enrollment Penalty (LEP). In your response, please include how the LEP will be billed and how this will be communicated to OSC.

8.5 IMPLEMENTATION

8.5.1 Provide an Implementation Project Plan for the national MA-PD PPO plan. Include a detailed timetable assuming a Notice of Contract Award by June 1 for a January 1, 2018 Program 'go-live' date. Note that OSC's Open Enrollment Period for retirees takes place in May through June for coverage beginning July 1. Development of communications is expected to commence upon Contract Award to assist OSC with any communications necessary prior to Open Enrollment. At a minimum, the Implementation Project Plan must provide specific details on the following:

a. Identification and timing of significant responsibilities and tasks

b. Names, titles, and implementation experience of key implementation staff and time dedicated to OSC during implementation

c. Identification and timing of OSC's responsibilities

d. Transition requirements with the incumbent vendors

e. Staff assigned to attend and present (if required) at Open Enrollment/educational sessions

f. Member communication plan - including development and assistance to OSC, prior to Open Enrollment, and on-site Open Enrollment meetings

g. Data and timing requirements from current vendors to ensure transition of care and prior-authorization data is appropriately transferred

1: Attached,
2: Not attached, explain:

8.5.2 Confirm that the Implementation Project Plan with timetable will be submitted to OSC within 5 (five) business days of receiving Notice of Contract Award.

1: Confirmed,
2: Not confirmed, explain:

8.5.3 Confirm that at least sixty (60) days prior to January 1, 2018 effective date, OSC will have a readiness review of the pending awardees, including an on-site review of the Bidder's facilities. Bidders shall participate in all readiness review activities conducted by OSC staff to ensure the Bidder's operational readiness. Readiness review will include verification (by OSC or its agent) that OSC's benefits have been properly loaded into your claims processing system. OSC will provide the Bidders with a summary of findings as well as areas requiring corrective action. Describe how your organization will comply with this requirement.

8.5.4 Demonstrate how your organization will test the program to ensure claims will process correctly on the Program 'go-live' date of January 1, 2018. Confirm you will conduct testing with an actual retail pharmacy from the Point-of-Sale transaction to a completed transaction where the pharmacy successfully processes the prescription drug claim for a successful fill of the medication.

8.5.5 Are you willing to provide a one-time implementation allowance to fund, as approved by OSC, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? What dollar amount are you willing to provide?

8.5.6 Identify the Implementation Team you propose to assign to this account and provide an organization chart defining the Implementation Team roles. Include names and titles for the entire proposed Implementation Team including key positions and support staff. Please provide resumes and MA-PD experience and qualifications for each individual

8.5.7 What challenges and disruptions do you foresee members experiencing as they change plans? How do you propose dealing with those challenges and disruptions in order to make the transition to a new plan go smoothly for members?

8.5.8 Confirm that all OSC members will have a valid ID card in hand prior to January 1, 2018.

1: Confirmed,
2: Not confirmed, explain:

8.5.9 Confirm your organization will provide a status report on the Implementation Project Plan detailing current activities, closed tasks, problems, and any recommendations.

1: Confirmed,
2: Not confirmed, explain:

8.5.10 Confirm your organization will provide a Final Report detailing all implementation activities and final enrollment is complete.

1: Confirmed,
2: Not confirmed, explain:

8.5.11 How long will the Implementation Team stay involved after the Program 'go-live' date for troubleshooting before a handoff to the Account Management team?

8.6 COMMUNICATION AND EDUCATION

8.6.1 Please complete the following table.

	Response
a. Describe how your organization can effectively communicate with and educate OSC's retirees.	
b. What will be your communication and education strategy, and why do you think that strategy is the right one?	
c. How will you implement that strategy?	

8.6.2 Please complete the following table:

	Response	Comments
a. Please list all communication and educational materials CMS requires you to provide.		
b. What do you provide above and beyond what CMS requires?		
c. Provide samples of communication and educational materials.		

8.6.3 Confirm each of the following:

Customized Communications	**Response**	**Comments**
Confirm that letters can be customized with OSC's logo as requested by OSC.		
Confirm that, upon request, specific letters can be suppressed.		
Confirm that OSC will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers.		

8.6.4 Please identify standard communication services included in your proposal.

	Included in Fee	Response
Prepare and issue plan document as specified by OSC (Summary Plan Descriptions)		
Maintain member eligibility files		
Certify member claim eligibility		
Handle all claim investigations		
Direct claim handling/maintaining claim files		
Notification and administration of disputed and denied claims and claims appeals		
Provide claim forms to members		
Distribute general letters/correspondence to participants		
Provide claims accumulator data at contract termination		
Toll free access		
Internet member and OSC staff access		

8.6.5 Do you publish a member newsletter for MA members? If so, provide a copy of the most recent member newsletter.

1: Yes. Copy is attached,
2: Yes. Copy is not attached, explain:
3: No

8.7 PERFORMANCE GUARANTEES

OSC is interested in negotiating performance standards on financial performance results with the selected Bidder to encourage the Bidder to provide superior performance. Bidder's failure to meet the performance guarantee(s) would result in financial penalties. Please propose Performance Guarantees. OSC is looking for measurements to be specific to this contract and not the Bidder's book of business.

8.7.1 Confirm that your bid contains proposed service level targets and associated guarantees.

1: Confirmed,
2: Not confirmed, explain:

9 PRICE PROPOSAL

9.1 Format of Pricing

Bidders shall submit pricing in the format described below for the national MA-PD PPO proposed, based on the terms and conditions set forth in this RFP. Price Proposals are to be submitted to OSC as outlined in section 3 above. Bidder's price offer shall serve as the basis for compensation terms of the resulting contract. Failure to submit pricing as provided in this section may render Bidder's entire offer non-responsive and ineligible for award.

Pricing shall be submitted in the following format: Provide the fully-insured per member monthly premium rates for 2018 (first year of the contract: January 1, 2018 - December 31, 2018) based on the services required as specified in this RFP by completing the Price Proposal Worksheet – **Attachment D**. It is understood that if CMS requires a certain benefit level that is superior to what is listed in this RFP, then the CMS benefit should be applied and noted. The premium rate quoted is to cover all services Bidder must provide as described in this RFP.

Bidder is required to break out its price between the medical (MA) and prescription drug (PD) components of the plan. It must further break out the two components into the claims components and the non-claims components as described in the Price Proposal Worksheet instructions.

PROPOSER'S PRICING OFFER: Attach additional pages if necessary or if the format of pricing specified requires additional pages.

1. Bidder's price for calendar year 2018: Bidder is to complete Price Proposal Worksheet

2. OSC is seeking a partner to provide MA-PD services as a viable long-term solution for its Medicare population. This requires pricing throughout the contract term that recognizes the need for reasonable year over year increases in premiums. While we recognize certain provisions of the pricing are dependent on CMS

pricing terms released annually, we also believe organizations should be able to price for such fluctuations in a three year contract. Therefore, we are requesting bidders to provide annual total premium rate guarantees for each succeeding year under the contract.

Subsequent annual premium rates will be based on claims experience of those enrolled in each plan, verified demographics, other documented actuarial factors, and projected health care cost trends. Subsequent annual premium rates will be negotiated annually and reflected in a written amendment to the Contract executed by both parties.

Note: All alternative, supplemental benefit and/or enhance benefits costs (including Sliver Sneakers) must be estimated and documented and broken out as individual line items in the Price Proposal Worksheet – **Attachment D.**

The State of Connecticut Pharmacy Benefit Plan requires pharmacies to offer generic scripts in place of brand scripts where available and chemically equivalent, unless otherwise directed by the prescribing physician.

9.2.1 This RFP requires that pricing be based on OSC's actual Medicare allowed claims data (claims line detail) as well as OSC's plan design provided to Bidders in connection with this RFP. Proposals based upon manual rates will not be accepted. Confirm your agreement with this requirement.
1: Confirmed,
2: Not confirmed, explain:

9.2.2 Compare OSC's actual claims data against your organization's MA-PD book of business and outline the differences between the two sets of data.

9.2.3 Confirm the pricing is based on OSC's current medical and prescription drug plan design as well as its current formulary.

1: Confirmed,
2: Not confirmed, explain:

9.2.4 Confirm that pricing will not include any taxes unless accompanied by proof that OSC is subject to the tax. If necessary, Bidders may request OSC’s tax exemption number and federal tax exemption information.

1: Confirmed,
2: Not confirmed, explain:

10 BID EXCEPTIONS AND DEVIATIONS

10.1 If your bid does not fully comply with the specifications in this RFP, please upload and complete the Bid Exceptions and Deviations Document, Attachment H.

1: Bid does not fully comply - Document Attached,
2: Bid does fully comply - Document Not Attached

11 RESPONSE DOCUMENTS

11.1 Please complete the OSC Price Proposal Worksheet - **Attachment D** in its native format.

1: Attached,
2: Not provided

11.2 Please complete the Medical and Rx Providers Excel File - to be included in the Reference Documents in its native format

1: Attached,
2: Not provided

12 REFERENCE DOCUMENTS

12.1 Please note that Reference Documents (i.e., claims data, census, etc.) will only be provided to Bidders that have submitted a completed and signed Non-Disclosure Agreement (NDA). NDAs will be provided as part of the RFP. Completed and signed NDA's should be emailed to osc.rfp@ct.gov

- Current EGWP Formulary
- Census
- Pharmacy EGWP Risk Scores
- Medical Claims
- Pharmacy Claims
- Eligibility File

13 ADDITIONAL DOCUMENTS TO INCLUDE WITH YOUR RESPONSE

- Copy of most recently completed HIPAA Assessment
- Information Security Policy and Procedures
- Documentation to confirm financial viability
- Operational and System Redundancy and Disaster Recovery Procedures

ATTACHMENT A

RETIREES HEALTH CARE OPTIONS PLANNER

SUMMARY OF BENEFITS

STATE OF CONNECTICUT

2016 | 2017

Retirement Date October 1, 2011 or Earlier

RETIREES HEALTH CARE OPTIONS PLANNER

A MESSAGE FROM

Kevin LEMBO

STATE COMPTROLLER

Our daily choices affect our health and what we pay out of pocket for health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

Please take a few minutes to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health care.

Kevin Lembo
State Comptroller

A CAMPAIGN TO QUIT. KICK ASH

Find free resources to help you or your loved one to quit smoking for good.

- **The Quitline:** You can call the smoker's Quitline at 1-800-Quit-Now any time, day or night for support.
- **CVS Minute Clinics:** CVS's "Start to Stop" program offers counseling and support through their Minute Clinics. For a list of locations, visit: cvs.com/minuteclinic
- **SmokeFreeTxt:** Get encouragement, advice, and tips on how to quit smoking right to your cell phone. Sign up at: smokefree.gov/smokefreetxt
- **American Lung Association:** The American Lung Association's website offers resources and tips to help you, or someone you care about, quit smoking. Visit their website: lung.org

FOR MORE, VISIT
WWW.OSC.CT.GOV/KICKASH

TABLE OF CONTENTS

Retirement Date October 1, 2011 or Earlier

2016-2017 Premium Shares

2016-2017 medical premium shares are listed on pages 5, 9, and 13 (depending on your retirement date).

Dental premiums are listed on page 25.

For additional details, please go to the Comptroller's website at www.osc.ct.gov or check with the Retirement Health Insurance Unit at (860) 702-3533.

How to Use This Planner

This planner is for all State of Connecticut retirees who retired October 1, 2011 or earlier. However, there are some differences depending on your retirement date. The "Your Medical Plans at a Glance," "Your Prescription Drug Coverage at a Glance," and "Your 2016-2017 Medical Premium Share" pages are customized by group.

GROUP 1:
If your **retirement date is before July 1997,** see pages 5-7 for information that applies specifically to you.

GROUP 2:
If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program),** see pages 8-11 for information that applies specifically to you.

GROUP 3:
If your **retirement date is between June 1, 2009 and October 1, 2011,** see pages 12-15 for information that applies specifically to you.

What You Need to Do

Open Enrollment Through June 3, 2016

During open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you'd like to make a change for 2016-2017. The form must be postmarked by June 3, 2016. Any changes you make are effective July 1, 2016 through June 30, 2017 unless you have a qualifying status change. **If you don't want to make changes, you don't need to do a thing; your current coverage will continue automatically at the rates listed on page 5, 9 or 13 (as applicable).**

Return completed enrollment forms to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106

or

Fax: 860-702-3556

What to Do When You Become Eligible for Medicare

See Medicare and You on page 28 for important information about what to do when becoming eligible for Medicare.

Make Sure You Cover Only Eligible Dependents

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and State tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Children residing with you for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26 for medical or age 19 for dental. For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Once a judgment of divorce or legal separation is entered, your former spouse must be removed from the plan.

It is your responsibility to notify the Retirement Health Insurance Unit within 31 days when any dependent is no longer eligible for coverage.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.

This planner provides a brief summary of covered services. See Your Benefit Resources on page 31 to receive more detailed information.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit **within 31 days of the event.** The change you make must be consistent with your change in status.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – which include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.
- **Employment status** – Any event that changes your or your dependent's employment status, resulting in gaining or losing eligibility for coverage such as:
  - Beginning or ending employment
  - Starting or returning from an unpaid leave of absence
  - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage.
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit at (860) 702-3533. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$5 co-pay	80% [1]
Preventive Care	No copayment for preventive care visits and immunizations	80% [1]
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
Pre-Admission Testing	100%	80% [1]
Inpatient Physician	100% (prior authorization required)	80% [1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% [1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% [1] (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year	80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% [1]
Outpatient [2]	$5 co-pay	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids*	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%, [1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to $500 for no authorization

[1] You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

[2] Prior authorization may be required.

* Effective 7/1/2016.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2016-2017 Medical Premium Share

There are no monthly medical premium retiree shares for your medical and prescription benefits. See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose. The amount you pay depends on whether your prescription is for a generic drug or a brand-name drug and where you purchase your prescriptions:

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	$3	$0	20% of prescription cost
Preferred Brand	$6	$0	20% of prescription cost
Non-Preferred Brand	$6	$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a $0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order/ Maintenance Drug Network	
Generic	$3	$0	20% of prescription cost
Preferred Brand	$6	$0	20% of prescription cost
Non-Preferred Brand	$6	$0	20% of prescription cost

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!**

In order to receive the $0 copay, your maintenance prescriptions must be filled in one of two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug. The Coverage Exception Request form is available at www.osc.ct.gov.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Your Prescription Drug Coverage at a Glance (continued)

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay ($5 if retired before July 1, 1999)	80% [1]
Preventive Care	No copayment for preventive care visits and immunizations	80% [1]
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
Pre-Admission Testing	100%	80% [1]
Inpatient Physician	100% (prior authorization required)	80% [1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% [1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% [1] (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year	80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% [1]
Outpatient [2]	$15 co-pay ($5 if retired before July 1, 1999)	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids*	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%,[1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to $500 for no authorization

[1] You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

[2] Prior authorization may be required.

* Effective 7/1/2016.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2016-2017 Medical Premium Share

Monthly Medical Premiums July 1, 2016 through June 30, 2017

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford USA Out of Area plan
Anthem Out-of-Area plan

Point of Service (POS) Plans for 7/1/97 – 6/1/99 Retirees

Anthem State BlueCare POS
Anthem State Preferred POS
UnitedHealthcare Oxford Freedom Select POS

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS Retirement Date 7/1/99 - 5/1/09	ANTHEM STATE PREFERRED POS Closed to New Enrollment Non-ERIP Retirement Date 7/97 - 6/99	ANTHEM STATE PREFERRED POS Closed to New Enrollment Retirement Date 7/1/99 - 5/1/09	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS Retirement Date 7/1/99 - 5/1/09
1 Person on Medicare	$0.00	$0.00	$0.00	$0.00
1 Person not on Medicare	$14.61	$0.00	$14.79	$15.09
1 Person not on Medicare and 1 on Medicare	$14.61	$0.00	$14.79	$15.09
1 not on Medicare and 2 on Medicare	$14.61	$0.00	$14.79	$15.09
2 on Medicare	$0.00	$0.00	$0.00	$0.00
2 not on Medicare	$32.15	$0.00	$32.53	$33.19
2 not on Medicare and 1 on Medicare	$32.15	$0.00	$32.53	$33.19
3 or more on Medicare	$0.00	$0.00	$0.00	$0.00
3 or more not on Medicare	$39.45	$0.00	$39.93	$40.73
3 or more not on Medicare and 1 on Medicare	$39.45	$0.00	$39.93	$40.73

See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose. The amount you pay depends on whether your prescription is for a generic drug or a brand-name drug and where you purchase your prescriptions:

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	$3	$0	20% of prescription cost
Preferred Brand	$6	$0	20% of prescription cost
Non-Preferred Brand	$6	$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a $0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order/ Maintenance Drug Network	
Generic	$3	$0	20% of prescription cost
Preferred Brand	$6	$0	20% of prescription cost
Non-Preferred Brand	$6	$0	20% of prescription cost

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** Maintenance prescriptions can be filled in two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

Your Prescription Drug Coverage at a Glance (continued)

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug. The Coverage Exception Request form is available at www.osc.ct.gov.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	BOTH CARRIERS POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay	80% [1]
Preventive Care	No copayment for preventive care visits and immunizations	80% [1]
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% [1]
Pre-Admission Testing	100%	80% [1]
Inpatient Physician	100% (prior authorization required)	80% [1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% [1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% [1] (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year	80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% [1]
Outpatient [2]	$15 co-pay	80% [1]
Durable Medical Equipment [2]	100%	80% [1]
Hearing Aids*	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period	80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics [2]	100%	80% [1]
Skilled Nursing Facility	100% (prior authorization required)	80%,[1] up to 60 days/year (prior authorization required)
Home Health Care [2]	100%	80%,[1] up to 200 visits/year
Hospice	100% (prior authorization required)	80%,[1] up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	$300
Family (3 or more)	None	$900
Annual Out-of-Pocket Maximums		
Each Individual	$2,000	$2,000 (plus deductible)
Family	$4,000	$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to $500 for no authorization

[1] You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

[2] Prior authorization may be required.

* Effective 7/1/2016.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2016-2017 Medical Premium Share

Monthly Medical Premiums July 1, 2016 through June 30, 2017

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford Out of Area plan
Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	$0.00	$0.00	$0.00
1 Person not on Medicare	$14.61	$14.79	$15.09
1 Person not on Medicare and 1 on Medicare	$14.61	$14.79	$15.09
1 not on Medicare and 2 on Medicare	$14.61	$14.79	$15.09
2 on Medicare	$0.00	$0.00	$0.00
2 not on Medicare	$32.15	$32.53	$33.19
2 not on Medicare and 1 on Medicare	$32.15	$32.53	$33.19
3 or more on Medicare	$0.00	$0.00	$0.00
3 or more not on Medicare	$39.45	$39.93	$40.73
3 or more not on Medicare and 1 on Medicare	$39.45	$39.93	$40.73

See page 25 for dental premiums.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. See page 28 for information.

Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug.

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	$5	$0	20% of prescription cost
Preferred Brand	$10	$0	20% of prescription cost
Non-Preferred Brand	$25	$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a $0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order/ Maintenance Drug Network	
Generic	$5	$0	20% of prescription cost
Preferred Brand	$10	$0	20% of prescription cost
Non-Preferred Brand	$25	$0	20% of prescription cost

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

For information about SilverScript visit http://stateofconnecticut.silverscript.com or call 1-866-693-4624.

When You Become Eligible for Medicare

See Medicare and You on page 28 for more details.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark's Pharmacy and Therapeutics Committee on a quartly basis. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

Your Prescription Drug Coverage at a Glance (continued)

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** Maintenance prescriptions can be filled in two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on previous page, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Frequently Asked Questions

1. *Where can I get more details about what the State health insurance plan covers?*

All medical plans offered by the State of Connecticut cover the same services and supplies with the same co-pays. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 31.

2. *If I live outside Connecticut, do I need to choose an Out-of-Area Plan?*

If you live permanently outside of Connecticut, we will automatically place you in an Out of Area plan, giving you access to a national network of providers whether you are enrolled with Anthem or UnitedHealthcare Oxford. There are no retiree premium shares for enrollment in an Out-of-Area plan.

3. *What's the difference between a service area and a provider network?*

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

4. *What are my options if I want access to doctors across the U.S.?*

Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans – both have national networks.

5. How do I find out which networks my doctor is in?

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 31. It's likely your doctor is covered by more than one network.

6. Can I enroll myself in one option and my family member in another?

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well. It is also important to note that you may not double cover yourself under another State of Connecticut retiree's health benefits.

7. Can I enroll later or switch plans mid-year?

Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 4). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

8. If I'm eligible, should I sign up for Medicare?

Yes. Please be sure to enroll in Medicare Part A and B as soon as you're eligible. Your standard premium for Medicare Part B will be reimbursed by the State beginning when the Retirement Health Insurance Unit receives your Medicare card. See page 28 for more information.

Making Your Decision – Medical

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your premium share varies quite a bit from plan to plan. How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See sidebar at left for pages specific to your retirement date.)
2. **Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans.

   However, your premium share varies quite a bit depending on the carrier and plan selected. (see sidebar at left for pages specific to your retirement date).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 19-20.)
4. **Plan features** – how you access care and what kinds of "extras" the insurance carrier offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 19-23).

The following pages are designed to help you compare your options.

GROUP 1:
If your **retirement date is before July 1997,** see pages 5-7 for information that applies specifically to you.

GROUP 2:
If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program),** see pages 8-11 for information that applies specifically to you.

GROUP 3:
If your **retirement date is between June 1, 2009 and October 1, 2011,** see pages 12-15 for information that applies specifically to you.

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs.

Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each insurance carrier contracts with a group of doctors and hospitals for discounted rates on health care services. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. Take a look at your options before you decide.

How the Plans Work

Point of Service (POS) Plans – These plans offer health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a Primary Care Physician (PCP) to coordinate all care and referrals are required for all specialist services.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 31).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 31).

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more – for most services. In most cases, the plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see pages 5, 8 and 12 as applicable), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network.

For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the geographic area covered by Oxford's regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.

Comparing Plan Features

All State of Connecticut plans cover the same health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 31 for phone numbers and websites.)

About Value-Added Programs

Another area where the insurance carriers may differ is the value-added programs they offer.

These programs are outside the contracted plan benefits – they're "extras" that each company offers in hopes of making their plan stand out, such as:

- Wellness programs
- Member discounts (for example, on weight-loss programs or health clubs)
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the insurance carrier. However, you may want to see what each company offers before you decide.

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford Out of Area
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* Closed to new enrollment.

Good health starts with a plan

Check out our programs and services to help improve your health

Anthem BlueCross BlueShield

Customer service: get answers and much more

The State of Connecticut Enhanced Member Service Unit can answer your questions and give you information on your benefits and our wellness programs and services.

- Call them at 1-800-922-2232.
- Visit anthem.com/statect to find information just for you.

Health and wellness programs to help you take healthy steps

Lose weight, quit smoking. Control diabetes. Get help for autism and eating disorders. We have a full range of wellness programs, online tools and resources designed to meet your needs.

24/7 NurseLine is here for you

Health problems often happen when you least expect them. Call the 24/7 NurseLine at **1-800-711-5947** to talk with a registered nurse, who can answer questions about getting care. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments.

When you need care right away

The emergency room (ER) shouldn't be your first stop — unless it's a true emergency. Depending on the situation, there are different types of providers you can see if your doctor isn't available. This includes a walk-in doctor's office, retail health clinic and urgent care center. Call the Enhanced Member Service Unit or go to anthem.com/statect to find care near you. **Note:** Call 911 or go to the ER if you think you could put your health at serious risk by delaying care.

When you need a helping hand

We offer programs if you or a family member needs behavioral health care or substance use disorder treatment. You can reach an Anthem Behavioral Health Care Manager by calling **1-888-605-0580**. To see how to access care, visit anthem.com/statect.

Access to care — wherever you go, we've got you covered

If you travel out of Connecticut, you have access to doctors and hospitals across the country with the BlueCard® program. Call **1-800-810-BLUE (2583)** to learn more. And, with the BlueCard® Worldwide program, you have access to providers in nearly 200 countries around the world.*

Manage your benefits online — and on the go

Log on at anthem.com/statect to find a doctor, check your claims and compare costs for care near you. If you haven't registered to use the website, choose **Register Now** and follow the steps. You can also download our free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store® or Google PlayTM. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and much more!

SpecialOffers@Anthem

Go to anthem.com/statect to find special discounts on things that encourage healthy habits. This includes weight-loss programs, gym memberships, vitamins, glasses, contact lenses and much more.

[1]Blue Cross Blue Shield Association website, Coverage Home and Away (accessed March 2016): bcbs.com/already-a-member/coverage-home-and-away.html.

Step up to better health

Comparing Plans: A Message From UnitedHealthcare

We are dedicated to helping people live healthier lives.

This is our mission and we take it seriously. By making healthier decisions, you can live a healthier life. It's that simple. Our programs and network can help you do just that.

Our Network

We have a robust local and national network. Nationally and in the tri-state area, we have a large number of doctors, health care professionals and hospitals. For years, our members have accessed our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll have seamless access to our UnitedHealthcare Choice Plus Network of physicians and health care professionals outside of the tri-state area. This gives State of Connecticut employees, retirees and their families better access to care whether you are in Connecticut, traveling outside the tri-state area, or living somewhere else in the country.

Just giving you a list of doctors is not very helpful. The UnitedHealth Premium® designation program recognizes doctors who meet standards for quality and cost-efficiency. We use evidence-based medicine and national industry guidelines to evaluate quality and the cost-efficiency standards are based on local market benchmarks for the efficient use of resources in providing care. The 2016 UnitedHealth Premium program covers 27 specialty areas of medicine, including two new specialties (Ear, Nose and Throat, and Gastroenterology).

For more information about our network and the Premium designation program or to search for physicians participating in our local network and the national UnitedHealthcare Choice Plus Network, please visit welcometouhc.com/stateofct.

Administrative services provided by Oxford Health Plans. LLC. CT-15-206

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call* program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call*.

If you are a member and you need to reach *Oxford-On-Call*, please call 800-201-4911. Press option 4. *Oxford On-Call* can give you helpful information on general health information, deciding where to go for care, choosing self-care measures or guidance for difficult decisions.

Custom Website

We created this website for State of Connecticut employees and retirees to provide the tools and information to help you make informed health care decisions. Visit welcometouhc.com/stateofct to search for a doctor or hospital, or learn about the health plans we offer. You also can get Health Enhancement Program information at cthep.com, or by phone at 877-687-1448.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

For information on discounts and special offers, please visit welcometouhc.com/stateofct.

Your Dental Plan Choices at a Glance

Cigna is the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO).

New for 2016! Implants are now covered under the DHMO.

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	DHMO® PLAN (network only)
Annual Deductible	None	$25 individual, $75/family	None
Annual Maximum	None ($500 per person for periodontics)	$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 100%	Covered at 100% (network only)	Covered at 100%
Simple Restoration Fillings	Covered at 80%	Covered at 80%	Covered*
Oral Surgery	Covered at 67%	Covered at 80%	Covered*
Periodontal Maintenance	Covered at 80%	Covered at 100%[1]	Covered*
Other Periodontal Services	Covered at 50%	Covered at 80%	Covered*
Major Restoration Crowns	Covered at 67%	Covered at 67%	Covered*
Dentures, Fixed Bridges	Not covered**	Covered at 50%	Covered*
Implants	Not covered**	Covered at 50% (up to $500)	***New*** Covered*
Orthodontia	Not covered	Plan pays $1,500 per person per lifetime	Covered*

1 **In the Enhanced plan, be sure to use an in-network dentist to ensure receiving 100% coverage; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.**

* **Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.**

** **While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 25 for details).**

Terms to Know

Basic Plan – This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan – This plan offers dental services both within and outside a network of dentists and dental specialists without a referral. **However, your out-of-pocket expenses may be higher if you see an out-of-network provider.**

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of-network. The Enhanced Plan pays for covered dental services based on "MAC" or "Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

DHMO Plan – This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

More details about covered expenses are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

Dental coverage ends for dependent children at age 19 (unless disabled*).

* *For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

Enhanced Plan Money-Saving Tip — Avoid Balance Billing

It pays to use network dentists if you are enrolled in the Enhanced Plan. Network dentists have agreed to discounted fees. Visit www.cigna.com/stateofct to find a network dentist.

If you use an out-of-network dentist, you will be subject to balance billing if your dentist charges more than the maximum allowable charge. For example, exams are covered at 100%; if you see a network dentist your exam is covered in full but if you see an out-of-network dentist you could still receive a bill.

Your 2016-2017 Dental Premium Share

Monthly Dental Premiums July 1, 2016 through June 30, 2017

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	$31.86	$25.94	$30.18
2 Persons	$63.73	$51.87	$66.40
3 or More Persons	$63.73	$51.87	$81.50

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age, or missing tooth limitations.

- You can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

* *Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional or contact Cigna customer service before receiving care to determine if these discounts will apply to you.*

Frequently Asked Questions

1. How do I know which dental plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on page 26 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

The Affordable Care Act extended benefits for children until age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19 (unless they are disabled*).

* *For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays $1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

A Message From Cigna

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

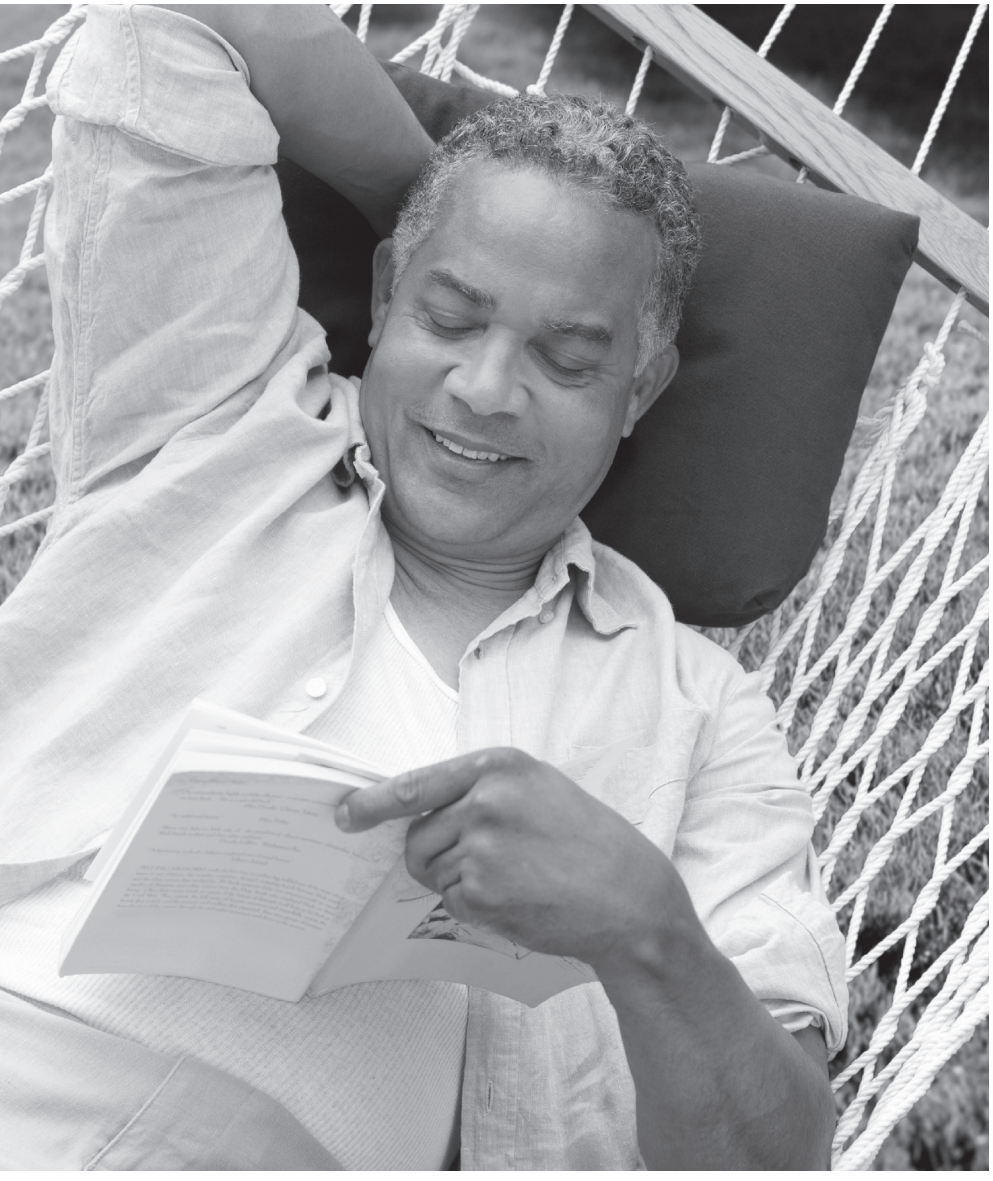
As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **Cigna DHMO**

Learn Before You Enroll

Employee and Retiree Website

Access your dental benefit information at: **www.cigna.com/stateofct** – the website developed by Cigna just for State of CT employees.



Cigna's Information Line

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.Cigna24**. Call today to learn the following about your Cigna Dental coverage:

- Information on plan specifics
- Help finding participating dentists and specialists
- Programs and plan features available to you

Finding a Network Dentist is Easy

For the most current information on network dental offices in your area, search our online directory at www.cigna.com/stateofct or call the Dental Office Locator at **1.800.Cigna24**.

Once You're Enrolled:

Personalized benefit information available around the clock

Online:

Visit **www.myCigna.com**. Once registered, you can:

- Access dental plan information
- Plan your dental care with the Treatment Cost Estimator
- Check claim status and review year-to-date maximum & deductible amounts
- Verify eligibility for you and your dependents

By Phone:

Call **1.800.Cigna24**; customer service representatives are available 24/7 to answer your questions.

Coverage for Fillings under the Basic and Enhanced Plan

There's not always one simple answer for treating a dental condition. You and your dentist should discuss the various options, and then you can decide on the best approach. Your costs may vary based on the treatment plan you choose.

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive restoration. Both of these methods are recognized by the dental profession as acceptable treatment plans; however, the silver filling is the least costly alternative for treatment.

Programs to Support Your Overall Health

Your health. Our focus.

In the real world, you have to balance your time, commitments and priorities. At Cigna, we keep our focus on helping you live healthier. Value-added programs such as wellness programs and discount savings are included with your Cigna dental plan.

Oral Health Integration Program®

Research shows an association between oral health and overall health.[1] By getting the right oral health care, along with regular medical treatments, high-risk individuals may be able to improve their overall health. Eligible State of Connecticut employees and retirees who enroll will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP).

With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. The qualifying medical conditions for OHIP: heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head & neck cancer radiation.

For additional information regarding OHIP, please visit www.cigna.com/stateofct.

[1] Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Presented at the International Association for Dental Research Meeting March 2013, Seattle

Healthy Rewards®

Cigna's Healthy Rewards Program provides discounts of up to 60% on healthy programs and services as part of Cigna's ongoing effort to promote wellness. There's no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins.

After you enroll in the insurance plan, you can learn more about Healthy Rewards by visiting Cigna.com/rewards (password savings) or calling 1.800.258.3312.

Access your dental benefit information by going to www.cigna.com/stateofct.

Medicare and You

Medicare is a federal healthcare insurance program for people age 65 and older. While the Social Security retirement age is creeping up, the eligibility age to start Medicare is age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions (such as permanent kidney failure or Lou Gehrig's disease). If you or a dependent becomes eligible for Medicare due to disability no matter what age, be sure to contact the Retirement Health Insurance Unit at 860-702-3533. This section covers Medicare for retirees only.

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are automatically covered by Medicare Part A (hospital care) and must enroll yourself in Medicare Part B (physician services).

What to Do When You Become Eligible for Medicare

When you reach age 65, your State of Connecticut medical and prescription drug benefits will "wrap around" your Medicare benefits. Medicare will be your primary coverage and your State of Connecticut sponsored plan will pay after Medicare. This means you continue the same level of benefits that you are used to.

Do Enroll in Medicare Part A and B

Medicare Part A is free and enrollment automatic if you are at least age 65. You must enroll in Medicare Part B and pay a premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically this is the first of the month in which you turn 65. **We recommend that you contact Medicare to begin the enrollment process no later than 3 months prior to your 65th birthday.** Failing to do so will result in a "hole" in your coverage. Your State sponsored medical and prescription coverage will automatically be noted as secondary upon your 65th birthday.

Your standard premium for Medicare Part B will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.) The 2015 standard Medicare Part B/Part D premium reimbursement is $104.90, as long as you are not receiving reimbursement from any other source.

Be sure to send us a copy of your red, white and blue Medicare card as soon as you receive it. You will receive a letter from the Retirement Health Insurance Unit with more information just prior to your reaching age 65.

Additionally, you may be required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard rate. Social Security will advise you by letter annually if you are required to pay a higher rate. Send a copy of this letter along with your red, white, and blue Medicare card in order to receive full reimbursement.

Do Not Enroll in Medicare Part C or Part D

The State of Connecticut prescription coverage with SilverScript (a subsidiary of Caremark) is a Medicare Part D plan. When you or your covered dependents become eligible for Medicare, you will automatically be enrolled in the Part D prescription drug plan administered by SilverScript. You do not need to do anything except start using your SilverScript card once received.

Once enrolled, you will receive more information. However, there are four key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- **Do not opt out of the SilverScript prescription drug program.** SilverScript is required by Medicare to send you a letter giving you a chance to opt out or cancel your prescription drug enrollment, **but don't do it.** If you opt out, medical and prescription drug coverage for you and your dependents will terminate. **Please ignore the opt out letter.**
- **Do not enroll in an individual Medicare prescription drug plan (through Medicare Part C or Part D).** You are only able to enroll in one Medicare Part D plan. Your State sponsored coverage with SilverScript is a Medicare Part D plan enrollment. Enrolling in any other Medicare Part D plan will cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.
- **Do make sure we have your street address.** If you receive your mail at a post office box, you must provide a residential street address to the Retirement Health Insurance Unit (per Center for Medicare and Medicaid Services regulations). All communication will still go to your noted mailing address.
- **Do promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your 2016/2017 IRMAA notice to the Retirement Health Insurance Unit to ensure proper reimbursement.

If Family Members Are Not Yet Eligible for Medicare

If you have covered dependents who are not yet eligible for Medicare (typically those under age 65), their current coverage through CVS Caremark will stay the same. There will be no change to their co-pay structure, and they will continue to participate in the mandatory maintenance drug network program. This means that after their first fill of a maintenance medication, refills must be filled through a pharmacy participating in the State's Maintenance Drug Network or through the CVS Caremark mail-order pharmacy. A full list of all participating pharmacies is available on the Comptroller's website at **www.osc.ct.gov.**

For More Information

Contact SilverScript with questions about your prescription coverage, ID cards, and participating pharmacies or the Retirement Health Insurance Unit with questions about eligibility or premiums. Contact information is at the back of the booklet.

Have Questions for SilverScript?

Call 866-693-4624

Retirement Health Insurance
Open Enrollment Application

CO-744-OE REV. 7/2015

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

TYPE OR PRINT AND FORWARD TO THE RETIREMENT HEALTH INSURANCE UNIT

RETIREE LAST NAME (Person Receiving Benefit)	RETIREE FIRST NAME, MI	RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)

MAILING ADDRESS	TELEPHONE NUMBER

YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan.

Check the box to the left of the plan you wish to select.

MEDICAL

ANTHEM

- ☐ State BlueCare POS
- ☐ State BlueCare POE
- ☐ State BlueCare POE Plus POE-G
- ☐ State Preferred POS – **Currently Enrolled Only**
- ☐ Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

OXFORD

- ☐ Oxford Freedom Select POS
- ☐ Oxford HMO Select POE
- ☐ Oxford HMO POE-G
- ☐ Oxford USA - Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

- ☐ Waive/Cancel Medical and Prescription Coverage

DENTAL

☐ Basic Dental Plan ☐ Enhanced PPO Dental Plan ☐ Dental HMO Plan ☐ Waive/Cancel Dental Coverage

RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER F	GENDER M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	☐	☐			☐	☐
	Dependent 1:	☐	☐			☐	☐
	Dependent 2:	☐	☐			☐	☐
	Dependent 3:	☐	☐			☐	☐

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

Is any member listed above eligible for Medicare? ☐ Yes ☐ No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

ARE YOU PRESENTLY RECEIVING WORKERS' COMPENSATION? ☐ YES ☐ NO

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check and/or bill me as necessary for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE

CO-744-OE HEALTH BENEFITS OPEN ENROLLMENT

Forms must be postmarked by June 3, 2016.

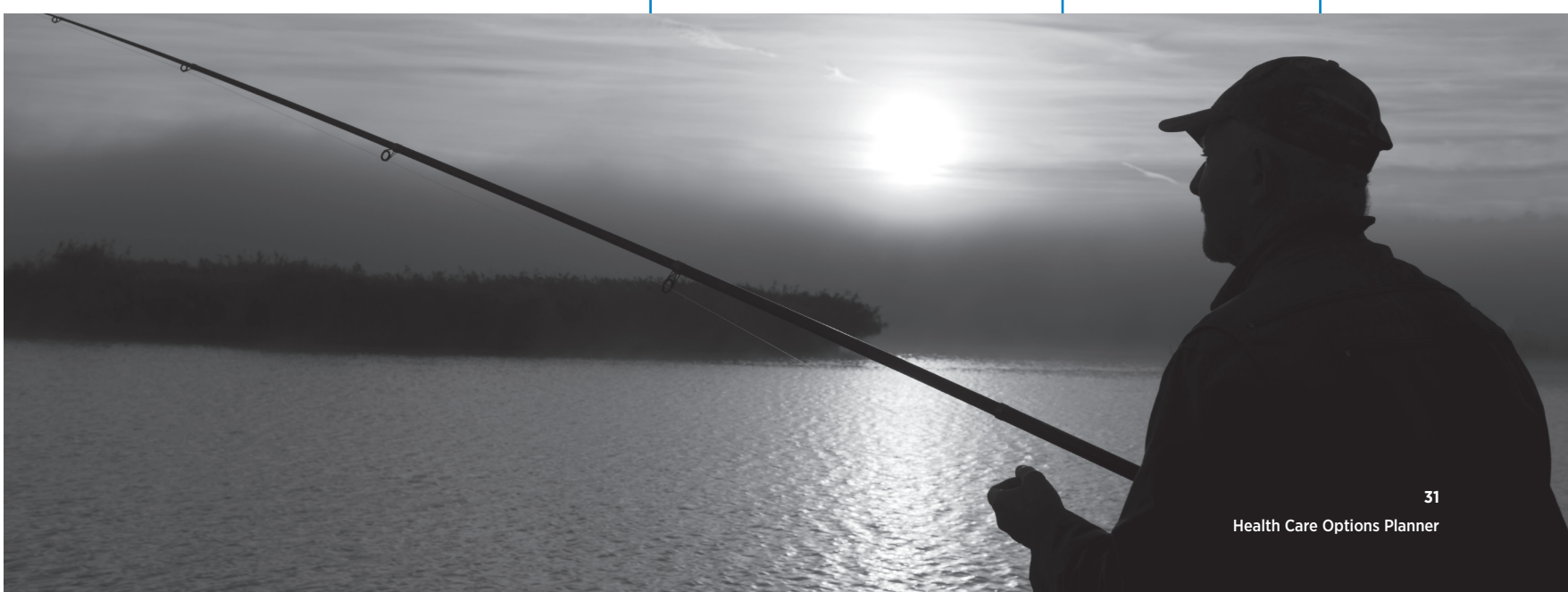
To enroll or make changes, clip out this form,
complete it and return it to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775

or
Fax: 860-702-3556

Your Benefit Resources

For details about specific plan benefits and network providers, contact:			
Anthem Blue Cross and Blue Shield • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State Preferred POS (POS)	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford Out-of-Area	**www.welcometouhc.com/stateofct**	**1-800-385-9055** Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	**www.Caremark.com**	**1-800-318-2572**	
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	**http://stateofconnecticut.silverscript.com**	**1-866-693-4624**	
CIGNA • Basic Plan • Enhanced Plan • DHMO Plan	**www.Cigna.com/stateofct**	**1-800-244-6224**	
For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:			
Office of the State Comptroller Retirement Health Insurance Unit 55 Elm Street Hartford, CT 06106-1775	**www.osc.ct.gov**	**(860) 702-3533**	



Healthcare Policy & Benefit Services Division
Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775

New 2016-2017 premium shares.

See pages 5, 9 and 13 (depending on your retirement date).

RETIREES HEALTH CARE OPTIONS PLANNER

STATE OF CONNECTICUT

2016 | 2017

STATE OF CONNECTICUT

2016 | 2017

Retirement Date October 2, 2011 or Later

RETIREES HEALTH CARE OPTIONS PLANNER

A MESSAGE FROM

Kevin LEMBO

STATE COMPTROLLER

Our daily choices affect our health and what we pay out of pocket for health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

Please take a few minutes to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health care.

Kevin Lembo
State Comptroller

TABLE OF CONTENTS

Check Your HEP Status

The Health Enhancement Program features an easy-to-use website to keep you up to date on your requirements.

On the HEP website, you can check which HEP requirements you still have to complete, including for spouses and dependents.

What You Need to Do

Current Retirees

Open Enrollment Through June 3, 2016

During open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you'd like to make a change for 2016-2017. The form must be postmarked by June 3, 2016. Any changes you make are effective July 1, 2016 through June 30, 2017 unless you have a qualifying status change. **If you don't want to make changes, you don't need to do a thing; your current coverage will continue automatically at the rates listed on page 5 for medical and page 18 for dental.**

Return completed enrollment forms to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106
or
Fax: 860-702-3556

What to Do When You Become Eligible for Medicare

See Medicare and You on page 23 for important information about what to do when becoming eligible for Medicare.

New Retirees

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (Form CO-744 – Choice of Health Insurance After Retirement) included in your retirement packet; this form is different from the one included in this booklet for open enrollment.
3. Return the form with your retirement packet.

If you enroll as a new retiree, your coverage begins the first day of the second month of your retirement. For example, if your retirement date is October 1, your coverage begins November 1. If you waive coverage when you're initially eligible, you may enroll within 31 days of losing other coverage, or during any open enrollment period.

This planner provides a brief summary of covered services. See Your Benefit Resources on page 25 to receive more detailed information.

Make Sure You Cover Only Eligible Dependents

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and State tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Your "children" include your biological children, stepchildren, and adopted children. Children residing with you for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26 for medical or age 19 for dental. For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Once a judgment of divorce or legal separation is entered, your former spouse must be removed from the plan.

It is your responsibility to notify the Retirement Health Insurance Unit within 31 days when any dependent is no longer eligible for coverage.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit **within 31 days of the event.** The change you make must be consistent with your change in status.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – which include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.
- **Employment status** – Any event that changes your or your dependent's employment status, resulting in gaining or losing eligibility for coverage such as:
  - Beginning or ending employment
  - Starting or returning from an unpaid leave of absence
  - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage.
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit at (860) 702-3533. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	$15 co-pay		80%[1]
Preventive Care	No co-payment for preventive care visits and immunizations		80%[1]
Emergency Care	$35 co-pay[2]		$35 co-pay[2]
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80%[1] (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80%[1]
Inpatient Physician	100% (prior authorization required)		80%[1] (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80%[1] (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80%[1] (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%		80%,[1] up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	$15 co-pay, 1 exam per year[3]		50%, 1 exam per year
Audiological Screening	$15 co-pay, 1 exam per year		80%,[1] 1 exam per year
Mental Health/Substance Abuse	Prior authorization required		Prior authorization required
Inpatient	100%		80%[1]
Outpatient	$15 co-pay (prior authorization may be required)		80%[1] (prior authorization may be required)
Durable Medical Equipment	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Hearing Aids*	100% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period		80% (prior authorization may be required.) Limited to one set of hearing aids within a 24 month period
Prosthetics	100% (prior authorization may be required)		80%[1] (prior authorization may be required)
Skilled Nursing Facility	100% (prior authorization required)		80%,[1] up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80%,[1] up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80%,[1] up to 60 days (prior authorization required)
Annual Deductible	Individual: $350[4] Family: $350 each member[4] ($1,400 maximum)		Individual: $300 Family: $900
Annual Out-of-Pocket Maximums	Individual: $2,000 Family: $4,000		Individual: $2,000 (plus deductible) Family: $4,000 (plus deductible)
Lifetime Maximum	None		None
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to $500 for no authorization

[1] You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

[2] Waived if admitted.

[3] HEP participants have $15 co-pay waived once every two years.

[4] Waived for HEP-compliant members.

* Effective 7/1/2016.

Visit www.osc.ct.gov for the Summary of Benefits and Coverage (SBC) for medical and pharmacy.

Your 2016-2017 Medical Premium Share

Monthly Medical Premiums July 1, 2016 through June 30, 2017

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans
Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans
Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans
UnitedHealthcare Oxford Out of Area plan
Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	$0.00	$0.00	$0.00
1 Person not on Medicare	$14.61	$14.79	$15.09
1 Person not on Medicare and 1 on Medicare	$14.61	$14.79	$15.09
1 not on Medicare and 2 on Medicare	$14.61	$14.79	$15.09
2 on Medicare	$0.00	$0.00	$0.00
2 not on Medicare	$32.15	$32.53	$33.19
2 not on Medicare and 1 on Medicare	$32.15	$32.53	$33.19
3 or more on Medicare	$0.00	$0.00	$0.00
3 or more not on Medicare	$39.45	$39.93	$40.73
3 or more not on Medicare and 1 on Medicare	$39.45	$39.93	$40.73

Important Note: Higher Premiums Without HEP

If your retirement date is October 2, 2011 or later you are eligible for the Health Enhancement Program (HEP). If you choose not to enroll, or enroll but do not meet the HEP requirements, your monthly premium share will be $100 higher than shown above.

If you would like to change your HEP enrollment status, you may complete a form. Forms are available at www.osc.ct.gov or from the Retirement Health Insurance Unit at (860) 702-3533.

If You Retired Early

If you retired early, you may pay additional retiree premium share costs per the 2011 SEBAC agreement. For additional information, please contact the Retirement Health Insurance Unit at (860) 702-3533.

The State reimburses your Medicare Part B premiums beginning when the Retirement Health Insurance Unit receives your Medicare card. If you aren't receiving this benefit, contact us. **See page 25.**

Making Your Decision – Medical

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your premium share varies quite a bit from plan to plan. How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 4).
2. **Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans (see page 4). However, your premium share varies quite a bit depending on the carrier and plan selected (see page 5).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 7 and 8).
4. **Plan features** – how you access care and what kinds of "extras" the insurance carrier offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 7-9).

The following pages are designed to help you compare your options.

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs.
Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each insurance carrier contracts with a group of doctors and hospitals for discounted rates on health care services. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. Take a look at your options before you decide.

How the Plans Work

Point of Service (POS) Plans – These plans offer health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a Primary Care Physician (PCP) to coordinate all care and referrals are required for all specialist services.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 25).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 25).

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more – for most services. In most cases, the plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see page 4), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the geographic area covered by Oxford's regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.

Comparing Plan Features

All State of Connecticut plans cover the same health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 25 for phone numbers and websites.)

About Value-Added Programs

Another area where the insurance carriers may differ is the value-added programs they offer. These programs are outside the contracted plan benefits – they're "extras" that each company offers in hopes of making their plan stand out, such as:

- Wellness programs
- Member discounts (for example, on weight-loss programs or health clubs)
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the insurance carrier. However, you may want to see what each company offers before you decide.

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford Out of Area
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* **Closed to new enrollment.**

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to. See page 23 for more details.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug.

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network			Out-of-Network
	Acute Drugs	**Maintenance Drugs***	**HEP Enrolled** (Maintenance Drugs to treat chronic condition)*	
Generic	$5	$5	$0	20% of prescription cost
Preferred Brand	$20	$10	$5	20% of prescription cost
Non-Preferred Brand	$35	$25	$12.50	20% of prescription cost

* **You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance drugs.**

MEDICARE-ELIGIBLE

Silverscript	In-Network			Out-of-Network
	Acute Drugs	**Maintenance Drugs**	**HEP Enrolled** (Maintenance Drugs to treat chronic condition)	
Generic	$5	$5	$0	20% of prescription cost
Preferred Brand	$20	$10	$5	20% of prescription cost
Non-Preferred Brand	$35	$25	$12.50	20% of prescription cost

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

For Information About SilverScript

http://stateofconnecticut.silverscript.com

1-866-693-4624

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark is reviewed quarterly. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

When You Become Eligible for Medicare

If you are eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits are the same but you use your SilverScript ID card for prescriptions instead.

Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

See Medicare and You on page 23 for more details.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on previous page, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Non-Medicare Retirees Mandatory 90-Day Refills

If you are not enrolled in Medicare, 90-day refills are mandatory for maintenance medications. The initial 30-day supply can be filled at any participating pharmacy. After that, you can fill your medication at a pharmacy that participates in the State's Maintenance Drug Network, or use Caremark's mail order service. A link to the complete list of pharmacies in the Network can be found on the Office of the State Comptroller's website at www.osc.ct.gov.

Health Enhancement Program

The Health Enhancement Program (HEP) has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your health care. Third, it will save money for the State long term by focusing our health care dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

You Save Money by Participating!

When you and all of your enrolled family members participate in HEP, you will pay lower monthly premiums and have no deductible for in-network care for the plan year. If one of you has one of the five chronic conditions identified below, you may also receive a $100 payment, provided you and all enrolled family members comply with HEP requirements. You also save money on prescription drugs to treat that condition (see page 10).

How to Enroll in HEP

Current Retirees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533.

Those who participated in HEP during 2015-2016 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2016-2017 and will continue to pay lower premiums for their health care coverage.

New Retirees:

If you are a new retiree, you do not have to make a new HEP election – your HEP enrollment status will follow you into retirement. If you're not currently enrolled in HEP, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

2016 Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

Additional Requirements for Those With Certain Conditions

If you or any of your enrolled family members have **1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure),** you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy co-pays for treatments related to your condition (see Your Prescription Drug Coverage at a Glance on page 10 for cost details).

Visit the HEP online portal at www.cthep.com to find out whether you have outstanding dental, medical or other requirements to complete by December 31, 2016. Those with chronic conditions can also complete requirements online. Care Management Solutions may also be reached by phone at (877) 687-1448.

2016 HEP Preventive Care Requirements

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

*Dental cleanings are required for family members who are participating in one of the state dental plans
**Or as recommended by your physician

For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant.
As is currently the case under your state health plan, any medical decisions will continue to be made by you and your physician.

For More HEP Information, Visit www.cthep.com

Care Management Solutions, an affiliate of ConnectiCare, is the administrator for the Health Enhancement Program (HEP). The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

You can also call Care Management Solutions to speak with a representative.

care management solutions
a ConnectiCare affiliate

Care Management Solutions
www.cthep.com
(877) 687-1448
Monday – Thursday, 8:00 a.m. – 6:00 p.m.
Friday, 8:00 a.m. – 5:00 p.m.

To Create a New Account

All HEP enrollees, spouses, and dependents age 18 and over need to create a new online account the first time they visit www.cthep.com.

Check Your Status

You have until December 31, 2016 to complete your 2016 HEP requirements. However, right now is a great time to check your status and schedule appointments for the requirements you need to complete this year.

Good health starts with a plan

Check out our programs and services to help improve your health

Anthem BlueCross BlueShield

Customer service: get answers and much more

The State of Connecticut Enhanced Member Service Unit can answer your questions and give you information onyour benefits and our wellness programs and services.

- Call them at 1-800-922-2232.
- Visit anthem.com/statect to find information just for you.

Health and wellness programs to help you take healthy steps

Lose weight, quit smoking. Control diabetes. Get help for autism and eating disorders. We have a full range of wellness programs, online tools and resources designed to meet
your needs.

24/7 NurseLine is here for you

Health problems often happen when you least expect them. Call the 24/7 NurseLine at **1-800-711-5947** to talk with a registered nurse, who can answer questions about getting care. You can talk to the nurse about your symptoms, medicines and side effects, and reliable self-care home treatments.

When you need care right away

The emergency room (ER) shouldn't be your first stop — unless it's a true emergency. Depending on the situation, there are different types of providers you can see if your doctor isn't available. This includes a walk-in doctor's office, retail health clinic and urgent care center. Call the Enhanced Member Service Unit or go to anthem.com/statect to find care near you. **Note:** Call 911 or go to the ER if you think you could put your health at serious risk by delaying care.

When you need a helping hand

We offer programs if you or a family member needs behavioral health care or substance use disorder treatment. You can reach an Anthem Behavioral Health Care Manager by calling **1-888-605-0580**. To see how to access care, visit anthem.com/statect.

Access to care — wherever you go, we've got you covered

If you travel out of Connecticut, you have access to doctors and hospitals across the country with the BlueCard® program. Call **1-800-810-BLUE (2583)** to learn more. And, with the BlueCard® Worldwide program, you
have access to providers in nearly 200 countries around the world.*

Manage your benefits online — and on the go

Log on at anthem.com/statect to find a doctor, check your claims and compare costs for care near you. If you haven't registered to use the website, choose **Register Now** and follow the steps. You can also download our free mobile app by searching for "Anthem Blue Cross and Blue Shield" at the App Store® or Google PlayTM. Use the app to show your ID card, get turn-by-turn directions to a doctor or urgent care, and much more!

SpecialOffers@Anthem

Go to anthem.com/statect to find special discounts on things that encourage healthy habits. This includes weight-loss programs, gym memberships, vitamins, glasses, contact lenses and much more.

[1]Blue Cross Blue Shield Association website, Coverage Home and Away (accessed March 2016): bcbs.com/already-a-member/coverage-home-and-away.html.

Step up to better health

Comparing Plans: A Message From UnitedHealthcare

We are dedicated to helping people live healthier lives.

This is our mission and we take it seriously. By making healthier decisions, you can live a healthier life. It's that simple. Our programs and network can help you do just that.

UnitedHealthcare® Oxford

Our Network

We have a robust local and national network. Nationally and in the tri-state area, we have a large number of doctors, health care professionals and hospitals. For years, our members have accessed our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll have seamless access to our UnitedHealthcare Choice Plus Network of physicians and health care professionals outside of the tri-state area. This gives State of Connecticut employees, retirees and their families better access to care whether you are in Connecticut, traveling outside the tri-state area, or living somewhere else in the country.

Just giving you a list of doctors is not very helpful. The UnitedHealth Premium® designation program recognizes doctors who meet standards for quality and cost-efficiency. We use evidence-based medicine and national industry guidelines to evaluate quality and the cost-efficiency standards are based on local market benchmarks for the efficient use of resources in providing care. The 2016 UnitedHealth Premium program covers 27 specialty areas of medicine, including two new specialties (Ear, Nose and Throat, and Gastroenterology).

For more information about our network and the Premium designation program or to search for physicians participating in our local network and the national UnitedHealthcare Choice Plus Network, please visit welcometouhc.com/stateofct.

Administrative services provided by Oxford Health Plans. LLC. CT-15-206

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call* program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call*.

If you are a member and you need to reach *Oxford-On-Call*, please call 800-201-4911. Press option 4. *Oxford On-Call* can give you helpful information on general health information, deciding where to go for care, choosing self-care measures or guidance for difficult decisions.

Custom Website

We created this website for State of Connecticut employees and retirees to provide the tools and information to help you make informed health care decisions. Visit welcometouhc.com/stateofct to search for a doctor or hospital, or learn about the health plans we offer. You also can get Health Enhancement Program information at cthep.com, or by phone at 877-687-1448.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

For information on discounts and special offers, please visit welcometouhc.com/stateofct.

Frequently Asked Questions

1. Where can I get more details about what the State health insurance plan covers?

All medical plans offered by the State of Connecticut cover the same services and supplies with the same co-pays. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 25.

2. If I live outside Connecticut, do I need to choose an Out-of-Area Plan?

If you live permanently outside of Connecticut, we will automatically place you in an Out of Area plan, giving you access to a national network of providers whether you are enrolled with Anthem or UnitedHealthcare Oxford. There are no retiree premium shares for enrollment in an Out-of-Area plan.

3. What's the difference between a service area and a provider network?

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

4. What are my options if I want access to doctors across the U.S.?

Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans – both have national networks.

5. How do I find out which networks my doctor is in?

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 25. It's likely your doctor is covered by more than one network.

6. Can I enroll later or switch plans mid-year?

Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 3). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

7. Can I enroll myself in one option and my family member in another?

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well. It is also important to note that you may not double cover yourself under another State of Connecticut retiree's health benefits.

8. If I'm eligible, should I sign up for Medicare?

Yes. Please be sure to enroll in Medicare Part A and B as soon as you're eligible. Your standard premium for Medicare Part B will be reimbursed by the State beginning when the Retirement Health Insurance Unit receives your Medicare card. See page 25 for information.

Your Dental Plan Choices at a Glance

Cigna is the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO).

New for 2016! Implants are now covered under the DHMO.

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	DHMO® PLAN (network only)
Annual Deductible	None	$25 individual, $75/family	None
Annual Maximum	None ($500 per person for periodontics)	$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 100%	Covered at 100%[1]	Covered at 100%
Periodontal Maintenance[2]	Covered at 80% (if enrolled in the Health Enhancement Program, covered at 100%)	Covered at 100%[1]	Covered[3]
Periodontal Root Scaling & Planing[2]	Covered at 50%	Covered at 80%	Covered[3]
Other Periodontal Services	Covered at 50%	Covered at 80%	Covered[3]
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	Covered[3]
Oral Surgery	Covered at 67%	Covered at 80%	Covered[3]
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	Covered[3]
Dentures, Fixed Bridges	Not covered[4]	Covered at 50%	Covered[3]
Implants	Not covered[4]	Covered at 50% (up to $500)	*New* Covered[3]
Orthodontia	Not covered[4]	Plan pays $1,500 per person per lifetime	Covered[3]

Before starting extensive dental procedures for which the dentist's charges may exceed $200, you can ask your dentist to submit a pre-treatment estimate to the Plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the Plan's website. More details about covered expenses are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

Enhanced Plan Money-Saving Tip — Avoid Balance Billing

It pays to use network dentists if you are enrolled in the Enhanced Plan. Network dentists have agreed to discounted fees.

Visit www.cigna.com/stateofct to find a network dentist.

If you use an out-of-network dentist, you will be subject to balance billing if your dentist charges more than the maximum allowable charge. For example, exams are covered at 100%; if you see a network dentist your exam is covered in full but if you see an out-of-network dentist you could still receive a bill.

1 **In the Enhanced plan, be sure to use an in-network dentist to ensure receiving 100% coverage; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.**

2 **If enrolled in the Health Enhancement Program, frequency limits and cost share are applicable; however, periodontal maintenance and periodontal root scaling & planing do not apply to the annual $500 maximum.**

3 **Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.**

4 **While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 18 for details).**

Terms to Know

Basic Plan – This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan – This plan offers dental services both within and outside a network of dentists and dental specialists without a referral. **However, your out-of-pocket expenses may be higher if you see an out-of-network provider.**

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of-network. The Enhanced Plan pays for covered dental services based on "MAC" or "Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

DHMO Plan – This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Your 2016-2017 Dental Premium Share

Dental Premiums July 1, 2016 through June 30, 2017

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	$31.86	$25.94	$30.18
2 Persons	$63.73	$51.87	$66.40
3 or More Persons	$63.73	$51.87	$81.50

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age, or missing tooth limitations.

- You can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

* *Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional or contact Cigna customer service before receiving care to determine if these discounts will apply to you.*

Frequently Asked Questions

1. How do I know which dental plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on page 18 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

The Affordable Care Act extended benefits for children until age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19 (unless they are disabled*).

* *For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays $1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

4. If I participate in HEP, are my regular dental cleanings 100% covered?

Yes, up to two per year. However, if you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge). And of course in the DHMO, you must use a network dentist or your exam won't be covered at all.

A Message From Cigna

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **Cigna DHMO**

Learn Before You Enroll

Employee and Retiree Website

Access your dental benefit information at: **www.cigna.com/stateofct** – the website developed by Cigna just for State of CT employees.

Cigna's Information Line

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.Cigna24**. Call today to learn the following about your Cigna Dental coverage:

- Information on plan specifics
- Help finding participating dentists and specialists
- Programs and plan features available to you

Finding a Network Dentist is Easy

For the most current information on network dental offices in your area, search our online directory at www.cigna.com/stateofct or call the Dental Office Locator at **1.800.Cigna24**.

Once You're Enrolled:

Personalized benefit information available around the clock

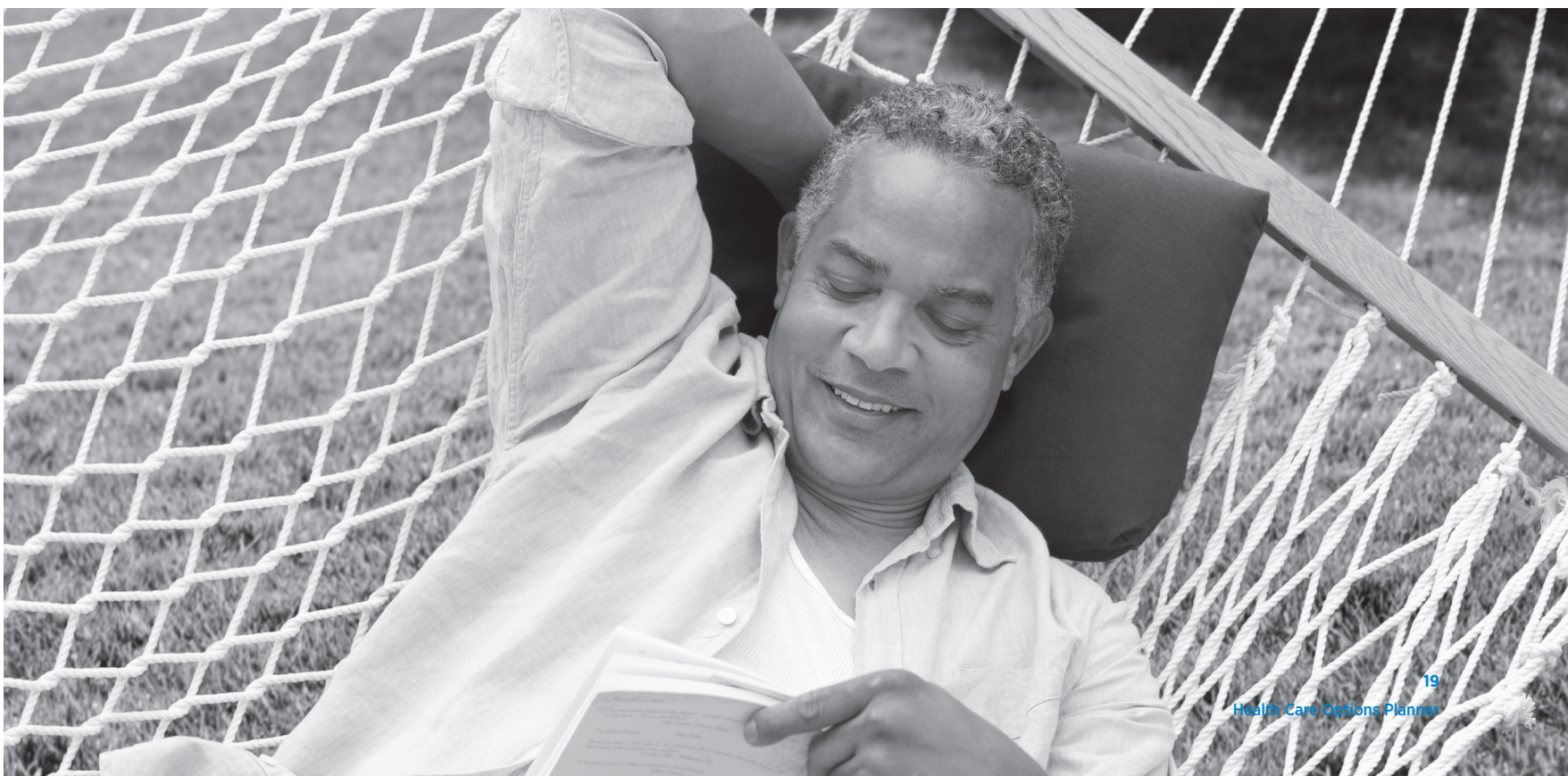
Online:

Visit **www.myCigna.com**. Once registered, you can:

- Access dental plan information
- Plan your dental care with the Treatment Cost Estimator
- Check claim status and review year-to-date maximum & deductible amounts
- Verify eligibility for you and your dependents

By Phone:

Call **1.800.Cigna24**; customer service representatives are available 24/7 to answer your questions.



Access your dental benefit information by going to www.cigna.com/stateofct.

Coverage for Fillings under the Basic and Enhanced Plan

There's not always one simple answer for treating a dental condition. You and your dentist should discuss the various options, and then you can decide on the best approach. Your costs may vary based on the treatment plan you choose.

The Basic and Enhanced Plans provide coverage for amalgam (silver) fillings. If you decide to get a composite (white) filling, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive restoration. Both of these methods are recognized by the dental profession as acceptable treatment plans; however, the silver filling is the least costly alternative for treatment.

Programs to Support Your Overall Health

Your health. Our focus.

In the real world, you have to balance your time, commitments and priorities. At Cigna, we keep our focus on helping you live healthier. Value-added programs such as wellness programs and discount savings are included with your Cigna dental plan.

Oral Health Integration Program®

Research shows an association between oral health and overall health.[1] By getting the right oral health care, along with regular medical treatments, high-risk individuals may be able to improve their overall health. Eligible State of Connecticut employees and retirees who enroll will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP).

With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. The qualifying medical conditions for OHIP: heart disease, stroke, diabetes, maternity, chronic kidney disease, organ transplants, and head & neck cancer radiation.

For additional information regarding OHIP, please visit www.cigna.com/stateofct.

[1] Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Presented at the International Association for Dental Research Meeting March 2013, Seattle

Healthy Rewards®

Cigna's Healthy Rewards Program provides discounts of up to 60% on healthy programs and services as part of Cigna's ongoing effort to promote wellness. There's no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins.

After you enroll in the insurance plan, you can learn more about Healthy Rewards by visiting Cigna.com/rewards (password savings) or calling 1.800.258.3312.

Retirement Health Insurance
Open Enrollment Application

CO-744-OE REV. 7/2015

State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

TYPE OR PRINT AND FORWARD TO THE RETIREMENT HEALTH INSURANCE UNIT

RETIREE LAST NAME (Person Receiving Benefit)	RETIREE FIRST NAME, MI	RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)

MAILING ADDRESS	TELEPHONE NUMBER

YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan.

Check the box to the left of the plan you wish to select.

MEDICAL

ANTHEM

- ☐ State BlueCare POS
- ☐ State BlueCare POE
- ☐ State BlueCare POE Plus POE-G
- ☐ State Preferred POS – **Currently Enrolled Only**
- ☐ Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

OXFORD

- ☐ Oxford Freedom Select POS
- ☐ Oxford HMO Select POE
- ☐ Oxford HMO POE-G
- ☐ Oxford USA - Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

- ☐ Waive/Cancel Medical and Prescription Coverage

DENTAL

☐ Basic Dental Plan ☐ Enhanced PPO Dental Plan ☐ Dental HMO Plan ☐ Waive/Cancel Dental Coverage

RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER F	GENDER M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	☐	☐			☐	☐
	Dependent 1:	☐	☐			☐	☐
	Dependent 2:	☐	☐			☐	☐
	Dependent 3:	☐	☐			☐	☐

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

Is any member listed above eligible for Medicare? ☐ Yes ☐ No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

ARE YOU PRESENTLY RECEIVING WORKERS' COMPENSATION? ☐ YES ☐ NO

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check and/or bill me as necessary for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE

Forms must be postmarked by June 3, 2016.

To enroll or make changes, clip out this form,
complete it and return it to:

Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775

or
Fax: 860-702-3556

Medicare and You

Medicare is a federal healthcare insurance program for people age 65 and older. While the Social Security retirement age is creeping up, the eligibility age to start Medicare is age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions (such as permanent kidney failure or Lou Gehrig's disease). If you or a dependent becomes eligible for Medicare due to disability no matter what age, be sure to contact the Retirement Health Insurance Unit at 860-702-3533. This section covers Medicare for retirees only.

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are automatically covered by Medicare Part A (hospital care) and must enroll yourself in Medicare Part B (physician services).

What to Do When You Become Eligible for Medicare

When you reach age 65, your State of Connecticut medical and prescription drug benefits will "wrap around" your Medicare benefits. Medicare will be your primary coverage and your State of Connecticut sponsored plan will pay after Medicare. This means you continue the same level of benefits that you are used to.

Do Enroll in Medicare Part A and B

Medicare Part A is free and enrollment automatic if you are at least age 65. You must enroll in Medicare Part B and pay a premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically this is the first of the month in which you turn 65. **We recommend that you contact Medicare to begin the enrollment process no later than 3 months prior to your 65th birthday.** Failing to do so will result in a "hole" in your coverage. Your State sponsored medical and prescription coverage will automatically be noted as secondary upon your 65th birthday.

Your standard premium for Medicare Part B will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.) The 2015 standard Medicare Part B/Part D premium reimbursement is $104.90, as long as you are not receiving reimbursement from any other source.

Be sure to send us a copy of your red, white and blue Medicare card as soon as you receive it. You will receive a letter from the Retirement Health Insurance Unit with more information just prior to your reaching age 65.

Additionally, you may be required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard rate. Social Security will advise you by letter annually if you are required to pay a higher rate. Send a copy of this letter along with your red, white, and blue Medicare card in order to receive full reimbursement.

Do Not Enroll in Medicare Part C or Part D

The State of Connecticut prescription coverage with SilverScript (a subsidiary of Caremark) is a Medicare Part D plan. When you or your covered dependents become eligible for Medicare, you will automatically be enrolled in the Part D prescription drug plan administered by SilverScript. You do not need to do anything except start using your SilverScript card once received.

Once enrolled, you will receive more information. However, there are four key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- **Do not opt out of the SilverScript prescription drug program.** SilverScript is required by Medicare to send you a letter giving you a chance to opt out or cancel your prescription drug enrollment, **but don't do it.** If you opt out, medical and prescription drug coverage for you and your dependents will terminate. **Please ignore the opt out letter.**
- **Do not enroll in an individual Medicare prescription drug plan (through Medicare Part C or Part D).** You are only able to enroll in one Medicare Part D plan. Your State sponsored coverage with SilverScript is a Medicare Part D plan enrollment. Enrolling in any other Medicare Part D plan will cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.
- **Do make sure we have your street address.** If you receive your mail at a post office box, you must provide a residential street address to the Retirement Health Insurance Unit (per Center for Medicare and Medicaid Services regulations). All communication will still go to your noted mailing address.
- **Do promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your 2016/2017 IRMAA notice to the Retirement Health Insurance Unit to ensure proper reimbursement.

If Family Members Are Not Yet Eligible for Medicare

If you have covered dependents who are not yet eligible for Medicare (typically those under age 65), their current coverage through CVS Caremark will stay the same. There will be no change to their co-pay structure, and they will continue to participate in the mandatory maintenance drug network program. This means that after their first fill of a maintenance medication, refills must be filled through a pharmacy participating in the State's Maintenance Drug Network or through the CVS Caremark mail-order pharmacy. A full list of all participating pharmacies is available on the Comptroller's website at **www.osc.ct.gov.**

For More Information

Contact SilverScript with questions about your prescription coverage, ID cards, and participating pharmacies or the Retirement Health Insurance Unit with questions about eligibility or premiums. Contact information is at the back of the booklet.

Have Questions for SilverScript?

Call 866-693-4624

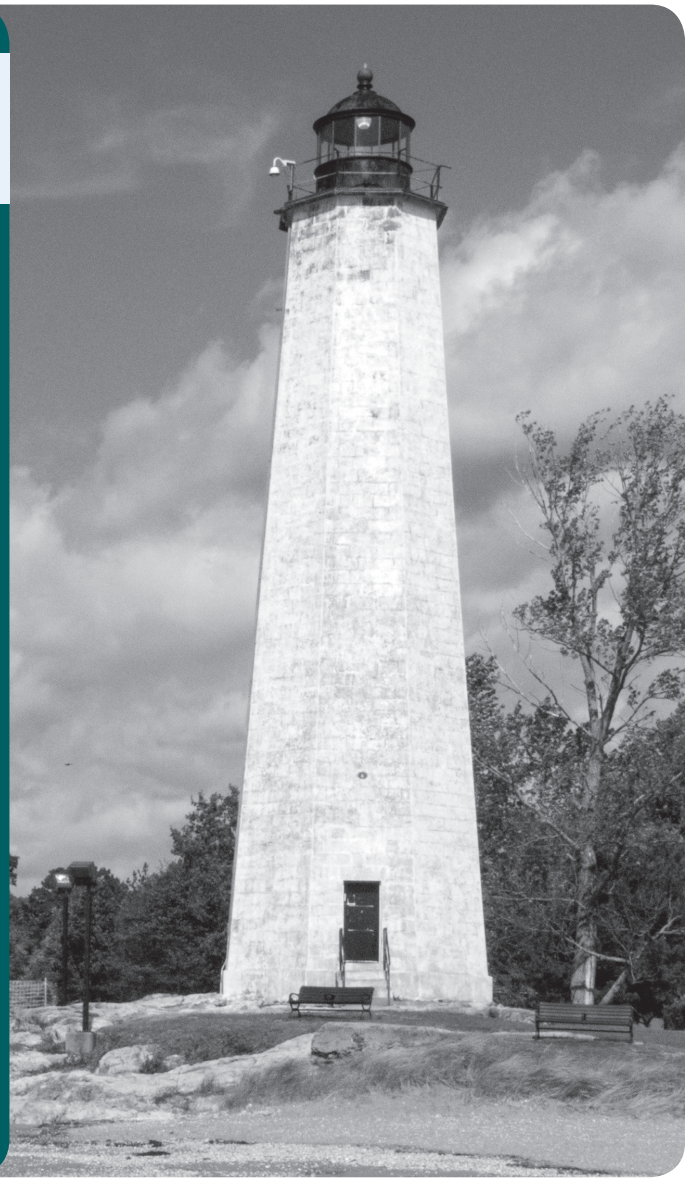
A CAMPAIGN TO QUIT.

KICK ASH

Find free resources to help you or your loved one to quit smoking for good.

- **The Quitline:** You can call the smoker's Quitline at 1-800-Quit-Now any time, day or night for support.
- **CVS Minute Clinics:** CVS's "Start to Stop" program offers counseling and support through their Minute Clinics. For a list of locations, visit: cvs.com/minuteclinic
- **SmokeFreeTxt:** Get encouragement, advice, and tips on how to quit smoking right to your cell phone. Sign up at: smokefree.gov/smokefreetxt
- **American Lung Association:** The American Lung Association's website offers resources and tips to help you, or someone you care about, quit smoking. Visit their website: lung.org

FOR MORE, VISIT WWW.OSC.CT.GOV/KICKASH



For details about specific plan benefits and network providers, contact:			
Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)	**www.cthep.com**	**1-877-687-1448**	
Anthem Blue Cross and Blue Shield • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State BlueCare (POS)	**www.Anthem.com/statect**	**1-800-922-2232**	
UnitedHealthcare (Oxford) • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford Out-of-Area	**www.welcometouhc.com/stateofct**	**1-800-385-9055** Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	**www.Caremark.com**	**1-800-318-2572**	
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	**http://stateofconnecticut.silverscript.com**	**1-866-693-4624**	
CIGNA • Basic Plan • Enhanced Plan • DHMO Plan	**www.Cigna.com/stateofct**	**1-800-244-6224**	
For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:			
Office of the State Comptroller **Retirement Health Insurance Unit** **55 Elm Street** **Hartford, CT 06106-1775**	**www.osc.ct.gov**	**(860) 702-3533**	

Healthcare Policy & Benefit Services Division
Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775

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See pages 5 and 18

RETIREES HEALTH CARE OPTIONS PLANNER

STATE OF CONNECTICUT **2016 | 2017**

ATTACHMENT B

INTENT TO BID FORM

INTENT TO BID FORM

Submit your Intent to osc.rfp@ct.gov no later than 2:30 pm EST by **January 27, 2017**.

RESPONSE:

I have reviewed the specifications AND requirements of this Request for Proposal; and,

Our company intends to submit a proposal that complies with all requirements, terms, conditions, tasks and schedules.

_____
Coverages/Benefits for Which We Intend to Bid

_____
Proposing Company

_____
Signature

_____
Printed Name and Title

_____
Date

Our company does not intend to submit a proposal.

_____
Proposing Company

_____
Signature

_____
Printed Name and Title

_____
Date

Briefly explain reason for decline

ATTACHMENT C

NON DISCLOSURE AGREEMENT

Non-Disclosure Agreement

Date:

Ms. Sarah Ormerod
Office of the State Comptroller
Business Services Office
State of Connecticut
55 Elm Street, Room 301
Hartford, CT 06106

Re: Non-Disclosure Agreement RFP – MA-PD—OSC Confidential Information

Dear Ms. Ormerod

I represent [_____] (the "Proposer") and sign this agreement on its behalf.

1. The Proposer agrees that:
   - The Office of the State Comptroller ("OSC") has issued a Request for Proposals, identified as MA-PD (the "RFP"), seeking bids for Medicare Advantage and Prescription Drug (MA-PD) services for its Medicare-eligible retirees services.
   - Access to certain confidential information ("OSC Confidential Information") will be required in order for the Proposer to submit a proposal to the RFP.
2. As a Proposer or potential Proposer, in exchange for being given access to OSC Confidential Information in connection with the RFP, the Proposer agrees to:
   - Limit disclosure of OSC Confidential Information only to (a) those members of its staff who are actually assigned to respond to the RFP and (b) potential subcontractors which have signed a Subcontractor Non-Disclosure Agreement in the form of the attached Subcontractor Non-Disclosure Agreement;
   - Limit use of OSC Confidential Information to the sole purpose of responding to the RFP;
   - Protect OSC Confidential Information to the same or greater extent that it protects its own confidential or proprietary information, but in no event will the protection afforded be at less than a reasonable standard of care;
   - Comply fully with all relevant export laws and regulations to ensure that no OSC Confidential Information is exported, directly or indirectly, in violation of law; and
   - If the Proposer determines it is necessary to disclose OSC Confidential Information to an entity the Proposer may engage as a subcontractor, to make such disclosure only after the Proposer has obtained an executed Subcontractor Non-Disclosure Agreement from such entity. Such Subcontractor Non-Disclosure Agreement shall be in the form of the attached Subcontractor Non-Disclosure Agreement. A copy of the executed Subcontractor Non-

Disclosure Agreement shall be submitted to OSC prior to the Proposer's disclosure of OSC Confidential Information to a potential subcontractor.

3. The Company agrees that this agreement is a continuing obligation, unless and until either:
   - OSC notifies the Proposer that OSC Confidential Information has ceased to be confidential; or
   - All copies of the OSC Confidential Information in the possession of the Proposer are returned to OSC or securely deleted or destroyed; or
   - The Proposer enters into a written agreement with OSC that varies the terms of this agreement with respect to OSC Confidential Information.

4. Upon the issuance by OSC of a Notice of Award of a contract pursuant to the RFP to an entity other than the Proposer, the Proposer shall, within ten (10) business days of such issuance, provide written certification to OSC to the effect that the Proposer has either (a) returned all OSC Confidential Information to OSC, or (b) securely deleted all OSC Confidential Information in electronic format, and destroyed in a secure manner all paper or other hardcopy OSC Confidential Information.

5. The Proposer acknowledges that in permitting OSC Confidential Information to be disclosed to the Proposer, OSC will rely upon the undertakings made by the Proposer in this agreement, and that the Proposer shall be responsible for consequences adverse to OSC that result from the Proposer's or its subcontractor(s)' failure to comply with the terms of this agreement.

6. The Proposer acknowledges that the OSC Confidential Information is provided to the Proposer with no warranty or representation of any kind.

7. Neither party will be liable for any indirect, incidental, special, punitive, or consequential damages, or for any lost profits, lost revenue, lost institutional operating savings, lost data, or loss of data use arising from breach of this agreement.

8. This agreement sets forth the entire agreement with respect to the OSC Confidential Information disclosed in connection with the RFP. All additions or modifications to this agreement must be made in writing and must be signed by authorized representatives of both parties.

9. Notwithstanding the foregoing, Proposer agrees that its obligation to limit disclosure of OSC Confidential Information described in section 2 above shall survive beyond the termination of this Agreement.

Very truly yours,

Proposer Name: _____

By: _____

_____

Agreed to:

Office of the State Comptroller

By: _____

Date:_____

Corporate Acknowledgment

STATE OF)
) ss:
COUNTY OF)

On the _____ day of _____, in the year 2017 before me personally came __ _____ to me known, who, being by me duly sworn did depose and say that (s)he resides in _____that (s)he is the _____in the firm/corporation described in and which executed the above instrument; and that (s)he signed his/her name thereto as a _____ thereof.

_____

Notary Public

ATTACHMENT D

PRICE PROPOSAL WORKSHEET

SEE SEPARATE FILE

ATTACHMENT E

BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGEEMENT

This BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into by and between the State of Connecticut, acting through the Office of the State Comptroller ("OSC"), and [insert name] ("Contractor") and will be effective as of [_____] (the "Effective Date"), and will terminate upon the expiration of Contractor's agreement with State, including any extension thereof. These parties acknowledge and agree as follows:

(a) Contactor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractor must comply with all terms and conditions of this Section of the Contract.

(b) The Contractor is required to safeguard the use, publication and disclosure of information on all applicants for, and all clients who receive, services under the Contract in accordance with all applicable federal and state law regarding confidentiality, which includes but is not limited to HIPAA, more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E; and

(c) OSC is a "covered entity" as that term is defined in 45 C.F.R. § 160.103; and

(d) The Contractor, on behalf of OSC, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. § 160.103; and

(e) The Contractor is a "business associate" of OSC, as that term is defined in 45 C.F.R. § 160.103; and

(f) The Contractor and OSC agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act (hereinafter the HITECH Act), (Pub. L. 111-5, sections 13400 to 13423), and

more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E.

(g) Definitions

(1) "Breach shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(1));

(2) "Business Associate" shall mean the Contractor.

(3) "Business Associate's Normal Customer Service Function" shall mean claims processing and customer care services rendered by Contractor pursuant the Administrative Services Agreement of which this exhibit is a part.

(4) "Covered Entity" shall mean OSC acting on behalf of the State of Connecticut.

(5) "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. § 164.501.

(6) "Electronic Health Record" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(5))

(7) "Individual" shall have the same meaning as the term "individual"' in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. § 164.502(g).

(8) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and parts 164, subparts A and E.

(9) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to information created or received by the Business Associate from or on behalf of the Covered Entity.

(10) “Required by Law”’ shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.

(11) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.

(12) “More stringent” shall have the same meaning as the term “more stringent” in 45 C.F.R. § 160.202.

(13) “This Section of the Contract” refers to the HIPAA Provisions stated herein, in their entirety.

(14) “Security Incident” shall have the same meaning as the term “security incident” in 45 C.F.R. § 164.304.

(15) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. part 160 and parts 164, subpart A and C.

(16) “Unsecured protected health information” shall have the same meaning as the term as defined in section 13402(h)(1)(A) of HITECH. Act. (42 U.S.C. §17932(h)(1)(A)).

(h) Obligations and Activities of Business Associates.

(1) Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Contract or as Required by Law.

(2) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Contract.

(3) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic

protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(4) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Contract.

(5) Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Section of the Contract or any security incident of which it becomes aware. Such report shall not include instances where Business Associate inadvertently misroutes Protected Health Information to a provider. The parties acknowledge and agree that this section constitutes notice by Business Associate to the Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to the Covered Entity shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

(6) Business Associate agrees to require that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same or more stringent restrictions and conditions that apply through this Section of the Contract to Business Associate with respect to such information.

(7) Business Associate will respond to an Individual's request for access to his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Covered Entity, Business Associate will respond to the request with respect to the PHI Business

Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, Business Associate will assist the Covered Entity in responding to requests by Individuals that are made to the Covered Entity to invoke a right of access under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Covered Entity, Business Associate will make available for inspection and obtaining copies by the Covered Entity, or at the Covered Entity's direction by the Individual (or the Individual's personal representative), any PHI about the Individual created or received for or from the Covered Entity in Business Associate's and/or its subcontractor's custody or control, so that the Covered Entity may meet its access obligations under 45 Code of Federal Regulations § 164.524, and, where applicable, the HITECH Act. Business Associate will make such information available in an electronic format where required by the HITECH Act or such other format as may be required under the Privacy Rule as amended.

(8) Business Associate will respond to an Individual's request to amend his or her PHI as part of Business Associate's normal customer service functions, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Covered Entity, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, Business Associate will assist the Covered Entity in responding to requests by Individuals that are made to the Covered Entity to invoke a right to amend under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Covered Entity, Business Associate will amend any portion of the PHI created or received for or from the Covered Entity in Business Associate's and/or its subcontractor's custody or control, so that the Covered Entity may meet its amendment obligations under 45 Code of Federal Regulations §164.526.

(9) Upon reasonable notice and during normal business hours, Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by, Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary in a time and manner agreed to by the parties or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(10) Business Associate will respond to an Individual's request for an accounting of disclosures of his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to the Business Associate directly by the Individual. Despite the fact that the request is not made to the Covered Entity, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Rule and HITECH Act. In addition, Business Associate will assist the Covered Entity in responding to requests by Individuals that are made to the Covered Entity to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by Business Associates and/or its subcontractor(s) performing the following functions so that the Covered Entity may meet its disclosure accounting obligation under 45 Code of Federal Regulations § 164.528(11)

Business Associate agrees to comply with any state or federal law that is more stringent than the Privacy Rule, to the extent applicable and not preempted by HIPAA.

(12) Business Associate agrees to comply with the requirements of the HITECH Act relating to privacy and security that are applicable to the Covered Entity and with the requirements of 45 C.F.R. sections 164.504(e), 164.308, 164.310, 164.312, and 164.316.

(13) Business Associate agrees that it shall not, directly or indirectly, receive any remuneration in exchange for PHI of an individual without (1) the written approval of the covered entity, unless receipt of remuneration in exchange for PHI is expressly authorized by this Contract and (2) the valid authorization of the individual, except for the purposes provided under section 13405(d)(2) of the HITECH Act, (42 U.S.C. § 17935(d)(2)) and in any accompanying regulations

(14) Obligations in the Event of a Breach

(A) The Business Associate agrees that, following the discovery of a breach of unsecured protected health information, it shall notify the Covered Entity of such breach in accordance with the requirements of section 13402 of HITECH (42 U.S.C. 17932(b) and the provisions of this Section of the Contract.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to section 13402 (g) of HITECH (42 U.S.C. 17932(g)) . A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been,

or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

(C) The Business Associate agrees to include in the notification to the Covered Entity at least the following information:

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

3. The steps the Business Associate recommends that individuals take to protect themselves from potential harm resulting from the breach.

4. A detailed description of what the Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

5. Whether a law enforcement official has advised either verbally or in writing the Business Associate that he or she has determined that notification or notice to individuals or the posting required under section 13402 of the HITECH Act would impede a criminal investigation or cause damage to national security and; if so, include contact information for said official.

(D) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed by the Covered Entity of a breach by the Business Associate have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures may include a toll-free telephone number, an e-mail address, a posting on its Web site and a postal address. Business Associate agrees to

include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.

(E) Business Associate agrees that, in the event of a breach, it has the burden to demonstrate that it has complied with all notifications requirements set forth above, including evidence demonstrating the necessity of a delay in notification to the Covered Entity.

(F) In addition to providing notice to Covered Entity of a Breach, Business Associate will provide any required notice to individuals and applicable regulators on behalf of Covered Entity, unless Covered Entity is otherwise notified by Business Associate.

(i) Permitted Uses and Disclosure by Business Associate.

(1) General Use and Disclosure Provisions Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(2) Specific Use and Disclosure Provisions

(A) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or

further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(D) Except as otherwise limited in this Section of the Contract, Business Associate may de-identify PHI in accordance with the requirements of 45 CFR §164.514(a)-(c), and may use or disclose the information that has been de-identified for benchmarking and other internal purposes only.

(j) Obligations of Covered Entity.

(1) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. § 164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(2) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(k) Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Covered Entity, except that Business Associate may use and disclose PHI for

data aggregation, and management and administrative activities of Business Associate, as permitted under this Section of the Contract.

(l) Term and Termination

(1) Term. The Term of this Section of the Contract shall be effective as of the date that Contract between OSC and Contractor is effective and shall terminate when the information collected in accordance with clause h. (10) of this Section is provided to the Covered Entity and all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(2) Termination for Cause. Upon either party's knowledge of a material breach by the other, the non-breaching party shall either:

(A) Provide an opportunity for the breaching party to cure the breach or end the violation and terminate the Contract if the breaching party does not cure the breach or end the violation within the time specified; or

(B) Immediately terminate the Contract if the breaching party has breached a material term of this Section of the Contract and cure is not possible; or

(C) If neither termination nor cure is feasible, the non-breaching party shall report the violation to the Secretary.

(3) Effect of Termination The parties agree that upon cancellation, termination, expiration or other conclusion of the ASO Agreement, destruction or return of all Protected Health Information, in whatever form or medium (including in any electronic medium under Business Associate's custody or control) is not feasible given (i) the regulatory requirements to maintain

and produce such information for extended periods of time after such termination and (ii) the Business Associate's documentation retention and disaster recovery programs. Upon receipt of written request from Covered Entity, Business Associate shall provide Covered Entity with information it has accumulated for the purpose of tracking disclosures under Paragraph 7 above. In addition, Business Associate is required to maintain such records to support its contractual obligations with its vendors and network providers. Business Associate shall extend the protections and requirements of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those consistent with applicable law for so long as Business Associate, or its subcontractors or agents, maintains such Protected Health Information. Business Associate may destroy such records in accordance with applicable law and its record retention policy that it applies to similar records upon 30 days prior notice to the Covered Entity.

(m) Miscellaneous Provisions.

(1) Regulatory References. A reference in this Section of the Contract to a section in the Privacy Rule means the section as in effect or as amended.

(2) Amendment. The Parties agree to take such action as in necessary to amend this Section of the Contract from time to time as is necessary for the parties to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(3) Survival. The respective rights and obligations of Business Associate under section (l) shall survive the termination of this Contract

(4) Effect on Contract. Except as specifically required to implement the purposes of this Section of the Contract, all other terms of the Contract shall remain in force and effect.

(5) Construction. This Section of the Contract shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the Contract shall be resolved in favor of a meaning that complies, and is consistent with, the Privacy Standard.

(6) Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, civil or criminal penalty, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, contractors or agents, or any third party to whom Business Associate has disclosed PHI contrary to the provisions of this Contract or applicable law. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

(7) Third Party Beneficiaries. Nothing in this Agreement shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of Covered Entity.

(8) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile or Portable Document Format (PDF) copies thereof shall be deemed to be originals.

(9) Informal Resolution. If any controversy, dispute, or claim arises between the parties with respect to this Agreement, the parties shall make good faith efforts to resolve such matters informally.

(10) Notices. All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by courier service. If to Covered Entity, the notice shall be sent to such address as Covered Entity notifies Business Associate of in writing. If to Business Associate, the notice shall be sent to the [insert applicable notice information].

IN WITNESS WHEREOF the parties have set their hands and seals as of the Effective Date.

State of Connecticut By:_____ Name:_____ Title:_____	. By:_____ Name:_____ Title:_____

ATTACHMENT F

ELIGIBILITY FILE FEED REQUIREMENTS APPLICABLE TO MEDICAL/PHARMACY/DENTAL

Eligibility File Feed Requirements applicable to Medical/Pharmacy/Dental

a. Vendor must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently for active employees and retirees, enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the State.

b. Vendor must agree to share data with health benefits administrators and the State's healthcare consultant and actuary, data manager and wellness plan coordinator.

c. Vendor must agree to accept the eligibility structure as defined by the State.

d. Enrollment data that does not pass carrier system edits must either be corrected or bypassed by the carrier. The remaining data must be posted without delay. Issues related to errant data must be addressed with the employing agency's benefit staff or the Healthcare Policy and Benefit Services Division as appropriate.

e. Vendor must agree to the State-defined Eligibility Periods; award of this contract means that any eligible employee and their dependents will be eligible for coverage.

f. Open enrollment shall be the period announced by the State to allow eligible subscribers to join the plan, change coverage, or add eligible dependents. The open enrollment periods are generally from May 1st to June 1st each year for active employees and retirees.

g. HIPAA Events: members may add, drop or make changes as appropriate if an allowable qualifying event occurs.

h. The vendor must agree to process active and retiree enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or information provided by the State. The State will provide a weekly file to report any changes within their enrollment data (to be known as the Change File). This file will include additions, terminations, coverage class changes, changes in dependent enrollment, etc. Towards the end of each month, the State will provide a monthly file to report a snapshot of all current live enrollment data (to be known as the Full File). The Full File is typically not loaded and used for comparative purposes only. After receipt of the monthly Full File, the vendor must reconcile all active employee and retiree enrollment data and report any discrepancies, in a format defined by the State, by the 15th of the next month to the appropriate State agency personnel;

aggregate information must be sent to the Healthcare Policy and Benefit Services Division. The State will review the discrepancies and provide feedback appropriate to the condition being reported and make any necessary corrections to State enrollment information.

i. Group Numbers – Department ID, as defined by the State, will substitute for any arbitrary vendor group number that might otherwise be assigned to a State agency or location. More specifically, enrollment and remittance information from the State will include the Department ID as the sole identifier of an employee's location. The vendor may translate the data to accommodate their own systems, however; all communications to and from the State and its data warehouse vendor, whether electronic or otherwise, will refer to the Department ID.

j. The vendor will capture and report the State provided Employee ID (EMPLID) in data stores and data transfers with the State and other state vendors. The member's EMPLID must also be connected to all associated dependents.

k. The vendor will provide the State with online access to their enrollment information in real time.

File Exchange Protocol
There are currently two methods for exchanging files with the State's Core-CT system:

1. The carrier logs into the secure Core-CT Production Supplier Portal via https to download files. The URL is https://corect.ct.gov:10400/psp/PSPRD/signon.html
-or-

2. The carrier logs into the secure Core-CT Axway Server. The URL is https://sfile.ct.gov/ For those using an automated system Axway has a client available at http://www.axway.com/productssolutions/securetransport

Testing Requirements
At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports.
The Core-CT Supplier Portal uses a non-standard port (10400 for Production, 15000 for Test) and that may require action by the carrier's Tech Support area to accomplish this. Vendors must report in their response to this RFP whether they were able to successfully reach the portal sign on page at: https://corect.ct.gov:10400/psp/PSPRD/signon.html or have obtained Axway client software and successfully connected to: https://sfile.ct.gov/
For testing purposes, the link to the TEST supplier portal is:

https://corect.ct.gov:15000/psp/PSTPR/?cmd=login&languageCd=ENG&
Additional information for all parties that exchange data with State's Core-CT system is available at: http://www.core-ct.state.ct.us/hrint/

ATTACHMENT G

STATE OF CONNECTICUT

STANDARD CONTRACT

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AGREEMENT

BY AND BETWEEN

THE STATE OF CONNECTICUT, OFFICE OF THE STATE COMPTROLLER

AND

_____

Pursuant to Connecticut General Statutes Sections _____, this Agreement (the "**Agreement**") is made and entered into as of _____, 2015 by and through the State of Connecticut (the "**State**") Office of the State Comptroller (the "**Comptroller**") and _____(the "**Contractor**," and together with the Comptroller and the State, the "Parties").

WHEREAS, the Comptroller issued a Request for Proposal (the "**RFP**") on _____, to [DESCRIPTION OF RFP]; and

WHEREAS, the Contractor was selected pursuant to the RFP process and has agreed to provide services to the Comptroller related [DESCRIPTION OF SERVICES TO BE PROVIDED] as described herein;

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which the Parties acknowledge, intending to be legally bound, the Comptroller and the Contractor, hereby agree as follows:

1. DEFINITIONS.

[INSERT DEFINED TERMS]

2. TERM OF AGREEMENT.

A. The term of this Agreement begins _____, 2015 (the "**Effective Date**"), and shall expire the on _____, or extended by the mutual agreement of the Parties as described in subsection (b), below.

B.

C. The Parties may agree to extend the Term of the Agreement for a period not to exceed one (1) year. Any such extension, and related cost and/or pricing, shall be agreed upon by the Parties and set forth in a written amendment to this Agreement.

3. SCOPE OF SERVICES.

[INSERT SCOPE OF SERVICES]

4. PAYMENT TERMS AND BILLING.

A. Payment

The Comptroller shall pay Contractor for Services actually performed and completed in an amount not to exceed _____ DOLLARS (US$ _____.00) in the manner set forth in Exhibit___ ("Payment Schedule"), and Contractor shall accept such payment as full compensation for any direct costs or expenses incurred by the Contractor.

B. Billing [STANDARD]

(i) Unless otherwise specified in the Agreement, payment shall be due within forty-five (45) days after Comptroller's receipt of a properly completed, undisputed invoice. Invoices shall include detailed information for Services delivered and performed.

(ii) In conformity with Connecticut General Statues §41-72, the Comptroller shall notify the Contractor within ten (10) business days of receiving an invoice, in writing, of any disputed charges under this Agreement for which the Comptroller is withholding payment and describe, in reasonable detail, the reason for such withholding. In no event shall the Comptroller withhold disputed payments or set off, in aggregate, any amounts in excess of five percent (5%) of the total value of this Agreement. Upon resolution of the dispute, any disputed amounts owed Contractor will be paid with interest, in accordance with Connecticut General Statutes §11-5, at the rate of the lesser of one and one-half percent (1.5%) per month or the highest rate allowed by law, calculated from the date the amounts were originally due.

(iii) For all Services to be provided by the Contractor and any Approved Subcontractors, if any, the Comptroller shall not be obligated to pay any amounts in addition to the charges payable to the Contractor under this Agreement unless such amounts are covered by a Change Order.

[INSERT FOR LEGAL SERVICES CONTRACT

(iv) The Comptroller agrees to compensate the Contractor for Services solely in accordance with the following hourly rate schedule:

[INSERT HOURLY RATE SCHEDULE]

(v) The above rates shall be charged only for actual time spent rendering such Services; the Contractor shall not "round off" time. The time spent rendering Services shall be billed to a tenth of an hour within any single workday. The Comptroller shall not be charged for any other time expended by the Contractor during travel, overnight stays, or the like associated with the performance of the Services.

(vi) Billings are to be on a monthly basis. The billings must contain, at a minimum, a detailed description of the work performed, the date of the performance, the actual time spent performing the work, the name and position of the person(s) rendering the Service and the rate charged for the Service. The monthly bill must also be accompanied by a summary of time and charges billed for each attorney and paralegal itemized on the invoice.

(vii) Upon request from the Comptroller, the Contractor must submit a summary memorandum describing how the Service rendered furthered the resolution of the matter and the current status of the matter.

(viii) The Comptroller agrees to reimburse the Contractor for actual, necessary and reasonable out-of-pocket disbursements and expenses, including filing fees, court costs, computerized research (at cost), commercial messenger and delivery service (at cost) expert witnesses, consultants, mediators, investigative services, long distance telephone calls, and transcript or deposition costs.

(ix) The Comptroller shall not reimburse the Contractor for any overhead related expenses, including, but not limited to, duplicating, secretarial, facsimile (other than long distance telephone line charges), clerical staff, library staff, proofreading staff, meals and in-state transportation costs unless they are otherwise approved by the Comptroller.

(x) The Contractor shall be reimbursed for reasonable expenses for transportation, parking and reasonable lodging and meals associated with interstate travel, specifically excluding first class airfare, as approved in advance by the Comptroller. Reimbursable interstate travel shall not include travel to meet with staff of the Comptroller and all such meetings shall be conducted in Hartford, Connecticut, unless otherwise specified by the Comptroller.

(xi) The Contractor shall not be compensated for time spent on background or elementary legal research or any legal training without prior written consent of the Comptroller. Charges for legal research must be accompanied by a detailed description setting forth the purpose of the reassure and summarizing its nature. Any written material produced as a result of such research shall be available to the Comptroller at on or before the third business day following the date of his written request. The Comptroller shall make the final decision in all disputes to this Agreement under this subsection.

(xii) The Contractor shall not be compensated for time spent in consultation with any other attorney or other employee of the Comptroller concerning the administration of this Agreement and/or issues relating to billing. Unless otherwise authorized by the Comptroller, compensation for communication between or among attorney's and/or staff within the Contractor's firm is limited to the time and billing rate of the most senior attorney or staff member participating in the communication. These charges must be accompanied by a detailed description setting forth the purpose of the communication and summarizing its

details. The Comptroller shall make the final determination, it his sole discretion, as to the adequacy of such description.

(xiii) Absent the consent of the Comptroller or his designee, the Contractor shall not be compensated for the attendance or participation of more than one attorney representing the State at or during any meeting, conference or proceeding, in person or otherwise, in any forum, in connection with performing the Services. Where more than one attorney has attended or participated in any such meeting, conference or proceeding without the consent of the Comptroller or his designee, the Contractor shall be compensated only for the time of the most senior attorney in attendance or participating.

(xiv) The Contractor shall not be compensated for the performance of paralegal or clerical type duties performed by an attorney. Paralegal duties or clerical duties include, by way of example and not limitation, routine proofreading of pleadings and other correspondence, preparation of trial or closing binders or notebooks, photocopying and coordinating the schedules of others.

(xv) The Comptroller shall approve for payment all undisputed fees and costs, as soon as the documentation can properly be processed in accordance with the usual State practice.

(xvi) Maximum payment under this Agreement shall not exceed _____ ($_____) over the term of the Agreement.]

C. Taxes

To the extent applicable, each Party will be responsible for its own income taxes, employment taxes, and property taxes. The Parties will cooperate in good faith to minimize taxes to the extent legally permissible. The State of Connecticut is exempt from Federal Excise, State and Local Sales Taxes. Each Party will provide to the other Party any resale exemption, multiple points of use certificates, treaty certification and other exemption information reasonably requested by the other Party. The Comptroller will reimburse Contractor for any deficiency relating to taxes that are the Comptroller's responsibility under this Agreement.

5. CONTRACTOR RESPONSIBILITIES.

Contractor shall, in addition to any other responsibilities described in this Agreement, perform the following coincident with performance of this Agreement:

A. Be responsible for the Contractor work force and its subcontractors as they interact with State employees, and other contractors present at the work site. Employment disputes which are caused by Contractor's employees' presence on the work site, or other action under the control of Contractor shall be quickly resolved by Contractor. Employment disputes amongst the work force of Contractor or its subcontractors shall not be deemed sufficient cause to any claim by Contractor for additional compensation for loss or

damage nor shall such disputes be deemed sufficient reason to relieve Contractor from any of its obligations under this Agreement.

B. Contractor's work shall be accomplished by Contractor at a minimum disruption or interruption to the State's normal business operation. Contractor's responsibility to perform the Services shall be in conformity with the provisions of this Agreement and shall not be confined or limited to the normal business hours of the State.

C. Contractor shall be responsible for its obligations under this Agreement whether or not Contractor performs them. Further, the Comptroller shall consider Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from this Agreement. Contractor is totally responsible for adherence by the Approved Subcontractor(s) to all applicable provisions of the Agreement.

D. Contractor shall keep itself fully informed of and shall, at all times, observe and comply with all ordinances, regulations, laws, orders and decrees applicable to its business operations as a Systems Integrator.

E. Provide timely staffing of qualified individuals in accordance with the terms of this Agreement.

F. Perform its obligations as set forth in in this Agreement in accordance with the time frames set forth for completion of those obligations.

G. Obtain consent from third parties with whom the Contractor has a contractual relationship for purposes of providing Services under this Agreement, if the Parties agree it is required for Comptroller to perform its obligations hereunder.

H. Be responsible for the relationships with third parties with whom Contractor has a contractual relationship for purposes of providing Services under this Agreement, and make commercially reasonable efforts to have those parties cooperate with the State.

6. COMPTROLLER RESPONSIBILITIES.

Coincident with Contractor's performance of this Agreement, the Comptroller shall, in addition to the responsibilities described in the Exhibits and elsewhere in this Agreement, perform the following tasks:

A. Be responsible for the Comptroller work force as they interact with Contractor employees and Approved Subcontractors present at the work site. Employment disputes which are caused by the Comptroller’s employees or other action under the control of Comptroller shall be quickly resolved by the Comptroller.

B. Supply on-site personnel of the Contractor with suitable office space, desks, storage, furniture, and other normal office equipment support, adequate computer resources, telephone and facsimile service, postage, copying, secretarial support, word processing,

and general office supplies which may be necessary in connection with the Contractor's performance of the Services hereunder. No bailment shall be created and no interest or obligation shall be conferred upon the Contractor regarding the Comptroller's property or the property of the Comptroller's employees, agents, vendors, or other contractors, beyond the limited right to use such property in furtherance of this Agreement. All such property, regardless of its physical location or use, shall be deemed to be in the care, custody and control of the Comptroller.

C. Provide timely staffing of qualified individuals in accordance with the terms of this Agreement and its Exhibits as needed for the successful completion of the Project.

D. Perform its obligations as set forth in the Agreement in accordance with the time frames set forth for completion of those obligations.

E. Obtain consent from third parties with whom the Comptroller has a contractual relationship if the Contractor notifies the Comptroller it is required for Contractor to perform its obligations hereunder.

F. Be responsible for third parties with whom the Comptroller has a contractual relationship and make reasonable efforts to have those parties cooperate with the Contractor.

7. REPRESENTATIONS AND WARRANTIES.

The Contractor represents and warrants to the Comptroller that:

A. it is duly and validly existing under the laws of its respective states of organization and authorized to conduct business in the State of Connecticut in the manner contemplated by the Agreement. Further, as appropriate, it have taken all necessary action to authorize the execution, delivery and performance of the Agreement and have the power and authority to execute, deliver and perform its obligations under the Agreement;

B. it will comply with all State and Federal laws and municipal ordinances governing Contractor and its business operations;

C. the execution, delivery and performance of the Agreement will not violate, be in conflict with, result in a breach of or constitute (with or without due notice and/or lapse of time) a default under any indenture, agreement, document or other instrument to which it is a party or by which it may be bound;

D. they are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any governmental entity;

E. as applicable it has not to the best of its knowledge, information and belief, within the three years preceding the Agreement, in any of their current or former jobs, been convicted of, or had a civil judgment rendered against it for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a

transaction or contract with any governmental entity. This includes, but is not limited to, violation of Federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

F. it is not presently indicted for or otherwise criminally or civilly charged by any governmental entity with commission of any of the offenses listed above;

G. they have disclosed whether one or more contracts with any governmental entity have been Terminated for Cause or Default that would adversely impact the Contractor's ability to perform under this Agreement within the three years preceding the Effective Date of this Agreement;

H. they have not improperly or illegally paid or agreed to pay any entity or person any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award or making of the Agreement or any assignments made in accordance with the terms of the Agreement;

I. they are able to perform under the Agreement using their own resources or the resources of a party who is an Approved Subcontractor;

J. the Contractor shall exercise commercially reasonable efforts to obtain in a written contract all of the representations and warranties in this section from any Approved Subcontractor and will notify the Comptroller in writing if such representation and warranties are not included in a written contract with any Approved Contractor providing Services under this Agreement.

8. APPROVAL OF CONTRACTOR KEY PERSONNEL AND SUBCONTRACTORS.

A. Contractor Key Personnel.

Each of the Contractor Key Personnel shall work in the role assigned to him or her as set forth in Exhibit___ ("**Key Personnel**") as such Exhibit may be modified from time to time by mutual agreement of the Parties to meet the requirements of this Agreement. The Comptroller shall have the right to interview, as deemed necessary, and participate in the selection of the Contractor Key Personnel, and Contractor shall not designate any Contractor Key Personnel without the prior written consent of the Comptroller which consent shall not be unreasonably withheld. However, pending the Comptroller's approval of an individual proposed by Contractor to be a Contractor Key Personnel, Contractor may designate an individual to serve in that position on an interim basis. Key Personnel shall be assigned to this Project for the Key Personnel Assignment Term, as set forth in Exhibit___ ("Key Personnel"), or until their assignment is complete, whichever is earlier.

B. Key Personnel Assignment Term.

Key Personnel shall remain assigned to the Project for the period equal to work required of said Key Personnel as set forth in Exhibit ___ ("**Key Personnel Assignment Term**"). During the Key Personnel Assignment Term, Contractor shall not, without the prior written consent of the Comptroller, which consent shall not be unreasonably denied, reassign that individual except: (i) if Contractor and the Comptroller mutually determine that the individual has failed to adequately perform his or her duties; or (ii) if the function or position is no longer required under the provisions of this Agreement; or (iii) if reasons exist that are beyond Contractor's commercially reasonable ability to control.

C. Replacement of Key Personnel.

If any one of the Contractor Key Personnel is reassigned in accordance with the provisions above; becomes incapacitated; ceases to be employed by Contractor; or leaves the Project for any reason beyond Contractor's reasonable control and therefore becomes unable to perform the functions or responsibilities assigned to him or her, Contractor shall promptly replace such person with another qualified person approved by the Comptroller.

D. Comptroller Right to Review Subcontractors.

The Comptroller reserves the right to review Subcontractors for this Agreement and all such approved subcontractors shall be Approved Subcontractors, and to request that Contractor replace Approved Subcontractors who are found at any time to be reasonably unacceptable.

E. Contractor's Continuing Obligation Regarding Subcontractors.

Contractor shall have the continuing obligation to identify all of its Approved Subcontractors and, upon request, which shall not be unreasonably made by the Comptroller nor unreasonably denied by the Contractor, shall provide the Comptroller with copies of its contracts (financial terms redacted) with Approved Subcontractors.

F. Objections to Assignment of Personnel or Subcontractors.

In the event either the Comptroller or the Contractor has an objection to the assignment of personnel or a subcontractor, the Comptroller or the Contractor shall file the objection in writing with the reasons enumerated. The Comptroller and the Contractor shall jointly consult on corrective action and handle objections on a case-by-case basis. This provision shall not be deemed to give the Comptroller the right to require Contractor to terminate any Contractor employee or Approved Subcontractor; it is intended to give the State only the right to recommend that Contractor discontinue using an employee or Approved Subcontractor in the performance of Services rendered under this Agreement.

9. AGREEMENT AMENDMENTS.

No amendment to or modification or other alteration of the Agreement shall be valid or binding upon the Comptroller unless made in writing, signed by both Parties and, if applicable as solely determined by Comptroller and evidenced by Comptroller's inclusion of the appropriate signature block, approved by the Connecticut Attorney General.

10. ASSIGNMENT.

The Contractor shall not assign any of its rights or obligations under the Agreement, voluntarily or otherwise, in any manner without the prior written consent of the Comptroller which consent shall not be unreasonably withheld. The Comptroller may void any purported assignment in violation of this section and declare the Contractor in breach of Agreement. Any Termination by the Comptroller for a breach is without prejudice to the Comptroller's or the State's rights or possible Claims.

11. TERMINATION.

A. Notwithstanding any provisions in this Agreement, the Comptroller, through a duly authorized employee, may terminate the Agreement whenever the Comptroller makes a written determination that such Termination is in the best interests of the State. The Comptroller shall notify the Contractor in writing of termination pursuant to this section, which notice shall specify the effective date of termination and the extent to which the Contractor must complete its existing performance obligations under the Agreement prior to such date.

B. Upon receipt of a written notice of Termination from the Comptroller, the Contractor shall cease operations as the Comptroller directs in the notice, and take all actions that are necessary or appropriate, or that the Comptroller may reasonably direct, for the protection and preservation of the Records, as this term is defined in the Indemnification Section of this Agreement. Except for any work which the Comptroller directs the Contractor to perform in the notice prior to the effective date of Termination, and except as otherwise provided in the notice, the Contractor shall terminate or conclude all existing subcontracts and purchase orders and shall not enter into any further subcontracts, purchase orders or commitments.

C. The Comptroller shall, within forty-five (45) days of the effective date of termination, reimburse the Contractor for Services rendered by the Comptroller in accordance with this Agreement, and all actual and reasonable costs incurred after termination in completing those portions of the Services which the notice required the Contractor to complete. However, the Contractor is not entitled to receive and the Comptroller is not obligated to tender to the Contractor any payments for anticipated or lost profits. Upon request by the Comptroller, the Contractor shall assign to the Comptroller, or any replacement contractor which the Comptroller designates, all subcontracts, purchase orders and other commitments, deliver to the Comptroller all Comptroller Records and other information pertaining to its performance of the Services as necessary to facilitate the Comptroller or a third party to take over the provisioning of Services, and remove from State premises, whether leased or owned, all of Contractor's property, equipment,

waste material and rubbish related to its performance of the Services, all as the Comptroller may request.

D. Upon termination of the Agreement, all rights and obligations shall be null and void, so that no Party shall have any further rights or obligations to any other Party, except with respect to the sections which survive termination. All representations, warranties, agreements and rights of the Parties under the Agreement shall survive such termination to the extent not otherwise limited in the Agreement and without each one of them having to be specifically mentioned in the Agreement.

E. Termination of the Contract pursuant to this section shall not be deemed to be a breach of contract by the Comptroller.

12. BREACH.

If either Party breaches the Agreement in any material respect, the non-breaching Party shall provide written notice of such breach to the breaching Party and afford the breaching Party an opportunity to cure the breach within thirty (30) days from the date that the breaching Party receives such notice. Such right to cure period shall be extended if the non-breaching Party is satisfied that the breaching Party is making a good faith effort to cure but the nature of the breach is such that it cannot be cured within the right to cure period. The notice may include an effective Agreement termination date if the breach is not cured by the stated date and, unless otherwise modified by the non-breaching Party in writing prior to the termination date; no further action shall be required of any Party to effect the termination as of the stated date. If the notice does not set forth an effective Agreement termination date, then the non-breaching Party may terminate the Agreement by giving the breaching Party no less than thirty (30) days prior written notice.

13. WAIVER.

A. No waiver of any breach of the Agreement shall be interpreted or deemed to be a waiver of any other or subsequent breach. All remedies afforded in the Agreement shall be taken and construed as cumulative, that is, in addition to every other remedy provided in the Agreement or at law or in equity.

B. A Party's failure to insist on strict performance of any provision of the Agreement shall only be deemed to be a waiver of rights and remedies concerning that specific instance of performance and shall not be deemed to be a waiver of any subsequent rights, remedies or breach.

14. INDEMNIFICATION.

A. For the purposes of this section the following terms are defined as follows:

(i) "Claims" means all actions, suits, claims, demands, investigations, and proceedings of any kind, open, pending or threatened, whether mature, unmatured, contingent, known or unknown, at law or in equity, in any forum.

(ii) "Contractor Agent" means the Contractor's members, directors, officers, shareholders, partners, managers, principal officers, representatives, agents, servants, consultants, employees, or any one of them or any other person or entity with whom the Contractor is in privity of an oral or written contract and the Contractor intends for such person or entity to perform under the Agreement in any capacity.

(iii) "Records" means all working papers and such other information and materials as may be accumulated by the Contractor or Contractor Agents in performing the Agreement, including but not limited to, documents, data, plans, books, computations, drawings, specifications, notes, reports, records, estimates, summaries and correspondence, kept or stored in any form.

B. The Contractor shall indemnify, defend and hold harmless the State and its officers, representatives, agents, servants, successors and assigns from and against any and all:

(i) Claims arising, directly or indirectly, in connection with the Agreement, including acts of commission or omission (collectively, the Acts) of the Contractor or Contractor Agents; and

(ii) Liabilities, damages, losses, costs and expenses, including but not limited to, attorney's and other professionals' fees, arising, directly or indirectly, in connection with Claims, Acts or the Agreement.

C. The Contractor's obligations under this section to indemnify, defend and hold harmless against Claims includes Claims concerning confidentiality of any or all of the proposal or any Records, any intellectual property rights, other proprietary rights of any person or entity, copyrighted or un-copyrighted compositions, secret processes, patented or unpatented inventions or articles furnished or used in the performance of this Agreement.

D. The Contractor shall reimburse the State for any and all damages to the real or personal property of the State caused by Acts of the Contractor or any Contractor Agents. The State shall give the Contactor reasonable notice of any such Claims.

E. This section shall survive the Termination of the Agreement and shall not be limited or expanded by reason of any insurance coverage.

15. FORUM AND CHOICE OF LAW.

The Parties deem the Agreement to have been made in the City of Hartford, State of Connecticut. Both Parties agree that it is fair and reasonable for the validity and construction of the Agreement to be, and it shall be, governed by the laws and court decisions of the State of Connecticut, without giving effect to its principles of conflicts of laws. To the extent that any immunities provided by Federal law or the laws of the State of Connecticut do not bar an action against the State, and to the extent that these courts are courts of competent jurisdiction, for the

purpose of venue, the complaint shall be made returnable to the Judicial District of Hartford only or shall be brought in the United States District Court for the District of Connecticut only, and shall not be transferred to any other court, provided, however, that nothing here constitutes a waiver or compromise of the sovereign immunity of the State of Connecticut. The Contractor waives any objection which it may now have or will have to the laying of venue of any Claims in any forum and further irrevocably submits to such jurisdiction in any suit, action or proceeding.

16. FORCE MAJEURE.

The Comptroller and the Contractor shall not be excused from their obligation to perform in accordance with the Agreement except in the case of Force Majeure events and as otherwise provided for in the Agreement. In the case of any such Force Majeure exception, the nonperforming Party shall give immediate written notice to the other, explaining the cause and probable duration of any such nonperformance. Upon receipt of notice of failure or delay in performance caused by the Force Majeure, performance time shall be considered extended for at least a period of time equivalent to the time lost as a result of any such delay.

17. ADVERTISING.

The Contractor shall not refer to sales to the State for advertising or promotional purposes, including, but not limited to, posting any material or data on the Internet, without the Comptroller's prior written approval. Use of Contractor's name or logos, including a response to any public or media inquiries, are subject to Contractor's consent.

18. AMERICANS WITH DISABILITIES ACT.

The Contractor shall be and remain in compliance with the Americans with Disabilities Act of 1990 ("Act"), to the extent applicable, during the Term of the Agreement. The Comptroller may terminate the Agreement if the Contractor fails to comply with the Act.

19. DISCLOSURE OF CONTRACTOR PARTIES LITIGATION.

The Contractor shall require that all Contractor Parties, as appropriate, disclose to the Contractor, to the best of their knowledge, any Claims involving the Contractor Parties that might reasonably be expected to materially adversely affect their businesses, operations, assets, properties, financial stability, business prospects or ability to perform fully under the Agreement, no later than ten (10) Days after becoming aware of any such Claims. Disclosure shall be in writing.

20. ENTIRETY OF AGREEMENT.

The Agreement is the entire agreement between the Parties with respect to its subject matter, and supersedes all prior agreements, proposals, offers, counteroffers and understandings of the

Parties, whether written or oral. The Agreement has been entered into after full investigation, neither Party relying upon any statement or representation by the other unless such statement or representation is specifically embodied in the Agreement.

21. EXHIBITS.

All exhibits referred to in and attached to this Agreement are incorporated in this Agreement by such reference and shall be deemed to be a part of it as if they had been fully set forth in it.

22. EXECUTIVE ORDERS.

This Agreement is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings and Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace, all of which are incorporated into and are made a part of the Agreement as if they had been fully set forth in it. The Agreement may also be subject to Executive Order No. 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms and Executive Order No. 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services, in accordance with their respective terms and conditions. If Executive Orders 7C and 14 are applicable, they are deemed to be incorporated into and are made a part of the Agreement as if they had been fully set forth in it. At the Contractor's request, the Client COMPTROLLER or DAS shall provide a copy of these orders to the Contractor.

23. NON DISCRIMINATION AND AFFIRMATIVE ACTION PROVISIONS

(a) For purposes of this Section, the following terms are defined as follows:

(i) "Commission" means the Commission on Human Rights and Opportunities;

(ii) "Contract" and "contract" include any extension or modification of the Contract or contract;

(iii) "Contractor" and "contractor" include any successors or assigns of the Contractor or contractor;

(iv) "Gender identity or expression" means a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person's core identity or not being asserted for an improper purpose.

(v) "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations;

(vi) "good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements;

(vii) "marital status" means being single, married as recognized by the state of Connecticut, widowed, separated or divorced;

(viii) "mental disability" means one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", or a record of or regarding a person as having one or more such disorders;

(ix) "minority business enterprise" means any small contractor or supplier of materials fifty-one percent or more of the capital stock, if any, or assets of which is owned by a person or persons: (1) who are active in the daily affairs of the enterprise, (2) who have the power to direct the management and policies of the enterprise, and (3) who are members of a minority, as such term is defined in subsection (a) of Connecticut General Statutes § 32-9n; and

(x) "public works contract" means any agreement between any individual, firm or corporation and the State or any political subdivision of the State other than a municipality for construction, rehabilitation, conversion, extension, demolition or repair of a public building, highway or other changes or improvements in real property, or which is financed in whole or in part by the State, including, but not limited to, matching expenditures, grants, loans, insurance or guarantees.

For purposes of this Section, the terms "Contract" and “contract” do not include a contract where each contractor is (1) a political subdivision of the state, including, but not limited to, a municipality, (2) a quasi-public agency, as defined in Conn. Gen. Stat. Section 1-120, (3) any other state, including but not limited to any federally recognized Indian tribal governments, as defined in Conn. Gen. Stat. Section 1-267, (4) the federal government, (5) a foreign government, or (6) an agency of a subdivision, agency, state or government described in the immediately preceding enumerated items (1), (2), (3), (4) or (5).

(b)(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut; and the Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, mental retardation, mental disability or

physical disability, including, but not limited to, blindness, unless it is shown by the Contractor that such disability prevents performance of the work involved; (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the Commission; (3) the Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by the Commission, advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment; (4) the Contractor agrees to comply with each provision of this Section and Connecticut General Statutes §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes §§ 46a-56, 46a-68e and 46a-68f; and (5) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this Section and Connecticut General Statutes § 46a-56. If the contract is a public works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works projects.

(c) Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative advertising, recruitment and training; technical assistance activities and such other reasonable activities or efforts as the Commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

(d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the Commission, of its good faith efforts.

(e) The Contractor shall include the provisions of subsection (b) of this Section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes §46a-56; provided if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

(f) The Contractor agrees to comply with the regulations referred to in this Section as they exist on the date of this Contract and as they may be adopted or amended from time to time during the term of this Contract and any amendments thereto.

(g)(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation; (2) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the Commission on Human Rights and Opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment; (3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes § 46a-56; and (4) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor which relate to the provisions of this Section and Connecticut General Statutes § 46a-56.

(h) The Contractor shall include the provisions of the foregoing paragraph in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes § 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

24. ETHICS LAW SUMMARY.

Pursuant to the requirements of section 1-101qq of the Connecticut General Statutes, the summary of State ethics laws developed by the State Ethics Commission pursuant to section 1-81b of the Connecticut General Statutes is incorporated by reference into and made a part of this Agreement as if the summary had been fully set forth in this Agreement.

25. CAMPAIGN CONTRIBUTION RESTRICTIONS.

Pursuant to the requirements of Connecticut General Statutes §9-612(g)(2), as amended by P.A. 10-1, the authorized signatory to this Agreement expressly acknowledges receipt of the

State Elections Enforcement Commission's ("SEEC") notice advising State contractors of State campaign contribution and solicitation prohibitions, and will inform its Contractor Parties of the contents of the notice.

26. WORKERS' COMPENSATION.

Contractor agrees to carry sufficient workers' compensation and liability insurance with a company, or companies, licensed to do business in Connecticut, and furnish certificates if required.

27. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

(a) If the Contactor or Contractor Parties is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Contractor or Contractor Parties must comply with all terms and conditions of this Section of the Agreement. If the Contractor or Contractor Parties is not a Business Associate under HIPAA, this Section of the Agreement does not apply to the Contractor or Contractor Parties for this Agreement.

(b) The Contractor or Contractor Parties is required to safeguard the use, publication and disclosure of information on all applicants for, and all clients who receive, services under the Agreement in accordance with all federal and state law regarding confidentiality applicable to Contractor or Contractor Parties, which includes but is not limited to HIPAA, more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E; and

(c) The Client COMPTROLLER is a "covered entity" as that term is defined in 45 C.F.R. § 160.103; and

(d) The Contractor or Contractor Parties, on behalf of the Client COMPTROLLER, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. § 160.103; and

(e) The Contractor or Contractor Parties is a "business associate" of the Department, as that term is defined in 45 C.F.R.§ 160.103; and

(f) The Contractor or Contractor Parties and the Client COMPTROLLER agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the HITECH Act), (Pub. L. 111-5, sections 13400 to 13423), and more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E.

(g) Definitions. For the purposes of this Section of the Agreement:

(1) "Breach" shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(1)).'

(2) “Business Associate” shall mean the Contractor or Contractor Parties.
(3) “Covered Entity” shall mean the Client COMPTROLLER.
(4) “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. § 164.501.
(5) “Electronic Health Record” shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(5)).
(6) “Individual” shall have the same meaning as the term “individual”’ in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. § 164.502(g).
(7) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.
(8) “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to information created or received by the Business Associate from or on behalf of the Covered Entity.
(9) “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
(10) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.
(11) “More stringent” shall have the same meaning as the term “more stringent” in 45 C.F.R. § 160.202.
(12) “This Section of the Agreement” refers to the HIPAA Provisions stated herein, in their entirety.
(13) “Security Incident” shall have the same meaning as the term “security incident” in 45 C.F.R.§ 164.304.
(14) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. part 160 and part 164, subpart A and C.
(15) “Unsecured protected health information” shall have the same meaning as the term as defined in § 13402(h)(1)(A) of HITECH. Act. (42 U.S.C. §17932(h)(1)(A).

(h) Obligations and Activities of Business Associates.

(1) Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Agreement, as directed by the Covered Entity, or as Required by Law.

(2) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Agreement.

(3) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

(4) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Agreement.

(5) Business Associate agrees to report to Covered Entity any use or disclosure of PHI in its possession not provided for by this Section of the Agreement or any security incident of which it becomes aware provided that notice is hereby deemed given for Unsuccessful Security Incidents and no further notice of such Unsuccessful Security Incidents will be given. "Unsuccessful Security Incidents" include but are not limited to firewall pings and other broadcast attacks, port scans, unsuccessful log-on attempts, denial-of-service attacks, and any combination of the foregoing that do not result in unauthorized access, acquisition, use or disclosure of PHI.

(6) Business Associate agrees to insure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same restrictions and conditions that apply through this Section of the Agreement to Business Associate with respect to such information.

(7) Business Associate agrees to provide access, at the request of the Covered Entity, and in the time and manner agreed to by the parties, to PHI in a Designated Record Set maintained by Business Associate, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524.

(8) Business Associate agrees to make any amendments to PHI in a Designated Record Set maintained by Business Associate that the Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of the Covered Entity, and in the time and manner agreed to by the parties.

(9) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by, Business Associate on behalf of Covered Entity, available to the Secretary during normal business hours in a manner reasonably designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. Upon reasonable advance written notice to Business Associate that Covered Entity is subject to an investigation by the Secretary regarding the Covered Entity's compliance with the Privacy Rule, subject to any applicable privileges and if permitted by law, Business Associate agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by, Business Associate on behalf of Covered Entity, available to the Covered Entity in a reasonable time and manner agreed to by the parties during Business Associate's normal business hours, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(10) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(11) Business Associate agrees to provide to Covered Entity, in a time and manner agreed to by the parties, information collected in accordance with clause h. (10) of this Section of the Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §

164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder. Business Associate agrees that at the Covered Entity's direction to provide an accounting of disclosures of PHI directly to an individual in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

(12) Business Associate agrees to comply with applicable Connecticut state law that is more stringent than the Privacy Rule but only to the extent that the Privacy Rule does not preempt the Connecticut law.

(13) Business Associate agrees to comply with the requirements of the HITECH Act relating to privacy and security that are applicable to the Covered Entity pursuant to the requirements of 45 C.F.R. sections 164.504(e), 164.308, 164.310, 164.312, and 164.316.

(14) In the event that an individual requests that the Business Associate (a) restrict disclosures of PHI; (b) provide an accounting of disclosures of the individual's PHI; or (c) provide a copy of the individual's PHI in an electronic health record, the Business Associate agrees to notify the covered entity, in writing, within five (5)business days of the request.

(15) Business Associate agrees that it shall not directly or indirectly receive any remuneration in exchange for the sale of PHI as defined in 45 C.F.R § 164.502(a)(5)(ii)(B)of an individual without (1) the written approval of the covered entity, unless receipt of remuneration in exchange for PHI is expressly authorized by this Agreement and (2) the valid authorization of the individual, except for the purposes provided under section 13405(d)(2) of the HITECH Act,(42 U.S.C. § 17935(d)(2)) and in any accompanying regulations.

(16) Obligations in the Event of a Breach

(A)The Business Associate agrees that, following the discovery of a breach of unsecured protected health information, it shall notify the Covered Entity of such breach in accordance with the requirements of section 13402 of HITECH (42 U.S.C. § 17932(b) and the provisions of this section of the Agreement.

(B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to section 13402 (g) of HITECH (42 U.S.C. § 17932(g)) . A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate. The notification shall include the identification and last known address, phone number and email address of each individual (or the next of kin of the individual if the individual is deceased) to the extent such information is reasonably available to Business Associate whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed in a manner not consistent with this Agreement and the Privacy Rule and Security Rule during such breach.

(C) The Business Associate agrees to include in the notification to the Covered Entity at least the following information:

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
4. A detailed description of what the Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.
5. Whether a law enforcement official has advised either verbally or in writing the Business Associate that he or she has determined that notification or notice to individuals or the posting required under section 13402 of the HITECH Act would impede a criminal investigation or cause damage to national security and contact information for said official to the extent that Business Associate is legally permitted to disclose such information.
(D)Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed by the Covered Entity of a breach by the Business Associate have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Costs of such contact procedures will be borne by the Contractor or Contractor Parties.
(E) Business Associate agrees that, in the event of a breach caused by the negligent actions of Business Associate and failure to comply with laws applicable to it, it has the burden to demonstrate that it has complied with all notifications requirements set forth above, including evidence demonstrating the necessity of a delay in notification to the Covered Entity.

(i) Permitted Uses and Disclosure by Business Associate.

(1) General Use and Disclosure Provisions Except as otherwise limited in this Section of the Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.
(2) Specific Use and Disclosure Provisions.

(A)Except as otherwise limited in this Section of the Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(B) Except as otherwise limited in this Section of the Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Section of the Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(j) Obligations of Covered Entity.

(1) to obtain in writing any individual's consent, authorization, and other permissions that may be necessary or required by applicable laws in order to transfer or disclose the PHI to Business Associate
(2) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. § 164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
(3) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
(4) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R.§ 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(k) Permissible Requests by Covered Entity.

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Covered Entity, except that Business Associate may use and disclose PHI for data aggregation, and management and administrative activities of Business Associate, as permitted under this Section of the Agreement.

(l) Term and Termination.

(1) Term. The Term of this Section of the Agreement shall be effective as of the date the Agreement is effective and shall terminate when the information collected in accordance with clause h. (10) of this Section of the Agreement is provided to the Covered Entity and all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(2) Termination for Cause upon either Party's (non-breaching party) knowledge of a material breach by the other Party, the non-breaching Party shall either:

(A)Provide a thirty (30) day opportunity for the breaching Party to cure the breach and terminate the Agreement if Business Associate does not cure the breach within the cure period; or

(B) Immediately terminate the Agreement if a Party has breached a material term of this Section of the Agreement and cure is not possible; or

(C) If neither termination nor cure is feasible, the non-breaching Party shall report the violation to the Secretary as required under HIPAA.

(3) Effect of Termination.

(A)Except as provided in (l)(2) above, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity,

or created or received by Business Associate on behalf of Covered Entity. Business Associate shall also provide the information collected in accordance with clause h. (10) of this Section of the Agreement to the Covered Entity within ten business days of the notice of termination. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Except as set forth in Section 3(B) below, Business Associate shall retain no copies of the PHI.

(B) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon documentation by Business Associate that return of destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Agreement to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.

(m) Miscellaneous Provisions.

(1) Regulatory References. A reference in this Section of the Agreement to a section in the Privacy Rule means the section as in effect or as amended.
(2) Amendment. The Parties agree to take such action and shall reasonably cooperate as is necessary to amend this Section of the Agreement from time to time as is necessary for Covered Entity to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191provided, however, that if a change represents a material Change in Services, the Parties will address it utilizing the change control procedures set forth in Section 8 of this Agreement.
(3) Survival. The respective rights and obligations of the Parties shall survive the termination of this Agreement.
(4) Effect on Agreement. Except as specifically required to implement the purposes of this Section of the Agreement, all other terms of the Agreement shall remain in force and effect.
(5) Construction. This Section of the Agreement shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the Agreement shall be resolved in favor of a meaning that complies, and is consistent with, the Privacy Standard.
(6) Indemnification. The Business Associate shall indemnify, defend and hold harmless the Covered Entity for all civil penalties imposed on the Covered Entity by the Secretary or equivalent State entity pursuant to HIPAA or HITECH and regulations promulgated thereunder, in each case, to the extent that such civil penalties arise from the unauthorized use or disclosure of PHI to the extent attributable to Business Associate.

28. WHISTLE BLOWING.

This Agreement may be subject to the provisions of Section 4-61dd of the Connecticut General Statutes. In accordance with this statute, if an officer, employee or appointing authority of the Contractor takes or threatens to take any personnel action against any employee of the

Contractor in retaliation for such employee's disclosure of information to any employee of the contracting state or quasi-public Comptroller or the Auditors of Public Accounts or the Attorney General under the provisions of subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars for each offense, up to a maximum of twenty per cent of the value of this Agreement. Each violation shall be a separate and distinct offense and in the case of a continuing violation, each calendar day's continuance of the violation shall be deemed to be a separate and distinct offense. The State may request that the Attorney General bring a civil action in the Superior Court for the Judicial District of Hartford to seek imposition and recovery of such civil penalty. In accordance with subsection (f) of such statute, each large state contractor, as defined in the statute, shall post a notice of the provisions of the statute relating to large state contractors in a conspicuous place which is readily available for viewing by the employees of the Contractor.

29. NOTICE.

All notices, demands, requests, consents, approvals or other communications required or permitted to be given or which are given with respect to this Agreement (for the purpose of this section collectively called "Notices") shall be deemed to have been effected at such time as the notice is placed in the U.S. mail, first class and postage prepaid, return receipt requested, or, placed with a recognized, overnight express delivery service that provides for a return receipt. All such Notices shall be in writing with a copy of the same faxed or emailed to the receiving Party's Project Manager, and shall be addressed as follows:

If to the Comptroller:

State of Connecticut, Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775
Attention: _____

If to the Contractor:

[CONTRACTOR]
[ADDRESS]
[Attention:_____]

30. INSURANCE.

Before commencing performance of Services, the Contractor shall maintain at its own cost and expense for the Term of the Agreement, the following insurance as described in this section. Contractor shall assume any and all deductibles in the described insurance policies. Any failure to comply with the claim reporting provisions of the policy shall not affect coverage provided to the State.

A. Commercial General Liability: $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage. Coverage shall include Premises and

Operations, Independent Contractors, Products and Completed Operations, Contractual Liability and Broad Form Property Damage coverage. If a general aggregate is used, the general aggregate limit shall apply separately to the work covered by this Agreement or the general aggregate limit shall be twice the occurrence limit.

B. Automobile Liability: $1,000,000 combined single limit per accident for bodily injury. Coverage extends to owned, hired and non-owned automobiles. If the Contractor does not own an automobile, but one is used in the performance of the Services, then only hired and non-owned coverage is required. If a vehicle is not used in the performance of the Services, then automobile coverage is not required.

C. Workers' Compensation and Employers Liability: Statutory coverage in compliance with the Compensation laws of the State of Connecticut. Coverage shall include Employer's Liability with minimum limits of $100,000 each accident, $500,000 Disease–Policy limit, $100,000 each employee.

D. Professional Liability: The Contractor shall secure and maintain, at no cost or expense to the State, a professional liability insurance policy in a form acceptable to the Comptroller in the minimum amount of ten million dollars ($10,000,000.00) with a deductible not to exceed fifty thousand dollars ($50,000.00). The policy shall insure the Contractor against damages and costs resulting from negligent acts, errors or omissions in the work performed by the Contractor on and after the effective date of, and under the terms of, this Agreement. The Contractor may, at its election, obtain a policy containing a maximum of fifty thousand dollars ($50,000.00) deductible clause, but if so, the Contractor shall be liable, as stated above herein, to the extent of the deductible amount.

E. Contractor agrees to furnish to the State a "Certificate of Insurance" in conjunction with all insurance required by this Agreement, fully executed by an insurance company or companies or insurance broker, for the insurance policies required herein, which policies or policy shall be in accordance with the terms of said Certificate of Insurance.

31. HEADINGS.

The headings given to the sections in the Agreement are inserted only for convenience and are in no way to be construed as part of the Agreement or as a limitation of the scope of the particular section to which the heading refers.

32. NUMBER AND GENDER.

Whenever the context so requires, the plural or singular shall include each other and the use of any gender shall include all genders.

33. FURTHER ASSURANCES.

The Parties shall provide such information, execute and deliver instruments and documents and take such other actions, all as may be required by law or reasonably requested by the other

Party which are not inconsistent with the provisions of this Agreement and which do not involve the vesting of rights or assumption of obligations other than those provided for in the Agreement, in order to give full effect to the Agreement and to carry out the intent of the Agreement.

34. AUDIT AND INSPECTION OF PLANTS, PLACES OF BUSINESS AND RECORDS.

A. The State and its agents, including, but not limited to, the Connecticut Auditors of Public Accounts, Attorney General and State's Attorney and their respective agents, may, during normal business hours and subject to Contractor's standard security protocols, inspect and examine all of the parts of the Contractor's and Contractor Parties' plants and places of business which are used in the performance of this Agreement. In no event shall any audit permitted under this Agreement be conducted by a Contractor competitor.

B. The Contractor shall maintain, and shall require each of its Approved Subcontractors to maintain, accurate and complete Contractor Records in accordance with generally accepted accounting principles. The Contractor shall make, and require its Approved Subcontractors to make, those records required to support invoiced amounts and verify compliance with the terms of this Agreement ("Contractor Records"), available during normal business hours for audit and inspection by the State and its agents.

C. The State shall make all requests for any audit or inspection in writing and shall provide the Contractor with at least forty-eight (48) hours' notice prior to the requested audit and inspection date. If the State suspects fraud or other abuse, or in the event of an emergency, the State is not obligated to provide any prior notice.

D. All audits and inspections shall be at the State's expense.

E. The Contractor shall keep and preserve or cause to be kept and preserved all of its and Contractor Records until three (3) years after the latter of (i) final payment under this Agreement, or (ii) the expiration or earlier termination of this Agreement, as the same may be modified for any reason. The State may request an audit or inspection in accordance with the terms of this Agreement at any time during this period. If any Claim or audit is started before the expiration of this period, the Contractor shall retain or cause to be retained all Contractor Records until all Claims or audit findings have been resolved. Contractor Records shall be and remain Contractor Proprietary Information.

F. The Contractor shall exercise commercially reasonable efforts to cooperate fully with the State and its agents in connection with an audit or inspection. Following any audit or inspection, the State may conduct and the Contractor shall exercise commercially reasonable efforts to cooperate with an exit conference.

G. The Contractor shall incorporate this entire Section verbatim into any contract or other agreement that it enters into expressly for purposes of providing Services under this Agreement, with any Contractor Party.

35. CONTINUED PERFORMANCE.

If reasonably practical, both Parties shall continue to perform their obligations under the Agreement while any dispute concerning the Agreement is being resolved.

36. SEVERABILITY.

If any term or provision of the Agreement or its application to any person, entity or circumstance shall, to any extent, be held to be invalid or unenforceable, the remainder of the Agreement or the application of such term or provision shall not be affected as to persons, entities or circumstances other than those as to whom or to which it is held to be invalid or unenforceable. Each remaining term and provision of the Agreement shall be valid and enforced to the fullest extent possible by law.

37. PROPRIETARY INFORMATION.

A. In connection with the Services provided under this Agreement, the Comptroller and the Contractor each may be given access to information that relates to the other Party's past, present and future research, development, business activities, products, services, and technical knowledge (hereinafter "**Proprietary Information**"). Notwithstanding the foregoing, the term "Proprietary Information" will not include any information that identifies or directly relates to natural persons ("**Personal Data**"), and the terms of this Section and other provisions of this Agreement generally applicable to Proprietary Information will not be deemed to apply to Personal Data unless specifically stated otherwise.

B. Each Party's Proprietary Information will remain the confidential information of that Party except as otherwise expressly provided in this Agreement. The Parties agree that they shall each protect the Proprietary Information of the other Party in the same manner as it protects its own Proprietary Information of like kind but with not less than reasonable care. Proprietary Information shall include, but is not limited to, all information clearly marked as "Proprietary" or in such other manner which gives notice of its proprietary or confidential nature, or is identified as such at the time it is disclosed (either orally or in writing), or contains information that a reasonable person in like circumstance would understand to be confidential.

C. Each Party may disclose relevant aspects of the other Party's Proprietary Information to its employees, Affiliates, Approved Subcontractors and agents to the extent such disclosure is reasonably necessary for the performance of its obligations, or the enforcement of its rights, under this Agreement; provided, however, that such Party will be responsible for its employees, Affiliates, Approved Subcontractors or agents' compliance with these confidentiality provisions.

D. Neither Party will (i) make or use any copies of the Proprietary Information of the other except as contemplated by this Agreement; or (ii) acquire any right in or assert any lien against the Proprietary Information of the other; or (iii) sell, assign, lease or otherwise commercially exploit the Proprietary Information of the other Party. Neither Party may

withhold the Proprietary Information of the other Party or refuse for any reason (including due to the other Party's actual or alleged breach of this Agreement) to promptly return to the other Party its Proprietary Information (including copies thereof) if requested to do so. Upon expiration or termination of this Agreement and completion of a Party's obligations under this Agreement, each Party will, at the request of the other Party, (and except as otherwise provided in this Agreement) return or destroy, as the other Party may direct, all documentation in any medium that contains or refers to the other Party's Proprietary Information, and retain no copies. Subject to the foregoing confidentiality obligations, either Party may retain copies of the Proprietary Information of the other Party to the extent required for (i) in the case of Accenture, compliance with applicable professional standards or quality assurance purposes and (ii) in the case of the COMPTROLLER, as required to give effect to any licensing rights of Accenture Intellectual Property as set forth herein.

E. Proprietary Information shall not include information which:

(i) is or becomes a part of the public domain through no act or omission of the receiving Party;

(ii) was in the receiving Party's lawful possession prior to the disclosure and had not been obtained by the receiving Party either directly or indirectly from the disclosing Party;

(iii) is (to the receiving Party's knowledge) lawfully disclosed by a third party without restriction on disclosure;

(iv) is independently developed by the receiving Party;

(v) is disclosed by operation of law, or is required to be disclosed by law, rule or regulation, subpoena, summons, or order of a court of competent jurisdiction, or by a regulatory oversight agency, pursuant to the following: if the receiving Party receives a subpoena or other validly issued administrative or judicial process requesting Proprietary Information of the disclosing Party, it will promptly notify the disclosing Party of such receipt and tender to the disclosing Party the defense of such subpoena or process. If requested by the disclosing party, the receiving Party will reasonably cooperate (at the expense of the disclosing Party) in opposing such subpoena or process. Unless the subpoena or process is timely limited, quashed or extended, the receiving Party will then be entitled to comply with such request to the extent permitted by law; or,

(vi) is Personal Data, which is separately defined and addressed in Section 51 below and other provisions of this Agreement generally applicable to Proprietary Information shall not be deemed to apply to include Personal Data.

F. Nothing contained in this Section will be construed as obligating a Party to disclose its Proprietary Information to the other Party, or as granting to or conferring on a Party,

expressly or impliedly, any rights or license to the Proprietary Information of the other Party.

38. FREEDOM OF INFORMATION.

The Comptroller will afford due regard to the Contractor's request for the protection of proprietary or confidential information which the Comptroller receives. However, all materials associated with the Agreement are subject to the terms of the Connecticut Freedom of Information Act ("FOIA") and all corresponding rules, regulations and interpretations. If a FOIA request is made for materials or information that is Proprietary Information Comptroller will provide the Contractor with an opportunity to provide a written rationale in accordance with FOIA as to why the requested information should not be furnished pursuant to FOIA. In making such a request, the Contractor may not merely state generally that the materials are proprietary or confidential in nature and not, therefore, subject to release to third parties. Those particular sentences, paragraphs, pages or sections that the vendor believes are exempt from disclosure under the FOIA must be specifically identified as such. Convincing explanation and rationale sufficient to justify each exemption consistent with the FOIA must accompany the request. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the Contractor that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the FOIA. Comptroller agrees to furnish only that portion of the Proprietary Information that Comptroller is legally required to furnish. To the extent that any other provision or part of the Agreement, conflicts or is in any way inconsistent with this section, this section controls and shall apply and the conflicting provision or part shall not be given effect. If the Contractor indicates that certain documentation is submitted in confidence, by specifically and clearly marking said documentation as "**CONFIDENTIAL,"** the Comptroller will endeavor to keep said information confidential to the extent permitted by law. The Comptroller, however, has no obligation to initiate, prosecute or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information that is sought pursuant to a FOIA request. The Contractor shall have the burden of establishing the availability of any FOIA exemption in any proceeding where it is an issue. In no event shall the Comptroller or the State have any liability for the disclosure of any documents or information in its possession which the Comptroller reasonably believes are required to be disclosed pursuant to the FOIA or other requirements of law.

39. PERSONAL DATA.

A. Each Party will exercise commercially reasonable efforts not to disclose any Personal Data to the other Party and to restrict the other Party's access to its Personal Data, but if a Party is given access to the other Party's Personal Data, the receiving Party will protect such Personal Data using a reasonable standard of care. If Contractor requires access to Personal Data in connection with this Agreement or any amendments thereto, the Comptroller shall expressly identify the type of files and data which shall comprise Personal Data and which shall be accessed and/or processed by Contractor under this Agreement, and the means and circumstances by which it will be accessed or processed.

The Comptroller shall use commercially reasonable efforts to restrict Contractor's access to Personal Data to that described in this Agreement. In addition to the restrictions on use of Personal Data expressly provided for herein, the State and Comptroller alone will determine the purposes for which and the manner in which all Personal Data processed by Contractor will be processed under any applicable data privacy laws and regulations in connection with this Agreement.

B. Contractor is a data processor on behalf of the State under this Agreement. In that capacity, Contractor will:

(i) process State Personal Data only on written instructions of the State and to the extent reasonably necessary for the performance of this Agreement;

(ii) not disclose State Personal Data to any person except as required or permitted by this Agreement or with the State's prior written consent; and

(iii) implement commercially reasonable technical and organizational measures, including any additional measures specified by the State in advance and in writing, to protect State Personal Data against accidental or unlawful destruction or accidental loss, alteration, unauthorized disclosure or access, and against all other unlawful forms of processing. The State will be responsible for the sufficiency of such policies and safeguards. However, to the extent such additional technical and organizational measures have not been established by the State, Contractor will maintain safeguards no less rigorous than those maintained by Contractor for its own similar personal data.

C. Contractor may retain archival copies of State Personal Data, upon approval by the Comptroller, to the extent reasonably necessary to verify Contractor's compliance with this Agreement. Contractor will identify such data to the Comptroller at the time such archival copies are established.

D. Contractor may, as a result of this Agreement and its dealings with the Comptroller, come to possess Personal Data in relation to the Comptroller and the Comptroller's employees, directors, officers and other representatives. Contractor may receive such data from such persons, the Comptroller, or from other sources (for example, published or publicly available directories); and some limited data may be recorded indirectly by internal security and communication systems or by other means (for example, visitor logs maintained by security officials at Contractor's offices). Subject to compliance with the applicable data protection and data privacy legislation, Contractor may use and disclose such data for purposes connected with this Agreement and for the relevant purposes specified in the Accenture Data Privacy Policy (a copy of which is available on request) provided such policy is in compliance with applicable data privacy laws and the scope of such processing is directly related to the provision of services to the State or Accenture's dealings with the State or Accenture's internal business purposes. In particular, Accenture may for these purposes transfer such data to other Accenture entities around the world in compliance with the applicable data protection and data privacy legislation.

40. INTERPRETATION.

The Agreement contains numerous references to statutes and regulations. For purposes of interpretation, conflict resolution and otherwise, the content of those statutes and regulations shall govern over the content of the reference in the Agreement to those statutes and regulations.

41. CONFIDENTIAL INFORMATION; PROTECTION; BREACH.

A. **"Confidential Information"** shall mean any name, number or other information that may be used, alone or in conjunction with any other information, to identify a specific individual including, but not limited to, such individual's name, date of birth, mother's maiden name, motor vehicle operator's license number, Social Security number, employee identification number, employer or taxpayer identification number, alien registration number, government passport number, health insurance identification number, demand deposit account number, savings account number, credit card number, debit card number or unique biometric data such as fingerprint, voice print, retina or iris image, or other unique physical representation. Without limiting the foregoing, Confidential Information shall also include any information that the Board classifies as "confidential" or "restricted." Confidential Information shall not include information that may be lawfully obtained from publicly available sources or from federal, state, or local government records which are lawfully made available to the general public.

B. **"Confidential Information Breach"** shall mean an instance where an unauthorized person or entity accesses Confidential Information in any manner, including but not limited to the following occurrences: (1) any Confidential Information that is not encrypted or protected is misplaced, lost, stolen or in any way compromised; (2) one or more third parties have had access to or taken control or possession of any Confidential Information that is not encrypted or protected without prior written authorization from the State; (3) the unauthorized acquisition of encrypted or protected Confidential Information together with the confidential process or key that is capable of compromising the integrity of the Confidential Information; or (4) if there is a substantial risk of identity theft or fraud to the client, the Contractor, the Board or State.

C. Contractor and Contractor Parties, at their own expense, have a duty to and shall protect from a Confidential Information Breach any and all Confidential Information which they come to possess or control, wherever and however stored or maintained, in a commercially reasonable manner in accordance with current industry standards.

D. Each Contractor or Contractor Party shall implement and maintain a comprehensive data security program for the protection of Confidential Information. The safeguards contained in such program shall be consistent with and comply with the safeguards for protection of Confidential Information, and information of a similar character, as set forth

in all applicable federal and state law and written policy of the Board or State concerning the confidentiality of Confidential Information. Such data-security program shall include, but not be limited to, the following:

(i) A security policy for employees related to the storage, access and transportation of data containing Confidential Information;

(ii) Reasonable restrictions on access to records containing Confidential Information, including access to any locked storage where such records are kept;

(iii) A process for reviewing policies and security measures at least annually;

(iv) Creating secure access controls to Confidential Information, including but not limited to passwords; and

(v) Encrypting of Confidential Information that is stored on laptops, portable devices or being transmitted electronically.

E. The Contractor and Contractor Parties shall notify the Department and the Connecticut Office of the Attorney General as soon as practical, but no later than twenty-four (24) hours, after they become aware of or suspect that any Confidential Information which Contractor or Contractor Parties possess or control has been subject to a Confidential Information Breach.

F. If a Confidential Information Breach has occurred, the Contractor shall, within three (3) business days after the notification, present a credit monitoring and protection plan to the Connecticut Commissioner of Administrative Services, the Board and the Connecticut Office of the Attorney General, for review and approval.

(i) Such credit monitoring or protection plan shall be made available by the Contractor at its own cost and expense to all individuals affected by the Confidential Information Breach.

(ii) Such credit monitoring or protection plan shall include, but is not limited to reimbursement for the cost of placing and lifting one (1) security freeze per credit file pursuant to Connecticut General Statutes § 36a-701a.

(iii) Such credit monitoring or protection plans shall be approved by the State in accordance with this Section and shall cover a length of time commensurate with the circumstances of the Confidential Information Breach.

G. The Contractors' costs and expenses for the credit monitoring and protection plan shall not be recoverable from the Board, any State of Connecticut entity or any affected individuals.

H. The Contractor shall incorporate the requirements of this Section in all subcontracts requiring each Contractor Party to safeguard Confidential Information in the same manner as provided for in this Section.

42. SOVEREIGN IMMUNITY.

The Parties acknowledge and agree that nothing in the RFP or the Agreement shall be construed as a modification, compromise or waiver by the State of any rights or defenses of any immunities provided by Federal law or the laws of the State of Connecticut to the State or any of its officers and employees, which they may have had, now have or will have with respect to all matters arising out of the Agreement. To the extent that this section conflicts with any other section, this section shall govern.

43. NON-SOLICITATION.

Contractor and the Comptroller agree that neither Party shall directly or indirectly solicit for employment any employee of the other Party. This clause shall remain in effect during the term of this Agreement and for a period of one year after the Term of this Agreement, unless prior written consent of the other Party is first obtained. Notwithstanding the foregoing, this Section will not apply to employees who independently respond to indirect solicitations (i.e., general newspaper advertisements and internet postings).

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IN WITNESS WHEREOF, the Parties have executed this Agreement by their duly authorized representatives with full knowledge of and agreement with its terms and conditions.

[CONTRACTOR]

By:_____
Name:
Title:
Date:

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER

By:_____
Name: Kevin Lembo
Title: Comptroller
Date:

Approved as to form:

_____
State of Connecticut
Attorney General's Office
Date:_____

ATTACHMENT H

BID EXCEPTIONS / DEVIATIONS DOCUMENT

BID EXCEPTIONS / DEVIATIONS DOCUMENT

Completion of this proposal confirms authorization of your ability to duplicate requested benefits and administrative arrangements. If you are unable to meet ALL requirements and/or are not able to fully comply with the specifications in this Request for Proposal (RFP), please list ALL explanations, limitations, exceptions, and deviations below. Add rows as necessary.

Do Not Change the Formatting of this document. Additional lines may be added, as necessary.

Proposing Company: _____

	Question #	Question Text	Exception/Deviation
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