Third Party Administration Services Contract

This Third Party Administration Services Contract (Contract) is made by and between the Mississippi State and School Employees Health Insurance Management Board (Board), acting administratively through the Mississippi Department of Finance and Administration (MDFA), and [Insert] (Contractor), effective January 1, 2023, under which the Contractor agrees to provide administration services to the Mississippi State and School Employees' Life and Health Insurance Plan (Plan), subject to the following terms and conditions:

1. Identity of and Relationship between the Parties

A. [Insert] (the TPA), a corporation organized under the laws of the State of [Insert], is an organization capable of providing third party medical claims administration and related services as herein described, including any provider network services administratively through its wholly-owned subsidiary, [Insert].

B. The Board acting administratively through the MDFA, an agency of the State of Mississippi, administers the Plan. MDFA Office of Insurance (OI) acts on behalf of the Board in executing the Board's daily operational responsibilities concerning the Plan's administration.

C. The TPA and the Board are independent legal entities. Nothing in this Contract shall be construed to create the relationship of employer and employee or principal and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Contract.

D. Neither the TPA, the Board, nor any of their respective agents or employees shall control or have any right to control the activities of the other party in carrying out the terms of this Contract, nor shall either party, its respective agents or employees, be liable to third parties for any act or omission of the other party.

E. Nothing in this Contract is intended to be construed, nor shall it be deemed to create, any right or remedy in any third party.

2. Definitions

A. "Allowable Charge" means the lesser of the submitted charge or the amount established by the Plan, as provided through network contract(s) with a participating Provider or based on analysis of Provider charges for non-participating Providers, as the maximum amount for all such Provider services covered under the terms of the Plan.

B. "Third Party Administrator" or "TPA" means the organization under contract to the Board responsible for providing medical claims administration and provider network services.

C. "Complete Claim" means necessary information required by the TPA to adjudicate the claim.

D. "Confidential Business Information" of a party means all information concerning such party's properties, products, services, employees, finances, businesses and operations, including, without limitation, all information, in whatever form embodied, relating to such party's Creations, but excluding information which (i) is already known to the receiving party or is publicly available at the time of disclosure; (ii) is disclosed to the receiving party by a third party who is not in breach of

an obligation of confidentiality; or (iii) becomes publicly available after disclosure through no act of the receiving party.

E. "Health Information Technology for Economic and Clinical Health Act" (HITECH) shall refer to the portion of the "American Recovery and Reinvestment Act" (ARRA) of 2009 that addresses the privacy and security concerns associated with the electronic transmission of Protected Health Information.

F. "Health Insurance Portability and Accountability Act (HIPAA)" shall refer to the Health Insurance Portability and Accountability Act of 1996, as amended.

G. "Health Management" or "HM" means the provision of utilization review, including, but not limited to, hospital management services, continued stay management, discharge planning, retrospective review, outpatient diagnostic test review, pre-admission and post-discharge outreach, and medical review to determine medical necessity for specified medical services, the most appropriate setting, appropriate treatment and, where applicable, an appropriate length of stay. "Health Management" or "HM" also means the provision of wellness/health promotion, medical case management, disease management, and out-of-network review.

H. "Hospital Services" means acute care inpatient and hospital outpatient services or supplies for which payment may be sought under the terms of the Plan. "Hospital Services" do not include long-term, non-acute care inpatient services.

I. "Medical Services" means patient care services or supplies for which payment may be sought under the terms of the Plan, other than Hospital Services.

J. "Network" refers to the TPA's responsibility for direct network contracting services for the development and maintenance of a provider network.

K. "Participant" means an individual (active or retired employee, or covered dependent) who is eligible to receive health care services for which payment may be sought under the terms of the Plan.

L. "Plan" means the self-insured *Mississippi State and School Employees' Life and Health Insurance Plan* as defined in Mississippi Code Annotated §§ 25-15-1 *et seq.* (1972, as amended).

M. "*Plan Document*" (PD) is the document that states the benefits and eligibility terms of the Plan. This document is published and maintained by the Board.

N. "Provider" means a physician or other medical practitioner, health care professional, or facility as defined in the *Plan Document*.

3. Responsibilities of the TPA

This section contains information on services and procedures the TPA must provide, or adhere to, in servicing the Board's account, either directly or through identified subcontractors. The applicable *Plan Document* provides specific details of the Plan and is located on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/.

The TPA agrees to perform all services required in this Contract in accordance with customary and reasonable industry standards as well as in strict conformance to all laws, statutes, and ordinances and the applicable rules, regulations, methods and procedures of all government boards, bureaus, offices, and other agents whether currently in place, updated and replaced, or newly created. The TPA shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this Contract shall negate compliance with any applicable governing regulation. The absence of detail specifications or the omission of detail description shall be recognized as meaning that only the best commercial practices are to prevail and that only first quality materials and workmanship are to be used.

The TPA shall provide the following services:

A. Dedicated Account Service

All services performed on behalf of the Board and that is directly related to this Contract must be provided from an office located within the United States. A Service Center must be located in Mississippi to serve the Board, employer units, providers and participants. When the Board provides the TPA with written notification of a significant issue, the TPA will respond in writing to the Board with the resolution of the issue or an explanation of when the issue can be resolved, with a defined timetable, within an average (as measured on an annual basis) of two (2) business days. The TPA agree to operate a Service Center in Mississippi to include at a minimum, exclusive provider and participant customer service, enrollment and billing support functions, account service to the Board including a dedicated account manager, a dedicated and exclusive provider network manager, and a dedicated and exclusive client service representative.

B. Account Manager

The TPA must assign a dedicated (but not necessarily exclusive) account manager, located in the Mississippi Service Center, to participate in activities relative to all aspects of the contract between the Board and the TPA.

C. Provider Network Manager

The TPA will provide a dedicated and exclusive provider network manager who will consistently evaluate and manage the provider network, including recruiting, negotiating, and contracting with providers on behalf of the Plan and keep OI informed. The individual who serves in this role must have at least five (5) years of experience in provider contract negotiations. The Provider Network Manager shall analyze claims and network and non-network performance and shall meet with the OI staff at least quarterly to review network activities.

D. Client Service Representative

The TPA must designate an exclusive client service representative dedicated to the Board's account to receive and respond to inquiries and complaints. The client service representative must maintain records of all inquiries/complaints and the disposition, including but not limited to, date of inquiry/complaint received; party making inquiry of complaint; description of inquiry/complaint; disposition and date of disposition. This position must be located either in the local service center or, at the discretion of OI, within the OI office. If determined to be located at the OI office, the Client

Service Representative will not be an employee of the State nor under the direct supervision of the State. However, the client service representative will be expected to be physically present in the office during normal business hours to facilitate direct access by OI staff and participants. TPA must provide computer and other necessary equipment.

E. Welcome Packets & Identification (ID) Card

The Board requires custom welcome packets and ID cards to identify participants. The TPA is responsible for producing welcome packets and ID cards and for mailing these items to the participant's home address. The TPA is responsible for mailing, within five (5) days of receipt of eligibility, the welcome packets and ID cards under the following circumstances:

1. Initial enrollment in the Plan
2. New hires

In addition, the TPA is responsible for mailing additional ID cards within five (5) days of notification or of employee request under the following circumstances:

1. Enrollees who change coverage category (e.g. single to family);
2. Replacement of lost cards; and/or
3. Upon request of a participant

Participants with single coverage shall receive at least one (1) ID card; participants with dependent coverage shall receive at least two (2) ID cards. The information to be printed on each ID card must be according to the Board's specifications, satisfy all regulatory requirements, and comply with legislation and/or guidance currently in place, updated and replaced, or newly created. The ID card will include, at a minimum, the participant's name and identification number, Plan name, applicable deductibles, any applicable out-of-pocket maximum limitations, State Seal, the TPA name and toll free customer service line number, and website address for individuals to seek consumer assistance.

F. Vendor System Interface

The TPA is responsible for the electronic exchange of claims, provider and eligibility files and related information to and from the Board vendors. The TPA must provide a daily comprehensive review of all vendor file transmissions performed to ensure necessary files are transmitted to trading partners as expected. This monitoring process identifies any missing file transfers and ensures files are obtained within a timely manner. Current electronic transfer requirements include, but may not be limited to, the following:

Pharmacy Benefit Manager (PBM) - daily, detailed claims data by participant ID number will be transferred by PBM to the TPA for purposes of tracking benefit maximum accumulations. Eligibility data (changes, additions, terminations) will be transferred by the TPA to the PBM daily.

Medical Management Vendor - each day, inpatient/outpatient pre certification review and case management data will be transferred to the TPA. Each week, eligibility and network provider data will be transferred by the TPA to the medical management vendor. Detailed claims and biometric data is transferred to the medical management vendor by the TPA on a weekly basis for purposes of administering the Plan's medical management program. A network provider file is transferred each week from the TPA to the medical management vendor.

Health and Wellness (HWM) Vendor - Eligibility data (changes, additions, and terminations), detailed claims data, and biometric data will be transferred by the TPA to the HWM daily. Additional data transfer may be required to support the Health and Wellness program.

Decision Support Vendor – comprehensive claims and eligibility data will be transferred to the Decision Support Vendor each month.

Public Employees' Retirement System (PERS) – daily verification of retirement eligibility and monthly file to confirm premium deduction from retiree checks.

MDFA – daily exchange of files of premium receipts and related information.

G. Online Access for Board Staff

The TPA must provide, at no additional cost to the Board, the Board's staff direct online access to claim images and claim/membership/eligibility information. Online access must allow for viewable inquiry only including historical eligibility and claims information. In addition to viewable inquiry only access, the TPA is required to provide an electronic enrollment process to the Board for the purpose of approving retiree coverage.

H. Claims Administration

The TPA is responsible for maintaining a system for timely and accurate processing, adjudicating, and recording of claims for benefits in accordance with the current Plan Document, any applicable requirements established by the Board and any modifications or changes as communicated by the Board or as required by federal or state law. The TPA must maintain the resources, flexibility, and innovation to update and change the claims processing system as required by the Board. The TPA is responsible for reviewing submitted claims information for completeness and requesting any additional information necessary for proper adjudication of the claim in a timely manner. The claims payment system must be capable of accepting both electronic and paper submitted claims.

The Claim Administrator must have the capabilities to issue electronic prior authorizations, verify medical necessity, detect and report potential fraud and abuse cases; cross-reference family deductible accumulations when married employees are both participants of the Plan; compare total charges against total payments; identify duplicate charges; compare number of inpatient hospital days on each claim against admission and discharge dates; verify services are provided within the employee's eligibility date and maintain breaks in active service; recognize historical benefit maximums; verify provider license to the type of procedure billed; reconcile the diagnosis code to the procedure and gender and age codes for consistency; compute benefit year deductibles; integrate in network deductible accumulations with out of-network deductible requirements; ensure high-deductible health plan (HDHP) participants are not over-charged deductible by monitoring pharmacy deductible applications and adjusting medical claims, when necessary; identify and maintain information on potential coordination of benefits, subrogation, and other party liability situations; verify out-of-pocket amounts; review age limits for eligibility or coverage limits; determine coinsurance levels; identify unbundling of services, up coding of services, obsolete or invalid codes; identify ineligible services; apply multiple surgery guidelines; receive and process claims from other payers for secondary coverage payments to ensure the total combined payments from all payers do not exceed the maximum amount allowed by the Plan for covered expenses; track and process network provider fee schedules to include percentage of charge (POC), per diem rates,

Ambulatory Payment Group (APG), Ambulatory Payment Classification (APC), and Diagnosis Related Group (DRG) reimbursements.

Additional TPA services relative to claims administration include, but are not limited to, the following: preparing and distributing 1099 forms (as may be required) for providers, generating health insurance premium amounts reports for W2 reporting, supporting and/or generating Affordable Care Act (ACA) compliance reporting (Forms 1094 and 1095), filing of reports on the behalf of the Board as required by federal and State law, producing and distributing claim forms, communicating in a timely manner to all participants and employer units procedures for filing claims, interpreting explanation of benefits (EOB), filing appeals, making changes in eligibility, handling claims from providers who have a prompt-pay agreement, investigating returned checks for updated addresses, and related actions.

The TPA must maintain the following information for all claims: employee name, employee identification number, patient name or other specific identifier, claim number, provider number, provider name, service date, type of service, amount of charges, co-payment amount, amount allowed, and reason codes that specify the reason for claim payment/nonpayment. The information contained in the explanation of benefits must be available for inspection upon request by OI. OI will have on-line, direct access to all claims and related information utilized in the issuance of payments to participants and all providers.

I. Run-Out Claims Administration

Upon termination of the Contract, the TPA is responsible for adjudicating and processing all claims with service dates prior to the termination date of the contract that are received by the TPA for one (1) year after the termination date. The Board will fund claim payments in accordance with the terms and conditions of this Contract.

J. Data Security

The TPA shall provide a high level of data security and protection, including cyber security controls, including:

1. A data center facility to meet the needs of the business areas, participants, and provider network.
2. A business recovery model to support critical needs during a disaster.
3. Technology practices to support critical needs during a disaster.

K. Quality Control

The TPA will maintain formal policies and procedures regarding quality control. Quality control processes will be applied to regularly evaluate and ensure that the performance and accuracy of all areas of administration including, but not limited to, claims processing, customer service, and enrollment/eligibility, meet the performance measures established by the Board.

L. Provider Coding Accuracy

The TPA must utilize a system designed to evaluate coding accuracy and appropriateness relative to International Classification of Disease (ICD) and Physicians Current Procedural Terminology (CPT) coding and other coding references.

M. Hospital DRG Validations and Bill Audits

The TPA is responsible for initiating hospital DRG validations, charge/bill audits, and professional bill audits within one (1) year from the day the claim was processed. The TPA provides to the Board reports monthly of its findings in a format approved by the Board.

N. Credit Balance Recovery

The TPA is responsible for performing credit balance and overpayment recovery services as agreed upon by OI. The TPA will provide to OI monthly reports of its findings to include, at a minimum, the following details:

1. Overpaid Entity/Individual;
2. Provider Tax ID, if applicable;
3. Overpayment Amount;
4. Overpayment Reason;
5. Date Overpayment Identified;
6. Collection Activity, including letter and phone date(s); and
7. Date Debt Discharged.

O. Out of Network Review and Price Negotiation

The TPA is responsible for completing out-of-network request for services and, if necessary, negotiate the allowed amount of these services.

P. National Provider Indicator

The TPA's claims processing system must be capable of maintaining standard unique identifiers for health care providers in accordance with the Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA).*

Q. National Drug Codes

The TPA's claims processing system must be capable of capturing, storing and pricing claims based on National Drug Codes.

R. Prior Authorization of Benefits

The TPA is responsible for reviewing requests for prior authorization of benefits for physician and outpatient services based on the medical necessity of a particular case. The participant and provider must be notified of the determination of denial or approval in accordance with all federal requirements and Plan requirements. In compliance with the No Surprises Act, the TPA must assure that the Plan will pay for emergency services without prior authorization, without additional administrative requirements for nonparticipating providers and facilities, and without being solely based on diagnostic codes.

S. Participant and Provider Customer Service

The TPA is responsible for responding to inquiries from participants, providers, and OI regarding the services provided by the TPA through a toll free telephone line. The normal service hours, in Central Standard Time, are 8:00 AM to 5:00 PM Monday through Friday. In addition, a voice message system shall be available after normal business hours, 7 days-a-week, other than scheduled maintenance times, to participants and providers.

The TPA is responsible for maintaining a separate participant customer service area with a separate dedicated toll-free number for participants. The TPA must maintain a well-trained exclusive customer service department for participants capable of addressing all benefit and procedure questions.

The TPA is responsible for maintaining a separate provider customer service area with a separate toll-free number for verification of participant eligibility, benefit questions, and claims status, and if requested, an estimate of allowable charges. In addition, the TPA is responsible for maintaining a self-serve system to providers for verification of participant eligibility, benefit summaries, deductible and co-insurance maximum accumulation amounts and claims status. This self-serve system must be available twenty-four (24) hours, seven (7) days a week.

The TPA is responsible for maintaining an automatic call distribution system capable of tracking and reporting phone activity for both participant and provider customer service numbers.

The TPA is required to participate in activities with OI in responding to participant or provider inquiries or complaints relating to TPA services.

The TPA must cooperate with OI and with all other contractors of the Board with respect to ongoing coordination and delivery of health care services and in any transition of responsibilities.

The TPA is responsible for responding to inquiries from employer units concerning administrative procedures and benefits.

T. Participant Website and Mobile App

The TPA provides a website that enables participants the ability to access important information online at any time including, but not limited to, viewing claim information including deductible and out of pocket accumulations, viewing benefit information, accessing a virtual ID Card, ordering ID Cards, viewing articles on various health topics, updating phone number, updating email address, viewing and printing proof of insurance or certificate of creditable coverage, and viewing COBRA enrollment forms.

The TPA shall have a mobile app that enables participants to obtain important information from a mobile device. Information available through this app must include, but is not limited to, locating a provider, accessing a virtual ID Card, viewing benefit information, viewing claim information, viewing articles on various health topics, updating phone number, and updating email address.

U. Electronic Payment to Providers

The TPA must provide a system capable of electronic deposit of funds for health care providers.

V. Enrollment and Eligibility

The TPA must provide a web-based system for employer units and OI to view and maintain enrollment and eligibility information for the health insurance component of the Plan, as well as for the group term life insurance program provided by the Plan (**See AA below**). This includes but is not limited to employer unit access to all reference documents, procedural manuals, applications, newsletters, etc. The approximately 330 employer units are primarily responsible for entering and maintaining enrollment changes in the TPA electronic system for their respective employees and dependents. The TPA is responsible for processing any allowed changes for COBRA and retiree participants and any covered dependents. The TPA is responsible for verifying the eligibility for participants for benefits under the Plan based on the information provided by the employer units, participants, and OI.

The TPA will receive (primarily in electronic format) enrollment and eligibility information from the following unique groups:

- All Employer Units (approximately 330 State agencies, universities, community colleges, libraries, and school districts)
- OI (some initial retiree applications only)
- Mississippi PERS
- Retirees
- COBRA participants (primarily paper format)

The TPA must be able to receive and process enrollment data in electronic format. Payroll/personnel staff must enroll newly-hired employees and make updates to existing employees' coverage by entering the appropriate electronic transactions from the health and life insurance forms completed by the employees.

The TPA is required to place questionable eligibility transactions in a hold status for review. The TPA is also required to provide online access to the hold file to OI to approve/reject transactions and return such decisions to the employer unit via electronic means.

The TPA's web-based enrollment system is required to provide for employers units to convert employees from active to retiree status. The TPA's system needs to allow for an electronic interface with PERS, as well as OI as needed, to confirm retiree eligibility.

Life insurance coverage is a factor of an employee's salary. The TPA's system is required to provide a method for employer units to maintain an employee's life insurance amount. The system should provide a streamlined process updating coverage to support across-the-board salary increase.

Any information system proposed, developed, or modified that stores or disseminates, in any form or manner, information or material that contains the Social Security Number of an individual, must include mechanisms in place to prevent the inadvertent disclosure of the individual's Social Security Number to members of the general public or to persons other than those persons who, in the performance of their duties and responsibilities, have a lawful and legitimate need to know the individual's Social Security Number as required by Mississippi Code Annotated § 25-1-111.

Refer to the *Plan Document*. This document outlines the enrollment guidelines and provides a detailed explanation for the administration of the Plan.

The TPA is required to conduct training sessions relative to enrollment/eligibility policies and procedures for all employer units at least annually. The number of training sessions is dependent on many factors including payroll/personnel staff turnover, and changes to enrollment/eligibility requirements. The TPA is also required to conduct training sessions when legislation creates new agencies or new staff is hired at an existing agency.

W. Premium Billing and Account Reconciliation

The TPA is required to provide and maintain a premium billing and accounts receivable system which is capable of producing in both electronic and paper format monthly statements, tracking account balances and documenting payment histories for medical and life premiums. The billing and receivable system will manage medical and life premium reporting and collection for the Plan. The billing statements are based on the employer/employee premium contribution requirements as authorized by the Board. The premium billing system must be capable of pro-rating monthly premium contributions based on the participant's eligibility date. Each month, the TPA must produce approximately 330 premium electronic and paper billing statements for employer units, nearly 2,000 paper billing statements for COBRA and direct-billed retired participants.

Employer unit monthly billings should include a minimum of three sections:

1. Employer unit billing statement that includes remittance information and a summary of the unit's current amount due and any past due amount;
2. Premium billing section that includes a current list of employees participating in the unit, no more than the last 4 digits of the participant's Social Security numbers, payroll locations (if used by employer unit), life face value and premium amount, health premium and the total premium for each employee; and
3. Past due detail analysis section that lists information regarding any past due amounts.

In addition to employer unit and individual billings, the TPA is required to produce an electronic billing file containing all employer unit statements and provide same to the Board. Alternatives to the current electronic billing file distribution process, such as secure online access, will be considered.

The TPA must provide an ACH or bank draft payment option for employer units as well as for COBRA participants and direct-bill retirees. The TPA must also provide reports daily to OI of any premiums received for reconciliation purposes.

Employer units keep the TPA informed of any changes in the enrollment status of employees and their covered dependents. Each employer unit is responsible for prompt and accurate reconciliation of the monthly premium billing. The monthly premium billing is reconciled with payroll deduction records and a *Premium Billing Reconciliation Form* (recap) is completed by the employer unit. The recap is submitted to the TPA on or before the first of each month. The TPA is responsible for determining the appropriateness of enrollment data submitted by the employer units based on eligibility rules. The TPA is also responsible for reconciling the accounts receivable each month based on premium payments and additions, terminations, and changes submitted by employer units. The TPA is required to maintain adequate personnel for purposes of maintaining eligibility and premium billing/reconciliation functions.

X. Public Employees' Retirement System Billing Report

The TPA must produce an electronic monthly billing (deduction) report on retirees whose premium contributions are deducted by the PERS. The PERS billing report must be produced and sent to PERS by the 10th of each month for the following month's premiums. The report will include the minimal participant identifiable information and premium amount (medical and life). The TPA is responsible for updating eligibility records based on the edit report and address changes provided by PERS. Retirees who no longer receive sufficient pension benefits to fund their premium requirements will be transferred by the TPA to a direct-bill status.

Y. Eligibility Files

The TPA will be required to maintain HIPAA compliant information on each participant. In addition to such information, the Board requires that the following information be captured and maintained in the TPA's eligibility system:

1. Participant's name, date of birth, home address, phone number and email address;
2. Participant's unique identification number;
3. Participant's and any covered dependents' Social Security numbers;
4. Dependent child(ren)'s address (if different than parent);
5. Effective dates of coverage, changes and terminations for participants and dependents;
6. Subgroups The Plan currently has eight (8) subgroups which include active employees, COBRA participants, Medicare eligible service or disabled retirees over 65, Medicare eligible disabled retirees under 65, disabled retirees without Medicare, service retirees without Medicare, active employees with life insurance only coverage and retirees with life insurance only coverage;
7. Participant's marital status;
8. Participant's Employer Unit identifier;
9. Participant's payroll location;
10. Life insurance amount;
11. Qualifying event timeframe (i.e. 18 months, 36 months) for COBRA participants;
12. Family Cross-Reference The Plan requires that active employees be covered under their own individual contract and prohibits active employees from being covered as a dependent under another Plan contract. Also, a dependent child can be covered under only one (1) Plan contract. Family cross-reference is also required for the accumulation of the family deductible;
13. Disabled Dependents - The TPA is responsible for verifying, through medical review, that the dependent qualifies for continued coverage as a disabled dependent;
14. Eligibility History Historical information to be maintained includes, but is not limited to, prior contract types (e.g. single, family), prior coverage dates for dependents prior subgroups, etc.; and
15. Online Membership/Eligibility The TPA must provide OI staff read-only access to membership/eligibility and claims information via an online system.

Z. Storage and Retrieval of Enrollment Forms

The TPA must have the capability of electronic scanning, storage, and retrieval for health and life enrollment forms submitted for initial enrollment and enrollment/status changes.

AA. Life Insurance Support Functions

The Board currently contracts for a fully-insured group term life insurance policy with Minnesota Life Insurance Company to provide a fully insured group term life insurance policy for eligible

employees and retirees of State agencies, universities, public libraries, and certain community colleges and public school districts. Life insurance coverage is available to employees and retirees only; dependent life insurance coverage is not available. The TPA must maintain life insurance eligibility records and provide the following services:

1. Updates in the participant's life insurance benefit amount;
2. Premium billing and reconciliation; and
3. Electronic storage and retrieval of life insurance enrollment/information

The TPA is responsible for calculating monthly life insurance premiums due from the participant and from the employer unit (active employees only), based on the total premium due for the appropriate coverage amount, and including this information on the employer unit billing statements, direct bill statements and PERS deduction report. Refer to the *Plan Document* for additional information on the life insurance program.

BB. COBRA Administration

The TPA is responsible for providing full administration of the COBRA, including, but not limited to:

1. Distributing Initial Notice of Continuation of Coverage to new employees;
2. Maintenance of all COBRA eligibility;
3. Automated process for sending out COBRA notifications after employee termination;
4. Ability for participants to electronically enroll in COBRA;
5. Electronic monitoring of COBRA notification errors; mailing hardcopy notices if needed;
6. Receipt and maintenance of rejection forms;
7. 60 Day Notice of End of Election Period;
8. Premium Request after Election;
9. 45 Day Termination for Non Payment after Election;
10. Complete Monthly Billing for all COBRA participants with return envelope;
11. Provide Non-Sufficient Funds Notice;
12. Provide required 180-day warning for end of continuation period;
13. Notify insured of termination for non-payment of premium or any other reason;
14. Notify insured of termination for end of continuation period; and
15. COBRA participant monthly premium billing, collection, and reconciliation

Refer to the *Plan Document* for a detailed description of the Plan's COBRA provisions.

CC. Coordination of Benefits (COB) Administration

The TPA is responsible for providing full COB services. The necessary information concerning primary coverage for participants and their dependents and other coverage extended via other carriers or benefits systems must be encoded into the TPA's claims processing system and tracked and managed via the system. To administer the coordination of benefits, the TPA must exchange information with other plans involved in paying claims, request that the participant/provider furnish any necessary COB information, reimburse any plan that made payments that this Plan should have made, and recover any overpayment from health care providers and other insurance companies as necessary. If this Plan should have paid benefits that were paid by any other plan, the TPA will pay the plan that made the other payments in the amount the Plan determines to be proper under COB provisions.

DD. Subrogation Administration (Third Party Liability and Work-Related)

As a condition to receiving medical benefits under the Plan, participants agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. Benefits for work-related injuries or illnesses may be extended by the Plan where (1) liability is being controverted by the employer in a proceeding before the particular worker's compensation agency with jurisdiction and participant's related claims are unpaid; or (2) claims payments were made prior to notification to the Plan of their work-related nature. The TPA is responsible for full subrogation administration, including, but not limited to, efficiently identifying those cases that qualify for subrogation and the legal pursuit thereof.

EE. Overpayment/Recovery Administration

The TPA shall identify, collect and post overpayments from participants and providers in a timely manner. Overpayments will be posted to the participant's individual claims account.

FF. Medicare Secondary Payer (MSP)

The TPA is responsible for all functions related to MSP post-payment recoveries. The Plan is not liable for interest accrued as the result of untimely or unaccepted defenses. In these instances, the TPA will be responsible for any and all interest accrued.

GG. Satisfaction Surveys

The TPA must conduct at least one (1) participant satisfaction and one (1) network provider survey annually. The contents and process of the satisfaction surveys must be agreed upon by the Board and the TPA.

HH. Appeal and Grievance Procedures

The TPA must administer appeal and grievance procedures in accordance with all regulations required by ACA. A participant has the right to appeal any decision that denies payment of a claim or a request for coverage of a health care service or treatment. If a participant believes that the TPA incorrectly denied all or part of a claim, he has the right to obtain a full and fair review. A request for a review must be made in writing to the TPA. TPA is to adhere to the appeal procedures as described in the *Plan Document*.

II. Independent Review Organizations

The TPA is required to maintain contracts with a minimum of three (3) independent review organizations (IRO) that are accredited by Utilization Review Accreditation Commission (URAC) or by a similar nationally-recognized accrediting organization to conduct external reviews as required by the ACA. Cost for these services shall be included in the administrative fee.

JJ. Medical Director

The TPA must employ or contract with a full-time Medical Director to which the OI staff has direct access to support the claims management of the Plan. The medical director will be required to provide support in participant benefit appeals and benefit determinations. In addition, the medical

director will be required to work closely with Utilization Management Vendor to ensure accurate processing of claims which require review such as system updates, approval data clarification, etc. Support functions may include, but are not limited to: pre determination of benefits, medical necessity, and experimental or investigative procedures.

KK. Medical Review Department

The TPA must provide a well-staffed medical review department to administer the functions listed under “Medical Director”.

LL. Medical Consultation

The TPA must have readily available providers to assist OI staff by providing medical advice/expertise. This medical consultant role will include consulting with staff on such things as providing medical necessity opinions based on up-to-date medical literature, reviewing medical records to determine medical necessity, assisting participants to obtain appropriate care, and determining covered benefits. The TPA must administer medical consultation determinations in accordance with all regulations required by the ACA. Assistance shall be provided within one (1) business day of request.

MM. Medical Policy

The TPA is responsible for maintaining medical policies on medical services/procedures. Medical policy must be based on scientifically based evidence provided through research for a particular medical technology. Medical policy must also be based on data from peer-reviewed scientific literature from criteria developed by specialty societies and from guidelines adopted by other health care organizations. The TPA agrees to customize their medical policy in order to support health initiatives of the Board.

NN. Training Personnel

The TPA is required to conduct training sessions relative to enrollment/eligibility policies and procedures for employer units. The number of training sessions is dependent on many factors including payroll/personnel staff turnover, changes to enrollment/eligibility requirements, updates/changes in eligibility system, etc. The TPA must provide field representative personnel to conduct such employer/employee training sessions, including individual meeting with employers as needed. The TPA is also required to provide field representative personnel to conduct training for health care providers relative to claims filing procedures, electronic submission of claims, and other health care provider related issues.

OO. Explanation of Benefits

The TPA's EOB form and provider payment voucher must facilitate the separation of non-covered amounts, provider discounts, and the patient's financial responsibility amount. The TPA must issue EOBs for every claim filed, including zero-balance EOBs, and must accurately reflect patient responsibility, provider discounts, non-covered services, explanation codes, etc. The TPA must also provide the capability for participants and providers to access, download, and print EOBs and provider payment vouchers online. The TPA must monitor replies to EOB notifications and respond accordingly to participant inquiries received.

PP. HIPAA Compliance and Exemption

The Board has elected to exempt the Plan, as a non-federal governmental plan, from certain requirements of the HIPAA. The Board, however, has elected to generally comply with the intent of the requirements voluntarily. Although the Plan is exempt from certain requirements of HIPAA, the TPA must comply with all applicable requirements of HIPAA, including, but not limited to, the Administrative Simplification and Security Rule provisions.

QQ. Retrieval and Distribution of Records

Data contained on tapes, discs, files, batch files, and other records pertinent to the Plan, unless not otherwise prohibited by law, are the property of the Board and must be made capable of separate retrieval and distribution and be readily available to the Board on request. The TPA's physical security of all such records must comply with or exceed all applicable state and federal legal requirements. The TPA must have in place current procedures documenting its security and off-site storage.

RR. Claims and Performance Reviews

The Board, at its own expense, contracts with an independent third party vendor to conduct annual claims and performance reviews of the TPA. In addition, the operations of the TPA relative to the Plan are included in annual audits conducted by the State Auditor's Office or its designee. The TPA agrees that upon at least forty-eight (48) hour notice by the Board to the TPA, the Board has the right to audit all records maintained by the TPA relative to the TPA's performance. The Board maintains the right to perform financial, performance and other special audits on records maintained by the TPA during regular business hours. The TPA will make available all records, as defined by the selected auditor, for review at no cost to the Board. This does not preclude the auditing of other services or additional claims. Any errors detected via the audit will be addressed and corrected in a timely manner by the TPA. Any claim processing error will be adjusted to the proper account.

SS. Standard/Ad Hoc Reporting

The TPA must furnish standard reports in a form and content approved by the Board. These reports will be provided, at the Board's request, in electronic media format, as well as hard copy if so requested by the Board. The TPA shall provide web-based reporting tools that allow the Board to view, print, and download reports to spreadsheet software. All reports must include report parameters and definitions. Report parameters/definitions must be revised as appropriate when revisions to the report scope occur.

Additionally, the TPA will provide ad hoc reports at the Board's request. The TPA shall provide the Board, for the Board's approval, the time and cost for the development of ad hoc reports prior to the development of the report.

All other reports are to be performed and provided as stated in **Exhibit C, TPA Services Contractor Reports**.

TT. Benefit Fairs

The TPA agrees to participate in benefit fairs as requested by employer units to educate participants.

UU. Transition of Services

The TPA is responsible for coordinating with the existing TPA to transition services previously performed by the existing TPA. The TPA, as of the effective date of the services to be provided under this Contract and continuing for the duration of this Contract, shall process all claims for Health Care Services that were rendered prior to the termination date of this Contract and received within the timely filing period.

VV. System of Control (SOC) or Statement on Standards for Attestation Engagements Number 18 (SSAE 18)

The TPA agrees to provide an annual SOC or SSAE No. 18 report or equivalent prepared by a qualified Certified Public Accountant at its own expense for each year of the term of the contract. To the extent the selected TPA utilizes a third party vendor for any applicable component of the TPA services to be provided to the Board, as described within this Contract, the TPA must ensure that the third party vendor likewise provide a SOC or SSAE 18 report annually, and provide copies to the Board at no expense to the Board.

WW. Cost of Doing Business

The TPA shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should TPA default in these or other responsibilities, jeopardizing TPA's ability to perform services effectively, this Contract may be terminated for default at the Board's sole discretion.

XX. Informational Materials

The TPA, at its own cost, shall provide and maintain a supply of the TPA's informational materials to the Board. The TPA, at its own cost, shall provide a supply of the TPA's informational materials to all departments, agencies, universities, community colleges, public school districts, and public libraries throughout the terms of the Contract when requested. Participants will receive informational materials from the participant's employing department, agency, university, community colleges, public school district, or public library.

YY. Board Approval

The TPA is required to notify and receive approval from the Board prior to (1) using the Board's or the Plan's name or Plan benefit information in any social media, publications or printed material or (2) any publications or printed material mailed or provided directly to participants or (3) any change in the core services to be provided by the TPA.

ZZ. Exclusive State Network

The TPA will develop and manage an exclusive statewide network of health care providers to meet the health care needs of the participants. The TPA will be responsible for contacting, negotiating, and contracting with hospitals, providers, and other health care professionals throughout Mississippi. The TPA will be responsible for credentialing the providers, managing the network including

monitoring access, cost and quality, and providing related customer service to the participants and to the providers.

The network of providers will extend across the entire State of Mississippi, and must be sufficient in numbers and types of providers and facilities to ensure that all services will be accessible without unreasonable delay. Network adequacy will be determined by a number of factors, including the types of providers available by discipline, geographic accessibility, and travel distance. Where access is inadequate as determined by the Board, the TPA will be required to recruit providers to participate in the network.

AAA. National Network

The TPA will also be responsible for providing access to a comprehensive network of providers nationwide, not necessarily exclusive to the Plan.

BBB. Centers of Excellence (COE)

The TPA is expected to designate COE that include providers who specialize in particular medical services. Any designation of an institution as a COE must be based on objective measures for which there is clear evidence of improved outcomes and/or cost efficiency. COEs may include, but are not limited to, facilities that specialize in procedures such as bariatric surgery, hip and knee replacements, cardiac procedures, and back surgeries. The Board anticipates savings will result from improvements to quality of care and outcomes for services that are performed at a COE.

CCC. Contract Provisions

The TPA will maintain contracts with network providers that contain acceptable language relating to those contract requirements as required by the Board.

DDD. Provider Pricing

Throughout the term of this contract, the TPA will work with OI to develop a provider reimbursement schedule for the Plan. OI will have approval authority for all contracted rates and terms of the provider contracts for purposes of assuring that the contracted providers agree to participate in or cooperate with the Plan's medical management and utilization review programs, health and wellness promotion programs, and all other features and programs of the Plan as appropriate.

EEE. Adequate Provider Access

The TPA will maintain provider access standards as agreed upon in consultation with OI. Adequate provider access includes a match between the total number of participants in the provided population and the proposed PCP, specialty and acute hospital networks, by five-digit zip code. The Board is seeking a broad provider network with minimal impact on current patient-provider relationships. The access standards will be developed using the historical access standards of the Plan modified as necessary based on consultation with OI.

FFF. Access to Primary Care Providers (PCP)

The Board requires access to the following list of primary care providers:

- Internal Medicine
- Family Practice
- General Practice
- Family Nurse Practitioner
- Pediatrics
- Obstetrics & Gynecology
- Registered Dietitian (designated as PCP for copay purposes only)

GGG. Specialty Providers

The TPA will work with the Board to determine the appropriate access standards for specialty providers. The Board requires access to at least the following specialty providers:

- Anesthesiology
- Cardiology
- Dermatology
- Gastroenterology
- General Surgery
- Neurology
- Oncology
- Orthopedics
- Psychiatry
- Pulmonology
- Radiology
- Urology

HHH. Hospital Care

The TPA will develop adequate access to hospital facilities, which will be based on a standard of one (1) hospital within twenty-five (25) miles of a participant's home. To the extent possible, based on urban versus rural considerations, the TPA will maintain these standards for all participants. The TPA will identify all network hospitals where the corresponding hospital-based providers are not fully under contract.

The TPA must provide participants with adequate access to network hospitals capable of furnishing a full range of acute and tertiary services, including inpatient and emergency room services, and to ambulatory surgical facilities, rehabilitation facilities, and facilities for residential treatment of mental health disorders.

III. Provider Resolution

The TPA agrees to cooperate with OI in resolving any provider issues including, but not limited to, contracting terms, pricing disputes, claims issues, providers not accepting new patients, lengthy waits for appointments, or lack of specialty provider coverage. OI will have final decision authority for resolving provider issues.

JJJ. Provider Audit

The TPA must contractually require each participating provider to cooperate with any audit program implemented by the Board, including, but not limited to, hospital bill audit, DRG validation, and provider bill audit, and to provide, without charge, all necessary information for the completion of such audits.

KKK. Cooperation with Other Board Vendors

The TPA will cooperate as required with the Board's other contracted vendors.

LLL. Provider Roster

The TPA will develop and maintain a database of all providers, including name, billing address, physical address, telephone number, provider number, area(s) of practice or specialty, and for providers, the hospital(s) where admitting privileges are maintained. The TPA will develop linkages of providers to clinics, which will include clinic name, address, telephone number, and provider number in the database where applicable. The linkages will include providers that are associated with multiple clinics. Such information must conform to state and federal requirements, such as HIPAA and Health Information Technology for Economic and Clinical Health (HITECH).

The TPA, via toll free telephone line and searchable web site, will provide a listing of all providers. The searchable website shall, at a minimum, include functionality to search by provider type and specialty by county and/or zip code. The information returned should include provider name, address, telephone number, days and hours of operation, board certification status, hospital admitting privileges, and whether provider is accepting new patients. The format of the listing will be determined by agreement between the TPA and the Board. Printed lists of providers will be available to participants upon request.

The TPA must provide monthly updates to the provider listing (i.e., adds/deletes) to the Board including, but not limited to, the following components:

- Provider's Complete Name
- Tax ID
- Board Certification Status
- Provider Number
- Specialty
- Clinic Name
- Complete Address
- Notification Date
- Effective Date
- Termination Date
- Reinstatement Date
- Reason for update

The TPA agrees to the performance standards for maintaining updates to the provider roster as outlined in **Exhibit B, Performance Standards**, of this Contract.

MMM. Network Provider Requirements

The TPA shall require that all network providers adhere to the following:

1. To not discriminate in the treatment of participants on the basis of race, color, creed, sex, age, national origin, physical handicap, disability, religion, place of residence, source of payment or any other consideration made unlawful by federal and state laws;
2. To comply with all state and federal laws and regulations relating to the confidentiality of protected health information of participants;
3. To adhere to the medical/utilization management program requirements;
4. To not bill participants or the Plan for services that are not medically necessary as determined by the medical management/utilization program vendor or the claims administrator. Such services shall include those services that are not covered under the Plan's wellness/preventive services benefit. Covered wellness services are listed on the Plan's website at: http://knowyourbenefits.dfa.ms.gov;
5. To adhere to the Board's electronic business model requirements;
6. To file claims with other carriers when the Plan is secondary in coordination of benefits. Under such circumstances, the Plan will provide benefits for the patient's liability amount, as defined by the primary payor, not to exceed the allowable charge;
7. To accept, as the allowable charge, the lesser of covered charges, or the amount established by the TPA;
8. To file claims within twelve (12) months of the date on which the services were performed. The network provider will hold the participant and the Plan harmless for any charges for which a claim is not filed within twelve (12) months of the date of service;
9. To comply with the Healthcare Effectiveness Data and Information Set (HEDIS) measures, where applicable;
10. To submit biometric data on participants as requested to the claims administrator; and
11. To adhere to the requirements of the pharmacy clinical programs such as prior authorization, step therapy, and quantity limits.

NNN. Plan Communication

The TPA will develop a system for regularly communicating the Plan's benefits, medical management requirements, and billing procedures to network providers which will include written communications as well as annual workshops.

The TPA will develop and maintain a searchable website that contains a current provider directory. The website shall be accessible to participants and providers with no access restriction or registration requirement. A link must be provided to the MDFA website. The TPA will maintain a toll-free telephone number for usage by participants and providers. The Board will own the telephone number and the telephone number will revert back to the Board upon contract termination.

OOO. Network Provider Services

The TPA will hire and maintain sufficient provider relations and customer service staff to meet the needs of the Board and the participants. The TPA will report quarterly on the volume of calls received and the types of calls received.

The TPA must staff a provider services department to be operated at least during regular business hours (e.g. 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday). The TPA must maintain a provider service office within the state of Mississippi throughout the term of the contract. Provider services staff must be proficient in:

1. Assisting providers with prior authorization and referral procedures, including the use of non-participating providers;
2. Assisting providers with claims payment procedures including electronic submission of claims in accordance with HIPAA and HITECH electronic data interchange (EDI) standards;
3. Handling provider complaints and grievances;
4. Educating providers as to their responsibilities under the Plan;
5. Educating providers as to covered medical services, excluded medical services and benefit limitations; and
6. Facilitation of medical record transfer among providers as necessary.

PPP. Provider Website

The TPA must provide a secure provider service website where routine provider service inquiries can be handled. Information available through this website must include, but is not limited to, eligibility and benefits information, deductible accumulation, claim status, medical and coding policy, and online viewing of provider payment vouchers.

QQQ. Provider Manuals

The TPA shall develop, distribute, and maintain provider manuals. In addition, the TPA will be expected to notify network providers of subsequent contract clarifications and procedural changes. The provider manual will include at least the following information:

1. An introduction to the Plan which explains the TPA's organization and administrative structure;
2. A description of the Plan's case management process;
3. A description of covered medical services, excluded medical services, and benefit limitations;
4. Billing and encounter submission information indicating which form (e.g. UB92, HCFA 1500) is to be used for services and which fields and codes are required for a claim to be considered acceptable by the TPA, or the necessary protocol and procedural information for a provider to submit claims electronically in accordance with HIPAA and HITECH EDI standards;
5. Provider performance expectations including disclosure of medical management and quality assurance criteria and processes;
6. Emergency room utilization (appropriate and non-appropriate use of the emergency room);
7. Claim filing procedures (paper and electronic)A listing of key contacts and telephone numbers at the TPA;
8. Prior authorization requirements, including rules for referrals for specialty care and use of non-participating providers; and
9. How to register a complaint or grievance with the TPA.

RRR. Other Requirements

1. The TPA shall develop, implement, and maintain grievance and appeal procedures related to credentialing and pricing.
2. The TPA shall not prohibit or otherwise restrict a covered provider or other health care professional from advising a participant about their health situation or medical care or treatment for the participant's condition or disease, regardless of whether benefits for such care or treatment are provided under the Plan, if the professional is acting within his lawful scope of practice.

3. The TPA shall not prohibit a network provider from advocating on behalf of the participant within the medical management or grievance and appeal processes established by the TPA.
4. The TPA shall provide to the claims administrator notice of a provider's termination from the network within fifteen (15) working days of receipt or issuance of a notice of termination.
5. The TPA shall notify network providers of their responsibilities with respect to the Plan's applicable administrative policies and programs, including, but not limited to, payment terms, medical management, quality assessment and improvement programs, credentialing, grievance and appeal procedures, data reporting requirements, and any applicable federal and state programs.
6. Neither the TPA nor any subcontractor shall offer any inducement to any providers to provide less than standard quality medical care to participants than is medically necessary.
7. The TPA shall be responsible for notifying participants of any material changes in the network.

SSS. Quality

The TPA will cooperate with any quality initiatives including, but not limited to, provider profiling and outcome measurements established by the Board.

TTT. Provider Credentialing

The TPA will be responsible for credentialing all providers prior to their acceptance into the PPO. Additionally, the TPA will be responsible for re-credentialing the providers at least every three years. (This can be delegated to Provider Sponsored Organizations for those providers in a Provider Sponsored Organization). The TPA will utilize credentialing and re-credentialing standards that meet or exceed National Committee for Quality Assurance (NCQA) and/or URAC standards for credentialing providers. The only exception will be non-board certified physicians currently included in the Board's exclusive network. These physicians may be accepted into the TPA's network as long as they meet other TPA credentialing requirements.

UUU. Hospital Privileges

The TPA will contractually assure that each participating provider is required to possess and maintain admitting privileges at a minimum of one (1) participating hospital, unless the TPA has requested in writing and received approval from OI to exempt the participating provider from this requirement. In the event of such a request, the TPA must explain the need to have said provider as a participating provider along with the process of assuring that participants will not be adversely affected by the provider's lack of privileges at a participating hospital. The TPA will provide OI a quarterly report of network providers who do not have admitting privileges at a participating hospital.

VVV. Corrective Action

The TPA will notify OI of any corrective action taken against a participating provider, which would materially limit the participating provider's admitting privileges at a participating hospital. The TPA will notify OI of any corrective action taken against a participating hospital or other provider and the reason for such action.

WWW. Provider Performance Monitoring

The TPA will be responsible for monitoring and reviewing the performance of all providers and taking corrective action when necessary. The TPA will provide OI a quarterly report of utilization and cost trends, incidents of quality issues and/or non-compliance with medical management protocols, and outcomes of implemented benefit or reimbursement changes as well has any corrective action plans. The quarterly reports shall also include analysis of services of non-network providers.

XXX. Customer Service

The TPA will be responsible for maintaining a toll-free customer service telephone line for provider, participant, and employer unit inquiries and complaints. Customer service standards are outlined in **Exhibit B, Performance Standards**, of this Contract. In addition, the TPA will work with the Board to develop a system which directs calls to the most appropriate location.

YYY. Responding to Inquiries

The TPA will respond to inquiries from providers and participants concerning the provider network in a timely manner. The types of inquiries will be logged and reported to the Board on a quarterly basis. The Board will have final approval regarding the format and content of the reports.

ZZZ. Complaint Resolution Process

The TPA is responsible for responding to and documenting resolution of provider and participant complaints. A summary of this documentation will be provided to the Board on a quarterly basis. The Board will have final approval regarding the format and content of the summary report. The TPA will fully respond to all participant and provider complaints within ten (10) business days after receiving the complaint, or become subject to the liquidated damages described in **Exhibit B, Performance Standards**, of this Contract.

AAAA. Accreditation

The TPA agrees to actively seek accreditation within the first six (6) months of the Contract and achieve URAC accreditation, or comparable, within the first twelve (12) months of the Contract. The TPA must meet URAC's Health Network Accreditation standards, or equivalent, and must maintain such accreditation for the life of the Contract.

BBBB. Compensation to Participating Providers

The TPA agrees to provide and manage a comprehensive provider network in the State of Mississippi that will serve the Plan exclusively, and agrees that the Board will have approval authority for any or all contracted rates and terms of the provider contracts for purposes of assuring that the contracted providers agree to participate in or cooperate with the Plan's medical management and utilization review programs, health and wellness promotion programs, and all other features and programs of the Plan as appropriate.

The TPA's contracts with participating providers shall include provisions pertaining to the compensation of those providers, as described in the sections below.

1. Each network provider contracted by the TPA shall be entitled to compensation for covered services rendered in an amount not to exceed the TPA's allowable charge. For DRG or per

diem rates, the allowable charge is the lessor of the billed charge, the DRG or per diem rate. Network providers shall neither bill nor attempt to collect from the participant, the Plan, the Board, or any third party, any amount in excess of the TPA's allowable charge for any covered service.

2. The participating hospitals contracted by the TPA shall accept and adhere to the allowable charge for covered hospital services when the Plan is the primary payor. When the Plan is the secondary payor under coordination of benefits rules, the allowable charge shall not apply.
3. Network providers shall be entitled to collect from the participant any deductible, co payment, or co insurance amounts specified by the Plan.
4. Network providers shall be entitled to compensation from the participant for health care services not covered under the Plan, for health care services provided to a participant after the benefits set forth in the Plan have been exhausted, or for health care services which are otherwise excluded under the Plan (including any services for which payment is denied under the Plan's utilization management program provided that the network provider fully cooperated with the utilization management program up to and including the appeals process). Network providers shall not be entitled to compensation from the participant nor from the Plan for services that are not medically necessary, as determined by the medical management and utilization review vendor or by the claims administrator.

CCCC. Rebates

The Plan shall receive 100% of any and all rebates received by the TPA attributable to the Board's utilization of any medications. Rebates are defined as any compensation or remuneration of any kind received or recovered by the TPA, or any of its affiliates from a pharmaceutical manufacturer or intermediary attributable to the purchase or utilization of covered drugs by Plan participants, including, but not limited to, incentive rebates discounts; credits; regardless of how categorized; market share incentives; promotional allowances; commissions; market share of utilization; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that TPA, or any of its affiliates, receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access. Any fees or cost associated with rebates administration should be included in the TPA's bundled administration fee.

DDDD. Other Services

The TPA shall provide other services for which the TPA has the technical capability to render, as requested by the Board and agreed to in writing by the Board and the TPA.

4. Responsibilities of the Board, Administrator of the Plan

A. The Board reserves the exclusive right to amend, reduce, or eliminate any part of the Plan or change any benefits at any time. To the extent that such amendment, reduction, elimination, or change materially affects the services provided by the TPA under this Contract, the Board shall notify the TPA of such change via a letter of authorization in a timely manner and in advance of such change to the extent possible.

B. In case of conflict between this Contract and the applicable *Plan Document*, the *Plan Document* shall prevail.

C. The Board or its designee shall provide educational material to all Participants explaining conditions of coverage, cost sharing, benefit design, and financial incentives encouraging compliance with the Plan's programs and provisions.

D. The Board shall have final authority on any appeal, application, and interpretation of the Plan's benefits or eligibility policies. Benefit determinations shall not affect the attending physician's responsibility to provide all medically necessary care to covered individuals.

E. The Board shall not disseminate, sell, or license any proprietary information belonging to the TPA to others without the TPA's prior written approval, unless the information is subject to the Public Records Law of the State of Mississippi, or is required to be released by law.

5. Contract Term

A. The effective date of this Contract is January 1, 2023. The term of the Contract will be for four (4) years with an option to renew for up to one (1) year at the Board's discretion. Within nine (9) months of the end of the original term, MDFA will notify the Contractor, in writing, of MDFA's intent to renew the Contract for one (1) additional year.

B. This Contract may be terminated by either party, with or without cause, upon at least thirty (30) days prior written notice of intent to terminate provided to the other party. However, the TPA agrees to adjudicate and process all claims with service dates prior to the termination date of the contract that are received by the TPA for one (1) year after the termination date with claim payments funded by the Board in accordance with the terms and conditions of this terminated contract.

C. All records and information provided by the Board or through its vendors to the TPA are the sole property of the Board and shall be returned to the Board within thirty (30) days of the termination date of this Contract if so required by the Board. The TPA shall be entitled to retain and utilize data that have been captured, computed, or stored in the TPA's databases to the extent that such data cannot be identified or linked to the Board, Plan, or an individual Participant with the restrictions described in Item 16, of this Contract to apply.

D. Upon termination of this Contract, the TPA shall reasonably cooperate with the Board and the new TPA vendor during the transition of the Plan to the new TPA vendor. Upon request of the Board, the TPA shall provide all information maintained by the TPA in relation to the Plan in a time frame specified by the Board. Information provided shall be in a format designated by the Board and shall include, but not be limited to, where applicable, file layouts and legends. The TPA shall provide such explanation of the information provided in order to facilitate a smooth transition.

6. Consideration

The Board agrees to compensate the TPA for services approved by the Board and performed by the TPA under the terms of this Contract in an amount not to exceed [Insert Amount], as follows:

A. The per employee per month (PEPM) fees illustrated in *Exhibit A, Fee Schedule for Third Party Administration Services*, of this Contract shall constitute the entire compensation due to the TPA for services and all of the TPA's obligations hereunder regardless of the difficulty, materials, or equipment required. Said fees include, but are not limited to, all applicable taxes, fees, general office expense, travel, overhead, profit, and all other direct and indirect costs, incurred or to be incurred,

by the TPA, including various service fees that are typically passed through the claims wire. No additional compensation shall be provided by the Board for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the Board. Said fees are firm for the duration of this Contract and are not subject to escalation for any reason, unless this Contract is duly amended.

B. In accordance with State law and applicable Contract conditions, the Board shall compensate the TPA such fees after the appropriate services have been rendered. The Board shall not provide any prepayments or initial deposits in advance of services being rendered. Fees for services provided by the TPA shall be billable to the Board in arrears on a monthly basis. Only those services agreed to under this Contract shall be considered for reimbursement or compensation by the Board. Payment for any and all services provided by the TPA to the Board and/or the Plan shall be made only after said services have been duly performed and properly invoiced.

C. The TPA shall submit all invoices, in a form acceptable to the OI (provided that such acceptance will not be unreasonably withheld) with all the necessary supporting documentation, prior to any payment to the TPA of any administrative fees. Administrative fees shall be invoiced on a monthly basis, in sufficient detail and format as determined by the OI. Such invoices shall include, at a minimum, a description of the service(s) provided, the PEPM administrative fee, the number of enrollees, the time period in which services were provided, and total administrative fees requested for the period being invoiced. In the event of termination of this Contract for any reason, TPA shall be paid for services rendered and allowable up to the effective date of termination. Upon the effective date of termination of this Contract, the TPA's obligation to provide any further services under this Contract shall cease. The TPA shall, however, remain liable for any obligations arising hereunder prior to the effective date of such termination, including but not limited to, twelve (12) months administration of run-out claims. No additional compensation will be provided by the MDFA for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the MDFA.

D. The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. TPA's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the TPA, including but not limited to any liquidated damages resulting from the TPA's failure to satisfy any performance standards described in *Exhibit B, Performance Standards*, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the TPA under Contract between the parties any amounts which are or shall become due and payable to the Board by the Contractor; or (2) request and receive payment directly from the TPA within fifteen (15) days of such request, at the Board's sole discretion.

E. Compensation to the TPA for travel expenses for quarterly meetings and annual onsite trainings are included in the bundled fee. In the event the Board requests and authorizes the TPA for the performance of any of the services covered under this Contract for which travel expenses are not already included, compensation to the TPA for travel, meals and/or lodging must be approved in advance and shall be allowed subject to the following criteria:

1. In order to be compensable, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;
2. Air travel reimbursement will be limited to "Coach" or "Tourist" class rates, and must be supported by a copy of an original invoice;
3. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all meal and hotel receipts must be provided;
4. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;
5. Personal automobile mileage and related costs are not compensable expenses;
6. Time spent in "travel status" is not compensable.

7. E-Payment and Paymode

The TPA agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The MDFA agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of the invoice. Mississippi Code Annotated § 31-7-301, *et seq*. Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the TPA's choice. The MDFA may, at its sole discretion, require the TPA to submit invoices and supporting documentation electronically at any time during the term of this Contract. The TPA understands and agrees that the MDFA is exempt from the payment of taxes. All payments shall be in United States currency.

8. Availability of Funds

It is expressly understood and agreed that the obligation of the Board to proceed under this Contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of state and/or federal funds. If the funds anticipated for the continuing time fulfillment of the Contract are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the MDFA, the Board shall have the right upon ten (10) working days written notice to the TPA, to terminate this Contract without damage, penalty, cost or expenses to the Board of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

9. Record Retention and Access to Records

The TPA agrees that the Board or any of its duly authorized representatives at any time during the term of this Contract shall have unimpeded, prompt access to and the right to audit and examine any pertinent books, documents, papers, and records of the TPA related to the TPA's charges and performance under this Contract. The Board agrees to provide the TPA with reasonable advance notice for any standard audits or reviews, with the expectation that such reviews shall be made during normal business hours of the TPA. The parties shall cooperate to schedule and conduct such audit or inspection to prevent disruption to TPA's performance of the services hereunder and for TPA's other customers. All records related to this Contract shall be retained by the TPA for a period of six (6) years after final payment under this Contract and all pending matters are closed unless the Board authorizes their earlier disposition. However, if any litigation, claim, negotiation, audit or other action arising out of or related in any way to this Contract has been

started before the expiration of the six (6) year period, the records shall be retained for one (1) year after all issues arising out of the action are finally resolved or until the end of the six (6) year period, whichever is later. The TPA agrees to refund to the MDFA any overpayment disclosed by any such audit arising out of or related in any way to this Contract.

10. Right to Audit

TPA shall maintain such financial records and other records as may be prescribed by MDFA or by applicable federal and state laws, rules, and regulations. TPA shall retain these records for a period of three years after final payment, or until they are audited by MDFA, whichever event occurs first. These records shall be made available for inspection during regular business hours and with reasonable advance notice during the term of the Contract and the subsequent three-year period for examination, transcription, and audit by the Mississippi Office of the State Auditor, its designees, or other authorized bodies.

11. Right to Inspect

MDFA, the Mississippi Office of the State Auditor, or any other auditing agency prior-approved by MDFA, or their authorized representative shall, at all reasonable times, have the right to enter onto the TPA's premises, or such other places where duties under this Contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The TPA shall provide access to all facilities and assistance for MDFA and Mississippi Office of the State Auditor's representatives. All inspections and evaluations shall be performed in such a manner as to not delay work. Refusal by the TPA to allow access to all documents, papers, letters or other materials, shall constitute a breach of Contract. All audits performed by persons other than MDFA staff shall be coordinated through MDFA and its staff.

12. Applicable Law

The Contract shall be governed by and construed in accordance with the laws of the State of Mississippi (State), excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. The TPA shall comply with applicable federal, state, and local laws and regulations.

13. Severability

If any part of this Contract is declared to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision of the Contract, and to this end the provisions hereof are severable. In such event, the parties shall amend the Contract as necessary to reflect the original intent of the parties and to bring any invalid or unenforceable provisions in compliance with applicable law.

14. Anti-Assignment/Subcontracting

TPA acknowledges that it was selected by the Board to perform the services required hereunder based, in part, upon TPA's special skills and expertise. TPA shall not assign, subcontract, or otherwise transfer this Contract, in whole or in part, without the prior written consent of the Board, which the Board may, in its sole discretion, approve or deny without reason. Any attempted assignment or transfer of its obligations without such consent shall be null and void. No such approval by the Board of any subcontract shall be deemed in any way to provide for the incurrence of any obligation of the Board in addition to the total fixed price agreed upon in this Contract. Subcontracts shall be subject to the terms and conditions of this

Contract and to any conditions of approval that the State may deem necessary. Subject to the foregoing, this Contract shall be binding upon the respective successors and assigns of the parties.

15. Compliance with Laws

The TPA understands that the State is an equal opportunity employer and therefore maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and the TPA agrees during the term of the Contract that the TPA shall strictly adhere to this policy in its employment practices and provision of services. The TPA shall comply with, and all activities under this Contract shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

16. Information Designated by Contractor as Confidential

"Confidential Information" shall mean: (a) those materials, documents, data, and other information which the TPA has designated in writing as proprietary and confidential; and (b) all data and information which the TPA acquires as a result of its contact with and efforts on behalf of the Board and any other information designated in writing as confidential by the Board. Each party to this agreement agrees to the following:

A. To protect all confidential information provided by one party to the other to the extent allowed under State and/or federal law; and,

B. To treat all such confidential information as confidential to the extent that confidential treatment is allowed under State and/or federal law; and,

C. Any disclosure of those materials, documents, data, and other information which TPA has designated in writing as proprietary and confidential shall be subject to the provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1. As provided in the Contract, the personal or professional services to be provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret, or confidential commercial or financial information.

Any liability resulting from the wrongful disclosure of confidential information on the part of the TPA or its subcontractor shall rest with TPA. Disclosure of any confidential information by the TPA or its subcontractor without the express written approval of the Board shall result in the immediate termination of the Contract.

17. Disclosure of Confidential Information

In the event that either party to this Contract receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by law. This section shall survive the termination or completion of this Contract. The parties agree that this section is subject to and superseded by Mississippi Code Annotated § 25-61-1 *et seq*.

18. Confidentiality

Notwithstanding any provision to the contrary contained herein, it is recognized that MDFA is a public agency of the State of Mississippi and is subject to the Mississippi Public Records Act. Mississippi Code Annotated § 25-61-1 *et seq*. If a public records request is made for any information provided to MDFA pursuant to the Contract and designated by the TPA in writing as trade secrets or other proprietary confidential information, MDFA shall follow the provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1 before disclosing such information. The MDFA shall not be liable to the TPA for disclosure of information required by court order or required by law.

19. Transparency

This Contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated §§ 25-61-1 *et seq*. and 79-23-1. In addition, this Contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Mississippi Code Annotated § 27-104-151 *et seq*. Unless exempted from disclosure due to a court-issued protective order, a copy of this executed Contract is required to be posted to the Mississippi Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by TPA as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, shall be redacted.

20. E-Verification

If applicable, the TPA represents and warrants that it shall ensure its compliance with the Mississippi Employment Protection Act of 2008, and shall register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated § 71-11-1 *et seq.* The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The TPA agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security when required, the TPA agrees to provide a copy of each such verification. The TPA further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this agreement may subject the TPA to the following:

A. termination of this Contract for services and ineligibility for any State or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public; or

B. the loss of any license, permit, certification, or other document granted to the TPA by an agency, department, or governmental entity for the right to do business in Mississippi for up to one (1) year; or

C. both.

In the event of such cancellation/termination, the TPA would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

21. Independent Contractor Status

The TPA shall perform all services as an Independent Contractor and shall at no time act as an agent for the Board or MDFA. Nothing contained herein shall be deemed or construed by the Board or MDFA, the TPA, or any third party as creating the relationship of principal and agent, master and servant, partners, joint ventures, employer and employee, or any similar such relationship between the Board or MDFA and the TPA. Neither the method of computation of fees or other charges, nor any other provision contained herein, nor any acts of the Board or MDFA or the TPA hereunder creates, or shall be deemed to create a relationship other than the independent relationship of Board or MDFA and Contractor. The TPA's personnel shall not be deemed in any way, directly or indirectly, expressly or by implication, to be employees of the Board or MDFA. No act performed or representation made, whether oral or written, by the TPA with respect to third parties shall be binding on the Board or MDFA. Neither the TPA nor its employees shall, under any circumstances, be considered servants, agents, or employees of the Board or MDFA; and the Board or MDFA shall at no time be legally responsible for any negligence or other wrongdoing by the TPA, its servants, agents, or employees. The Board or MDFA shall not withhold from the Contract payments to the TPA any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the TPA. Further, the Board or MDFA shall not provide to the TPA any insurance coverage or other benefits, including Worker's Compensation, normally provided by MDFA for its employees.

22. Force Majeure

Each party shall be excused from performance for any period and to the extent that it is prevented from performing any obligation or service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such party and/or its subcontractors. Such acts shall include without limitation acts of God, strikes, lockouts, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, earthquakes, floods, or other natural disasters ("force majeure events"). When such a cause arises, the TPA shall notify MDFA immediately in writing of the cause of its inability to perform, how it affects its performance, and the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to force majeure events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless MDFA determines it to be in its best interest to terminate the Contract.

23. Authority to Contract

TPA warrants: (a) that it is a validly organized business with valid authority to enter into this Contract; (b) that it is qualified to do business and in good standing in the State of Mississippi; (c) that entry into and performance under this Contract is not restricted or prohibited by any loan, security, financing, contractual, or other contract of any kind; and, (d) notwithstanding any other provision of this Contract to the contrary, that there are no existing legal proceedings or prospective legal proceedings, either voluntary or otherwise, which may adversely affect its ability to perform its obligations under this Contract.

24. Debarment and Suspension

The TPA certifies to the best of its knowledge and belief, that it: (i) Is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transaction by any federal department or agency or any political subdivision or agency of the State of Mississippi; (ii) Has not, within a three-year period preceding this proposal, 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 public (federal, state, or local) transaction or contract under a public transaction; (iii) Has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against it for a 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; (iv) Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of these offenses enumerated in paragraphs two (ii) and three (iii) of this certification; and, (v) Has not, within a three-year period preceding this proposal, had one or more public transactions (federal, state, or local) terminated for cause or default.

25. Modification or Renegotiation

This Contract may be modified, altered or changed only by written agreement signed by the parties hereto. The parties agree to renegotiate the Contract if federal, State and/or the MDFA revisions of any applicable laws or regulations make changes in this Contract necessary.

26. Procurement Regulations

The Contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*, a copy of which is available at 501 North West Street, Suite 701E, Jackson, Mississippi 39201 for inspection, or downloadable at https://www.dfa.ms.gov/dfa-offices/personal-service-contract-review/opscr/.

27. Representation Regarding Contingent Fees

The TPA represents that it has not retained a person to solicit or secure a Board contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee.

28. Representation Regarding Gratuities

The TPA represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*.

29. Termination for Convenience

A. *Termination.* The Board may, when the interests of the Board so require, terminate this Contract in whole or in part, for the convenience of the Board. The Board shall give written notification of the termination to the TPA specifying the part of the Contract terminated and when the termination becomes effective.

B. *TPA's Obligations.* The TPA shall incur no further obligations in connection with the terminated work, and on the date set in the notice of termination, the TPA shall stop work to the extent specified. The TPA shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The TPA shall settle the liabilities and claims arising out of the termination of subcontractors and orders connected with the terminated work. The Board may direct the TPA to assign the TPA's right, title, and interest under terminated orders or subcontracts to the Board. The TPA shall still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

30. Termination for Default

A. *Default.* If the TPA refuses or fails to perform any of the provisions of this Contract with such diligence as shall ensure its completion within the time specified within this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Board may notify the TPA in writing of the delay or nonperformance and if not cured within ten (10) days or any longer time specified in writing by the Board, the Board may terminate the TPA's right to proceed with the Contract or such part of the Contract as to which there has been delay or failure to properly perform. In the event of termination in whole or in part, the Board may procure similar supplies or services in a manner and upon terms deemed appropriate by the Board. The TPA shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

B. *TPA's Duties.* Notwithstanding termination of the Contract and subject to any directions from the Board, the TPA shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the TPA in which the Board has an interest.

C. *Compensation.* Payment for completed services delivered and accepted by the Board shall be at the Contract price. The MDFA may withhold from amounts due the TPA such sums as the MDFA deems to be necessary to protect the MDFA against loss because of outstanding liens or claims of former lien holders and to reimburse the MDFA for the excess costs incurred in procuring similar goods and services.

D. *Excuse for Nonperformance or Delayed Performance.* Except with respect to defaults of subcontractors, the TPA shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by the TPA to make progress in the prosecution of the work hereunder which endangers performance) if the TPA has notified the Board within 15 days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or make progress, and if such failure arises out of causes similar to those set forth above, the TPA shall not be deemed to be in default, unless the services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the TPA to meet the Contract requirements. Upon request of the TPA, the Board shall ascertain the facts and extent of such failure, and, if the Board determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the TPA's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the Board under the clause of this Contract entitled “Termination for Convenience”. (As used in this Paragraph of this clause, the term “subcontractor” means subcontractor at any tier).

E. *Erroneous Termination for Default.* If, after notice of termination of the TPA's right to proceed under the provisions of this clause, it is determined for any reason that the Contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph D (Excuse for Nonperformance or Delayed Performance) of this clause, the rights and obligations of the parties shall, if the Contract contains a clause providing for termination for convenience of the State, be the same as if the notice of termination had been issued pursuant to a termination for convenience.

F. *Additional Rights and Remedies.* The rights and remedies provided under this clause are in addition to any other rights and remedies provided by law or under this Contract.

31. Termination for Bankruptcy

This Contract may be terminated in whole or in part by the Board upon written notice to the TPA, if the TPA should become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, or upon the execution by TPA of an assignment for the benefit of its creditors. In the event of such termination, TPA shall be entitled to recover just and equitable compensation for satisfactory work performed under this Contract, but in no case shall said compensation exceed the total Contract price.

32. Stop Work Order

A. *Order to Stop Work.* The Board may, by written order to the TPA at any time, and without notice to any surety, require the TPA to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to the TPA, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the TPA shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the Board shall either:

1. cancel the stop work order; or
2. terminate the work covered by such order as provided in the "Termination for Default" clause or the "Termination for Convenience" clause of this Contract.

B. *Cancellation or Expiration of the Order.* If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the TPA shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or TPA price, or both, and the Contract shall be modified in writing accordingly, if:

1. the stop work order results in an increase in the time required for, or in the TPA's costs properly allocable to, the performance of any part of this Contract; and
2. the TPA asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the Board decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

C. *Termination of Stopped Work.* If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

33. Oral Statements

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to the Contract shall be made in writing by the Board and agreed to by the TPA.

34. Ownership of Documents and Work Papers

The Board shall own all documents, files, reports, work papers and working documentation, electronic or otherwise, created in connection with the project which is the subject of this Contract, except for the TPA's internal administrative and quality assurance files and internal project correspondence, Confidential Business Information and Creations, proprietary rights, trademarks and trade names. The TPA shall deliver such documents and work papers to the Board upon termination or completion of the Contract if so requested by the Board. The foregoing notwithstanding, the TPA shall be entitled to retain a set of such work papers for its files. The TPA shall be entitled to use such work papers only after receiving written permission from the Board and subject to any copyright protections.

35. Trade Secrets, Commercial and Financial Information

It is expressly understood that Mississippi law requires that the provisions of this Contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

36. Third Party Action Notification

The TPA shall give the MDFA prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the TPA by any entity that may result in litigation related in any way to this Contract.

37. Indemnification

To the fullest extent allowed by law, the TPA shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, its Commissioners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by TPA and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Contract. In the State's sole discretion, upon approval of the Office of the Mississippi Attorney General, the TPA may be allowed to control the defense of any such claim, suit, etc. In the event the TPA defends said claim, suit, etc., the TPA shall use legal counsel acceptable to the Office of the Mississippi Attorney General. The TPA shall be solely responsible for all costs and/or expenses associated with such defense, and the State shall be entitled to participate in said defense. The TPA shall not settle any claim, suit, etc., without the concurrence of the Office of the Mississippi Attorney General, which shall not be unreasonably withhold.

38. Insurance, Bonds, or Other Sureties

The TPA shall maintain, throughout the term of this Contract, at its own expense,

A. **Implementation bond or escrow account** in an amount no less than Three Million Dollars ($3,000,000.00), naming the Board as exclusive beneficiary, to guarantee timely and complete establishment of the Contract and related services; Such bond or escrow account must be obtained or established within thirty (30) days of contract award. The bond shall be a corporate surety bond issued by a surety company authorized to do business in the State of Mississippi; while an escrow account is subject to approval by agency legal counsel. Any failure of the TPA to perform timely and complete establishment of such services shall result in damages recoverable by the Board against

the implementation bond or escrow account. Upon the agreement by the Board that the TPA has complied with its implementation responsibilities, the implementation bond shall be released.

B. **Blanket fidelity bond with third party liability** coverage in an amount no less than Two Million Dollars ($2,000,000) with the Board named as exclusive beneficiary for the duration of this Contract; Pursuant to such bond, any losses incurred by the Board due to theft or dishonesty of a TPA employee shall be fully repayable to the Board. The TPA shall be responsible for procuring any such recovery and reimbursing the Board accordingly.

C. **Professional and comprehensive general or commercial liability insurance** coverage in an amount no less than Five Million Dollars ($5,000,000) per occurrence and Five Million Dollars ($5,000,000) annual aggregate; and

D. **Workers' compensation** coverage as required by the State of Mississippi.

All insurances policies shall list the Board as an additional insured and shall be issued by insurance companies authorized to do business under the laws of the State of Mississippi, meaning insurance carriers must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. TPA shall not commence work under this Contract until it obtains all insurances required under this provision and furnishes certificate(s) or other form(s) showing proof of current coverage to the MDFA. After work commences, the TPA shall maintain in force all required insurance until the Contract is terminated or expires. TPA shall submit renewal certificates as appropriate during the term of the Contract. TPA shall ensure that should any of the above described policies be cancelled before the expiration date thereof, or if there is a material change, potential exhaustion of aggregate limits or intent not to renew insurance coverage(s), that written notice will be delivered to the MDFA. There shall be no cancellation, material change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) to MDFA. Any failure to comply with the reporting provisions of this clause shall constitute a material breach of Contract and shall be grounds for immediate termination of this Contract by MDFA.

39. Third Party Action Notification

The TPA shall give the Board prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the TPA by any entity that may result in litigation related in any way to this Contract. The Board shall give the TPA prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the Board by any entity that may result in litigation related in any way to this Contract.

40. Approval

It is understood that if this contract requires approval by the Mississippi State and School Employees Health Insurance Management Board (Board), the Public Procurement Review Board (PPRB) and/or the MDFA Office of Personal Service Contract Review (OPSCR) and this Contract is not approved by the Board, PPRB and/or OPSCR, it is void and no payment shall be made hereunder.

41. Change in Scope of Work

The Board may order changes in the work consisting of additions, deletions, or other revisions within the general scope of the Contract. No services may be changed, requiring changes to the amount of compensation to the TPA or other adjustments to the Contract, unless such changes or adjustments have

been made by written amendment to the Contract signed by the Board and the TPA. If the TPA believes that any particular work is not within the scope of the project, is a material change, or shall otherwise require more compensation to the TPA, the TPA shall immediately notify the Board in writing of this belief. If the Board believes that the particular work is within the scope of the Contract as written, the TPA shall be ordered to and shall continue the work as changed and at the cost stated for the work within the scope.

42. Disputes

Any dispute concerning the Contract which is not disposed of by agreement shall be decided by the Chair of the Board who shall reduce such decision to writing and mail or otherwise furnish a copy thereof to the TPA. The decision of the Chair of the Board shall be final and conclusive. Nothing in this paragraph shall be construed to relieve the TPA of full and diligent performance of the Contract.

43. Standards of Care/Remedies

The TP shall exercise reasonable care and due diligence consistent with standards in the industry in the performance of its obligations under this Contract.

44. Contractor Personnel

The Board shall, throughout the life of the Contract, have the right of reasonable rejection and approval of staff or subcontractors assigned to the work by the TPA. If the Board reasonably rejects staff or subcontractors, the TPA shall provide replacement staff or subcontractors satisfactory to the Board in a timely manner and at no additional cost to the Board. The day-to-day supervision and control of the TPA's employees and subcontractors is the sole responsibility of the TPA.

45. Recovery of Money

Whenever, under the Contract, any sum of money shall be recoverable from or payable by the TPA to the MDFA, the same amount may be deducted from any sum due to the TPA under the Contract or under any other contract between the TPA and the MDFA. The rights of the MDFA are in addition and without prejudice to any other right the MDFA may have to claim the amount of any loss or damage suffered by the MDFA on account of the acts or omissions of the TPA.

46. Failure to Enforce

Failure by the Board at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the Contract or any part thereof or the right of the Board to enforce any provision at any time in accordance with its terms.

47. Business Associate Statement

In the paragraphs that follow under this section, the term "BA Statement" shall refer to this section of the Contract, the term "Business Associate" shall refer to the TPA, and the term "Covered Entity" shall refer to the Plan. The purpose of this BA Statement is to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HHS) (the HIPAA Regulations) and other applicable laws, including the American Recovery and Reinvestment Act (ARRA)

of 2009, as applicable. The Covered Entity wishes to disclose certain information (Information) to Business Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI). The Covered Entity desires and directs Business Associate to share PHI with other Business Associates of the Covered Entity. In consideration of mutual promises below and exchange of information pursuant to this BA Statement, the parties agree as follows:

A. Definitions

Terms used, but not otherwise defined, in this BA Statement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Information (the Privacy Rule) and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the event of an inconsistency between the provisions of this BA Statement and mandatory provisions of the Privacy Rule and or the Security Standards, as amended, the Privacy Rule and/or the Security Standards shall control. Where provisions of this BA Statement are different than those mandated in the Privacy Rule and/or the Security Standards, but are nonetheless permitted by the Privacy Rule and/or the Security Standards, the provisions of this BA Statement shall control.

1. Breach. Breach shall be as defined in HITECH and the HIPAA regulations at 45 CFR §164.402.
2. Business Associate. Business Associate shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
3. Covered Entity. Covered Entity shall have the same meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
4. Designated Record Set. Designated Record Set shall have the same meaning given to such term under 45 CFR § 164.501 and shall mean a group of records maintained by or for the Covered Entity that is the payment, enrollment, claims adjudication and case or health management record systems maintained by or for the Covered Entity, or used, in whole or in part, by or for the Covered Entity, to make decisions about Individuals.
5. Electronic Media. Electronic Media has the same meaning as the term “electronic media” in 45 CFR § 160.103, which is:
    a. Electronic storage material on which data is or may be recorded electronically, including for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
    b. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.
6. Electronic Protected Health Care Information or (EPHI). EPHI has the same meaning as the term ‘electronic protected health care information’ in 45 CFR § 160.103, and is defined as that PHI that is transmitted by or maintained in electronic media.
7. Individual. Individual shall have the same meaning as the term “individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
8. Privacy Rule. Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E.

9. Protected Health Information or (PHI). PHI shall have the same meaning as the term “protected health information" in 45 CFR § 164.103, limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of Covered Entity.
10. Required By Law. Required By Law shall have the same meaning as the defined term “required by law” in 45 CFR § 164.103.
11. Security Incident has the meaning in 45 CFR § 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
12. Security Standards shall mean the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) codified at 45 CFR Parts 160 and 164, subpart C (Security Rule).
13. Unsecured PHI as defined in HIPAA and the HIPAA regulations at 45 CFR § 164.402, means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in guidance issued under 13402(h)(2) of Public Law 111-5 on HHS website.

B. Obligations and Activities of Business Associate

1. Compliance with Applicable Laws. Business Associate shall fully comply with the standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the HIPAA Regulations) and other applicable laws as of the date(s) the requirements under these laws become effective for Business Associates. This compliance shall include all requirements noted in Section 13404(a), (b) and (c) of the HITECH Act.
2. Business Associate directly subject to certain HIPAA provisions. Under HITECH, Business Associate acknowledges that it is directly subject to certain HIPAA provisions including, but not limited to, Sections 13401, 13404, 13405 of HITECH.
3. Use and Disclosure of Protected Health Information. Business Associate may use and/or disclose the Covered Entity’s PHI received by Business Associate pursuant to this BA Statement, the Contract, or as required by law, or as permitted under 45 CFR §164.512, subject to the provisions set forth in this BA Statement. Business Associate may use PHI in its possession for its proper management and administration or to fulfill any of its legal responsibilities. The Covered Entity specifically requests that Business Associate disclose PHI to other Business Associates of the Covered Entity for Health Care Operations of the Covered Entity. The Covered Entity shall provide a list of the affected Business Associates and shall request specific disclosures in written format. If any affected Business Associate is no longer under a BA Statement with the Covered Entity, the Covered Entity shall promptly inform Business Associate of such change.
4. Safeguards Against Misuse of Information. Business Associate shall use appropriate safeguards to prevent the use or disclosure of the Covered Entity’s PHI in any manner other than as required by this BA Statement or as required by law. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate’s operations and the nature and scope of its activities.
5. Reporting of Disclosures. Business Associate shall report to the Covered Entity any use or disclosure of the Covered Entity’s PHI in violation of this BA Statement or as required by law of which the Business Associate is aware, including Breaches of Unsecured PHI as required by 45 CFR §164.410, and agrees to mitigate, to the extent practicable, any harmful effect that is

known to Business Associate of a use or disclosure of the Covered Entity's PHI by Business Associate in violation of this BA Statement.

6. Business Associate's Agents. Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Business Associate on behalf of) the Covered Entity agree to be bound to by restrictions and conditions on the use or disclosure of PHI that are no less protective that those that apply to Business Associate with respect to such PHI. Business Associate represents that in the event of a disclosure of PHI to any third party, the information disclosed shall be in a limited data set if practicable and in all other cases the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
7. Nondisclosure. Business Associate shall not use or further disclose the Covered Entity's PHI otherwise than as permitted or required by this BA Statement, the Contract, or as required by law.
8. Availability of Information to the Covered Entity and Provision of Access and Accountings. Business Associate shall make available to the Covered Entity such Protected Health Information maintained by the Business Associate in a Designated Record Set as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, or provide a copy of, such Designated Record Set as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.524. Business Associate shall also maintain and make available the information required to provide an accounting of disclosures of Protected Health Information to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528.
9. Amendment of PHI. Business Associate shall make the Covered Entity's PHI available to the Covered Entity as the Covered Entity may require to fulfill the Covered Entity's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR § 164.526 and Business Associate shall, as directed by the Covered Entity, incorporate any amendments to the Covered Entity's PHI into copies of such PHI maintained by Business Associate. Business Associate agrees to make any amendment(s) to Protected Health Information that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity. [45 CFR § 164.504(e)(2)(F)]
10. Internal Practices. Business Associate agrees to make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PHI received from the Covered Entity (or received by Business Associate on behalf of the Covered Entity) available to the Secretary of the U.S. Department of Health and Human Services for inspection and copying for purposes of determining the Covered Entity's compliance with HIPAA and the HIPAA Regulations.
11. Notification of Breach. During the term of this BA Statement, Business Associate shall notify the Covered Entity following discovery and without unreasonable delay (but in no case later than 60 days) any Breach of Unsecured PHI. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
12. Safeguard of EPHI. The Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.
13. Subcontractors. The Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate safeguards to protect it.

14. Notification. The Business Associate shall report to the Covered Entity through the Mississippi Department of Finance and Administration, Office of Insurance any Breach of Unsecured PHI of which it becomes aware, without unreasonable delay, in the following time and manner:
    a. any actual, successful Security Incident shall be reported to the Covered Entity in writing, without unreasonable delay; and
    b. any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, shall be reported to the Covered Entity in writing, on a reasonable basis, at the written request of the Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the Security Rule.
15. Business Associate shall maintain and provide to the Covered Entity without unreasonable delay and in no case later than 60 days of discovery of a Breach of Unsecured PHI, (as these terms are defined in the HIPAA Regulations), the appropriate information to allow the Covered Entity to adhere to Breach notification.
16. The information provided to the Covered Entity shall include, at a minimum and to the extent possible, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during the Breach, and the Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in its notification to the Individual following discovery of a Breach and without unreasonable delay or promptly thereafter as information becomes available, including:
    a. A brief description of what happened, including the date of the breach, if known, and the date of the discovery of the breach.
    b. 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).
    c. The steps individuals should take to protect themselves from potential harm resulting from the breach.
    d. A brief description of what the Business Associate involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.
17. Minimum Necessary. Business Associate shall limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR § 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
18. Marketing. Business Associate shall not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.
19. Data Aggregation. Business Associate may use PHI in its possession to provide data aggregation services relating to the health care operations of the Covered Entity, as provided for in 45 CFR §164.501.
20. De-identification of PHI. Business Associate may de-identify any and all PHI, provided that the de-identification conforms to the requirements of 45 CFR § 164.514(b), and further provided that Business Associate maintains the documentation required by 45 CFR § 164.514(b), which may be in the form of a written assurance from Business Associate. Pursuant to 45 CFR § 164.502(d), de-identified information does not constitute PHI and is not subject to the terms of the BA Statement.

C. Obligations of the Covered Entity

1. Covered Entity's Representatives. The Covered Entity shall designate, in writing to Business Associate, individuals to be regarded as the Covered Entity's representatives, so that in reliance upon such designation Business Associate is authorized to make disclosures of PHI to such individuals or to their designee(s).
2. Restrictions on Use or Disclosure of PHI. If the Covered Entity agrees to restrictions on use or disclosure, as provided for in 45 CFR § 164.522 and the HITECH Act, of PHI received or created by Business Associate regarding an Individual, the Covered Entity agrees to pay Business Associate the actual costs incurred by Business Associate in accommodating such voluntary restrictions.
3. Limitation on Requests. The Covered Entity shall not request or require that Business Associate make any use or alteration of PHI that would violate HIPAA or HIPAA Regulations if done by the Covered Entity.

D. Audits, Inspection, and Enforcement

Upon reasonable notice, upon a reasonable determination by the Covered Entity that Business Associate has breached this BA Statement; the Covered Entity may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BA Statement. Business Associate shall promptly remedy any violation of any term of this BA Statement and shall certify the same to the Covered Entity in writing. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this BA Statement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this BA Statement. Business Associate shall fully cooperate with the U.S. Department of Health and Human Services, as the primary enforcer of the HIPAA, who shall conduct periodic compliance audits to ensure that both Business Associate and the Covered Entity are compliant.

E. Termination

1. Material Breach. A breach by Business Associate of any provision of this BA Statement, as determined by the Covered Entity, shall constitute a material breach of the BA Statement and shall provide grounds for immediate termination of the BA Statement and the Contract by the Board pursuant to Section E.2. of this BA Statement. [45 CFR § 164.504(e)(3)]
2. Reasonable Steps to Cure Breach. If either Party knows of a pattern of activity or practice of the other that constitutes a material breach or violation of that Party's obligations under the provisions of this BA Statement or another arrangement and does not terminate this BA Statement pursuant to Section E.1., then that Party shall take reasonable steps to cure such breach or end such violation, as applicable. If the Party's efforts to cure such breach or end such violation are unsuccessful, that Party shall either (i) terminate this BA Statement if feasible; or (ii) if termination of this BA Statement is not feasible, the non-breaching Party shall report the other Party's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]
3. Judicial or Administrative Proceedings. Either party may terminate this BA Statement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

4. Effect of Termination. Upon termination of this BA Statement and the Contract for any reason, Business Associate shall return or destroy PHI received from the Covered Entity (or created or received by Business Associate on behalf of the Covered Entity) that Business Associate still maintains in any form, and shall retain no copies of such PHI except for one copy that Business Associate shall use solely for archival purposes and to defend its work product, provided that documents and data remain confidential and subject to this BA Statement, or if return or destruction is not feasible, it shall continue to extend the protections of this BA Statement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(I)]

F. Disclaimer

The Covered Entity makes no warranty or representation that compliance by Business Associate with this BA Statement, HIPAA or the HIPAA Regulations shall be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or shall be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

G. Amendment

Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BA Statement and the Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the Covered Entity shall receive satisfactory written assurance from Business Associate that Business Associate shall adequately safeguard all PHI that it receives or creates pursuant to this BA Statement. Upon the Covered Entity's request, Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this BA Statement and the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The Covered Entity may terminate this BA Statement upon 90 days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BA Statement and the Contract when requested by the Covered Entity pursuant to this Section; or (ii) Business Associate does not enter into an amendment to this BA Statement and the Contract providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

H. Assistance in Litigation or Administrative Proceedings

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this BA Statement, available to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

I. No Third Party Beneficiaries

Nothing expressed or implied in this BA Statement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

J. Effect on Contract

Except as specifically required to implement the purposes of this BA Statement, or to the extent inconsistent with this BA Statement, all other terms of the Contract shall remain in force and effect.

K. Electronic Health Records (EHR)

If electronic health records are used or maintained with respect to PHI, individuals shall have the right to obtain a copy of such information in "electronic format".

L. No Remuneration for PHI

Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI, unless it first obtains a valid authorization from the individual whose PHI is being disclosed.

M. Interpretation

This BA Statement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations and applicable state laws. The parties agree that any ambiguity in this BA Statement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

48. <u>Notices</u>

All notices required or permitted to be given under this Contract shall be in writing and personally delivered or sent by certified United States mail, postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address.

If to the Board/MDFA:
Executive Director
Mississippi Department of Finance and Administration
501 N. West St., Suite 1301 Woolfolk Building
Post Office Box 267
Jackson, Mississippi 39205-0267

With a copy of any notice to:
State Insurance Administrator
Mississippi Department of Finance and Administration
Office of Insurance
501 N. West St., Suite 901-B Woolfolk Building
Post Office Box 24208
Jackson, Mississippi 39225-4208

If to the TPA: [Name, Title]
[Contractor Name]
[Address]
[City, State, Zip]

49. Incorporation of Documents

This Contract consists of and precedence is hereby established by the order of the following documents incorporated herein:

A. This Contract signed by the parties including ***Exhibit A, Fee Schedule for Third Party Administration Services; Exhibit B, Performance Standards;*** and ***Exhibit C, TPA Services Contractor Reports***;

B. The ***TPA Contractor's Response to the Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Third Party Administration Services, Dated January 12, 2022,*** and includes any applicable requested and submitted Best and Final Offer, and attached hereto as ***Exhibit C*** and incorporated fully herein by reference; and

C. The ***Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Third Party Administration Services, dated November 17, 2021***, attached hereto as ***Exhibit D*** and incorporated fully herein by reference. This RFP includes any amendment thereto, such as Questions and Answer document(s), if any were issued, as well as any Best and Final Offer request.

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IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed on the date shown below:

[Contractor Name]	**State and School Employees Health Insurance Management Board**
By: _____	By: _____
Name: _____	Name: Liz Welch
Title: _____	Title: Chairman of the Board
Date: _____	Date: _____

Exhibit A - Fee Schedule for Third Party Administration Services

All fees are guaranteed throughout the term of the Contract. The bundled monthly administration fee will be calculated and invoiced monthly in arrears by the TPA, using the current monthly enrollment and the Per Employee Per Month (PEPM) Rate provided below. For the purposes of the calculation of these fees, "Employee" refers to any active, COBRA, or retired employee, and excludes dependents.

Contract Year	Per Employee Per Month (PEPM) Rate
1/1/2023 – 12/31/2023	**$**
1/1/2024 – 12/31/2024	**$**
1/1/2025 – 12/31/2025	**$**
1/1/2026 – 12/31/2026	**$**
1/1/2027 – 12/31/2027*	**$**

*Optional renewal term

The fees listed above are firm for the duration of the Contract and are not subject to escalation for any reason unless the Contract is duly amended. No additional compensation shall be provided by the Board for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the Board. The Board will not pay any upfront fees prior to the January 1, 2023 Contract effective date.

Exhibit B - Performance Standards

The TPA agrees to the following minimum performance standards and the assessment of liquidated damages for failure to meet these standards. At the Board's discretion, an audit of the accuracy of the TPA's results will be performed via a randomly selected, statistically verifiable sample of claims by a qualified, independent third party. The results of the audit, after appropriate review and comment by the TPA, will be the final determinant of performance standard compliance. When sampling methods are used to estimate performance for the universe of claims, audit samples will be large enough to ensure a confidence interval whose deviation is no greater than plus or minus three (3) percent and whose confidence level is at least ninety-five percent (95%). The Board will consider the point estimate for the sample as the TPA's performance level in calculating liquidated damages. The TPA will be provided the opportunity to review and discuss the audit results before the application of liquidated damages. The Board reserves the right to reduce or waive any fees at risk if, in the Board's sole discretion, failure to meet a performance standard was due to extraordinary circumstances.

All payments made on behalf of the Plan to eligible participants and providers, for approved services, shall be in accordance with the *Plan Document* and policies of the Board. The TPA shall identify claims that have been incorrectly processed, and initiate appropriate action to correct processing outcomes. The TPA shall notify the OI in writing immediately upon discovery of any systems problem that has caused multiple overpayments, duplicate payments or incorrect payments, irrespective of cause, prior to initiating recovery or corrective action. The TPA shall notify the OI by letter of any system errors that result in a potential provider or participant overpayment or other incorrect payment and describe in detail the plan and deadlines for corrective action.

Claim Turnaround Time:

Claim turnaround time is calculated from the date the claim is received in the TPA's office to the date it is processed. Claim turnaround time will initially be measured using the TPA's internal turnaround time reports produced on a monthly basis.

Standard	Threshold	Total Annual Liquidated Damages
95.00% of all claims processed in 30 calendar days	**95.00% - 100.00%**	**None**
	85.00% - 94.99%	**2.00% of TPA Fees**
	Below 85.00%	**4.00% of TPA Fees**

Claim Financial Accuracy:

Mathematically, the financial accuracy of a universe of claims is the total dollars paid correctly divided by the total dollars paid, stated as a percentage.

Standard	Threshold	Total Annual Liquidated Damages
99.00% Accuracy	**99.00% - 100.00%**	**None**
	98.00% - 98.99%	**2.00% of TPA Fees**
	97.00% - 97.99%	**3.00% of TPA Fees**
	Below 97.00%	**4.00% of TPA Fees**

Claim Payment Accuracy:

The payment accuracy of a universe of claims is the number of claims paid correctly divided by the total number of claims, stated as a percentage. Payment accuracy reflects the percentage of claims that are paid correctly.

Standard	Threshold	Total Annual Liquidated Damages
97.00% Accuracy	**97.00% - 100.00%**	**None**
	95.00% - 96.99%	**2.00% of TPA Fees**
	Below 95.00%	**3.00% of TPA Fees**

Claim Processing Accuracy:

The Processing Accuracy of a universe of claims is the number of claims processed correctly divided by the total number of claims. Claims with payment errors will not be considered in the calculation of processing accuracy.

Standard	Threshold	Total Annual Liquidated Damages
95.00% Accuracy	**95.00% - 100.00%**	**None**
	93.50% - 94.99%	**2.00% of TPA Fees**
	Below 93.50%	**3.00% of TPA Fees**

If an overpayment, duplicate payment, or incorrect payment is made to a participant or provider and that payment is the result, in the sole determination of Board, of a failure of the TPA to process claims correctly, the Total Annual Liquidated Damages for Financial Accuracy and Payment Accuracy is doubled if ninety percent (90%) of the overpayments, duplicate payments, or incorrect payments are not recovered by the TPA within ninety (90) days of identification of such payment. The TPA has the right to recover such overpayments, duplicate payments, or incorrect payments by procedures approved by the Board. The TPA shall provide the Board with a monthly report of all overpayments, duplicate payments, and payments to the wrong payee reflecting the status of corrections, adjustments, and collections resulting from this error.

Hospital DRG Validations and Bill Audits:

The TPA is responsible for hospital DRG validations, charge/bill audits, and professional bill audits within one (1) year from the day the claim was processed. The TPA will provide to the Board reports monthly of its findings in a format approved by the Board. This measurement shall be monitored from TPA's reports. Should the TPA fail to satisfactorily validate and audit as agreed upon, the Board may assess the liquidated damages as follows:

Standard	Threshold	Total Annual Liquidated Damages
96.00% Complete	**96.00% - 100.00%**	**None**
	90.00% - 95.99%	**$10,000.00**
	Below 90.00%	**$15,000.00**

For purposes of determining completion of this process, the TPA shall provide the OI with a year-end report based on system generated data. This data will include number of claims processed in the year, the number of claims audited in the year, the number and percentage of claims audited where the audits were initiated within three hundred sixty-five (365) days, and the number and percentage of claims audited where the audits were not initiated within three hundred sixty-five (365) days.

Credit Balance Recovery:

The TPA will perform credit balance and overpayment recovery services as agreed upon by the OI within six (6) months from the date the overpayment was detected. This measurement will be monitored from TPA's reports. Should the TPA fail to satisfactorily perform credit balance and overpayment recovery services as agreed upon, the Board may assess liquidated damages as follows:

Standard	Threshold	Total Annual Liquidated Damages
96.00% Complete	**96.00% - 100.00%**	**None**
	90.00% - 95.99%	**$10,000.00**
	Below 90.00%	**$15,000.00**

For purposes of determining completion of this process, the TPA will provide the OI with a year-end report based on system generated data. This data will include number of claims detected during the year, the number of claims recovered within three hundred sixty-five (365) days, percentage of claims recovered within three hundred sixty-five (365) days, and percentage of claims not recovered within three hundred sixty-five (365) days.

Customer Service - Average Speed of Answer (ASA)

The average speed of answer is the average amount of time, measured in seconds, a Customer Service Representative (CSR) takes to answer an inbound call after the call is delivered from the Interactive Voice Response (IVR) System to the call queue. ASA includes the amount of time callers wait in queue plus the amount of time the assigned CSR's phone rings before the call is answered.

Standard	Threshold	Total Annual Liquidated Damages
ASA of 30 seconds or less	**≤30 Seconds**	**None**
	>30 Seconds - ≤35 Seconds	**2.00% of TPA Fees**
	>35 Seconds	**3.00% of TPA Fees**

Telephone Drop Rate:

A call "drop rate" is defined as an individual hanging up once in the queue.

Standard	Threshold	Total Annual Liquidated Damages
Less than 5.00%	**Less than 5.00%**	**None**
	5.00% - 8.00%	**2.00% of TPA Fees**
	Above 8.00%	**3.00% of TPA Fees**

Data Transfer:

Standard	Total Annual Liquidated Damages
All error transactions from the data transfer sent to the Board's vendors will be corrected and returned to the Board's vendors via data transfer within two (2) business days of receipt of the error report.	**Total of 2.00% of annual TPA Fees to be assessed at the end of each 12-month period**

Standard Reports:

TPA is to produce and provide the OI with reports. The final reporting format and elements are to be agreed upon between the Board, OI, and the TPA following contract award. All reports must include report parameters and definitions. Report parameters/definitions must be revised as appropriate when revisions to the report scope occur. Compliance with this standard will be evaluated by the OI at the end of each contract year. Liquidated damages will be assessed for failure to meet the reporting requirements for the performance standard if a required report is late, incomplete, or inaccurate.

All information supplied by the TPA is subject to audit by the Board or its designee. The Board, at its discretion, may also conduct an independent audit of the TPA's performance and if such audit is conducted, the results of the audit will be used to assess any liquidated damages. The TPA will be provided the opportunity to review and discuss the audit results before the application of liquidated damages.

Standard	Total Annual Liquidated Damages
All TPA reports due to the Board will be submitted within thirty (30) calendar days from the end of the reporting cycle.	**Total of 1.00% of annual TPA Fees to be assessed at the end of each 12-month period.**

All reports must be delivered to the Board according to the schedule specified by the Board. Refer to **Exhibit C, TPA Services Contractor Reports**. In the event a report is late or does not comply with format and content as approved by the Board, Board may assess One Hundred Dollars ($100.00) per workday per report for each day report is late or unacceptable.

System Enhancement and Modification Requests:

All enhancements and modifications requested by the OI must be operational on the date agreed upon by OI and the TPA. The TPA will respond to all requests for system enhancements and modifications, whether categorized as maintenance or enhancement, within ten (10) workdays of receipt of a written request for an enhancement or modification. The written response will illustrate an understanding of the request, a date of completion, an assessment of the impact of the change, and the estimated cost, if applicable. The estimate of cost for the modifications will be categorized as (1) labor, by job class, in hours; (2) equipment; (3) general and administrative support in hours; and (4) other identified miscellaneous costs.

The TPA shall provide OI a weekly progress report as to the current status of these system changes. The report should include an outline of the change, projected implementation date, estimated hours and an overview of the work performed and to be performed. In all cases, the TPA shall respond to all system claims payment problems within twenty-four (24) hours.

In the event of failure by the TPA to comply with these standards, OI may assess Five Hundred Dollars ($500.00) per workday for each enhancement that is not operational on the date specified, One Hundred Dollars ($100.00) for each change order not acknowledged by the TPA within ten (10) working days of receipt and providing a recommended course of action, and Five Hundred Dollars ($500.00) per workday for each maintenance task not completed by the effective or mutually agreed upon completion date.

Transfer of Medical Claim Data to Medical Management Vendor:

The TPA will provide and receive electronic transfer of data to/from the Board's vendors in a format approved by the OI. Should the TPA fail to satisfactorily provide and receive electronic transfer of data to/from the

Board's vendors with the agreed upon time frame and in a form that supports our Plan benfits, the Board may assess a Twenty Thousand Dollars ($20,000.00) per day per occurrence in liquidated damages.

Network Access:

The TPA shall maintain the following network access to a minimum of eighty-five percent (85%) of in-state participants:

Two (2) Primary Care Providers* located:
Urban/Suburban – within 10 miles **Rural – within 20 miles**
One (1) Acute Hospital located:
Urban/Suburban – within 25 miles **Rural – within 35 miles**

*A primary care provider is defined as any of the following provider types: Internal Medicine, Family Practice, General Practice, and Family Nurse Practitioner.

This will be measured by access reports produced by the TPA, the OI, or its designee (to be determined at the discretion of the OI, but no less than annually), using GeoAccess® or similar software. The TPA must produce the access report results quarterly to be provided thirty (30) calendar days after each quarter ends and semi-annually with results as of June 30th to be provided to OI by July 31st, and results as of December 31st to be provided to OI by January 31st. The match is to be conducted separately for urban/suburban zip code areas and for rural zip code areas. The term urban/suburban area is defined as a zip code with a population density of one thousand (1,000) or more persons per square mile and a rural area is defined as a zip code with a population density of less than one thousand (1,000) persons per square mile or as defined by GeoAccess®. The mapping or methodology used to measure distance must be based on actual driving distance. The elements used to measure participant access are (1) the five digit zip code census of covered participants as of the end of the measurement period; and (2) the five digit zip code census of the provider network (using the address of their practice locations) under contract as of the end of the measurement period. Any deficiencies identified must be investigated and resolved within thirty (30) days. The final outcome must be communicated to OI in writing. In the event of failure by the TPA to comply with these standards, OI may assess Five Hundred Dollars ($500.00) per workday for each requirement that is not satisfied on the date specified.

The TPA's compliance will be evaluated at the end of each contract year. OI will use the semi-annual reports to monitor the TPA's performance. The assessment period will begin after OI's receipt of the required contract year-end report from the TPA.

Liquidated damages will be assessed if the access for the contract year under review for any provider type was not in compliance with the performance standards. Five Thousand Dollars ($5,000.00) for each full percentage below the performance standard for each provider type each contract year will be assessed. In addition, Five Hundred Dollars ($500.00) will be assessed for each calendar day any required report is late, incomplete, or inaccurate.

Participant Complaints/Issues Regarding Providers:

The TPA will respond to all complaints from participants or issues pertaining to a provider in the network within ten (10) business days after receiving the complaint or issue. If at least ninety-five percent (95%) of all complaints or issues do not receive a full and complete response within ten (10) business days, measured on an annual basis, liquidated damages in the amount of Twenty Thousand Dollars ($20,000.00) will be assessed.

Contractual Compliance:

Upon OI's notice of non-compliance with a condition(s) of the Contract, the TPA will have thirty (30) days to become compliant. OI may assess, starting on the thirty-first (31st) day, One Thousand Dollars ($1,000.00) per day for each day the TPA is not in compliance with the Contract.

Measurement of Performance

Performance and activity reports will be submitted monthly to the Board. The Board will use the TPA's internal reports to measure the TPA's performance relative to the standards included in this Exhibit. The TPA's internal reports and/or data (including detail claims data) supporting the TPA's internal reports may be reviewed/audited by the Board, or at the Board's discretion, by an independent reviewer. The report and determination of the independent reviewer shall be final, binding and conclusive as to an administrative review on TPA and the Board; provided, however, that before a final report and determination is issued, the Board and TPA shall each have a reasonable opportunity to review the non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer.

Payment of Liquidated Damages

In the event the Board determines that the TPA has not met a given Performance Standard, under which liquidated damages are payable to the Board for failure to comply, TPA shall remit the applicable at-risk fees for failing to meet the corresponding Performance Standard to the Board within forty-five (45) days after the end of the measurement period.

Measurement Period

Quarterly and Annual Measurement Periods are measured based on the calendar year.

Exhibit C - TPA Services Contractor Reports

TPA will provide reporting which will reflect transactional (weekly and monthly) elements as well as the overall success of the program (quarterly, semi-annual, and annual) elements. All reports must include report parameters and definitions. The report list and frequency will be as follows:

Deliverable	Ongoing Frequency	Description
Claims Administration Report	Monthly – by the 10th of the month following the previous month and as required by state and federal law.	Detailed reports showing potential fraud and abuse cases, health insurance premium amounts for W2 reporting, Affordable Care Act (ACA) compliance reports (Forms 1094 and 1095) and filing of reports on behalf of the Board as required by federal and state law.
Claim Turnaround Time/Claims Lag Report	Monthly – by the 10th of the month following the previous month	Detailed report showing of the date the claim is received and the date the claim is processed.
Top Payment Reports	Monthly – by the 10th of the month following the previous month	Detailed reports on the following by payment: • Top 20 Patients • Top 20 Hospitals (Inpatient) • Top 20 Hospitals (Outpatient) • Top 20 DRGs • Top 20 Physicians/Medical Providers • Top 20 Surgical Procedures • Top 100 Surgical Procedures
Claims Detail Report	Weekly – by the first business day following the EOW of week reported	Detailed report showing weekly claim payments made. This report should include current and prior year rolling average claim payments made. Also, current and prior year claims volume.
Medicare Secondary Payer (MSP) Report	Weekly – by the first business day following the EOW of week reported	Detailed report of current status of MSP cases.
Pended Claims Report	Weekly – by the first business day following the EOW of week reported	Detailed report to include number of claims pended, pend code reasons/descriptions and timeframe of pends.
Claims QA Report	Monthly – by the 10th of the month following the previous month	Detailed report of all claims processing errors identified as a result of vendor's internal QA review.
Appeals Report	Monthly – by the 10th of the month following the previous month	Detailed report which includes the following appeals details: • Receipt Date, • Completion Date, • Turnaround time (TAT), • Appeal Reason, • Appeal Outcome, and • Type of Appeal.
Prior Authorization Request Report	Monthly – by the 10th of the month following the	Detailed report providing authorizations requested and reviewed by the vendor's medical review staff.

	previous month	
Coordination of Benefits (COB) & Subrogation Activity Report	Monthly – by the 10th of the month following the previous month	Detailed report of COB and subrogation activity on a monthly basis.
Customer Service Telephone Call Report	Monthly – by the 10th of the month following the previous month	Detailed customer service telephone call report to include, but not limited to: • Number of calls • Call answer time • Telephone drop rate • Reason for call list • Hold time
Customer Service QA Report	Monthly – by the 10th of the month following the previous month	Detailed report of all customer service errors identified as a result of vendor's QA review.
Telemedicine Utilization Report	Monthly – by the 10th of the month following the previous month	Detailed report of participant telemedicine utilization for all providers.
Field Rep Activity Report	Monthly – by the 10th of the month following the previous month	Detailed report of all activities completed by field reps. This report should include all visits, conferences, and any other field activity performed by the field reps.
Network Access Report	Quarterly – 30 calendar days after the quarter ends Semi-Annually of results as of June 30th due by July 31st & results as of December 31st due by January 31st	Detailed reports provided which confirm in-state network access.
Provider Network Inquiry Report	Quarterly – 30 calendar days after the quarter ends	Detailed report of inquiries from providers and participants concerning the provider network.
Provider Network Manager Report	Monthly – by the 10th of the month following the previous month	Detailed report of provider network manager activity to include contracted providers activity, network performance and claims analysis.
Network Provider Hospital Privileges Report	Quarterly – 30 calendar days after the quarter ends	Detailed report of network providers who do not have admitting privileges at a participating hospital.
Provider and Participant Complaint Resolution Report	Quarterly – 30 calendar days after the quarter ends	Detailed summary tracking participant and provider inquiries or complaints and resolutions and timeframe for resolution.
Provider Performance Monitoring Report	Quarterly – 30 calendar days after the quarter ends	Detailed report of utilization and cost trends, incidents of quality issues and/or non-compliance with medical management protocols and outcomes of implemented corrective action plans.
Participant Satisfaction	Annually	Summary of participant survey responses completed.

Survey Report		
Provider Satisfaction Survey Report	Annually	Summary of provider survey responses completed.
Hospital DRG Validations and Charge/Bill Audits Finding Report	Monthly – by the 30th of the month following the previous month	Detailed report showing hospital DRG validations, charge/bill audits and professional bill audits within one (1) year from the day the claim was processed in a format approved by the Board.
Year-End Hospital DRG Validations and Charge/Bill Audits Finding Report	Annually	Detailed report including the number of claims processed in the year, the number of claims audited in the year, the number and percentage of claims audited where the audits were initiated within 365 days, and the number and percentage of claims audited where the audits were not initiated within 365 days.
Credit Balance Recovery Report	Monthly – by the 30th of the month following the previous month	Detailed report should include at a minimum, the following details: 1. Overpaid Entity/Individual; 2. Provider Tax ID, if applicable; 3. Overpayment Amount; 4. Overpayment Reason; 5. Date Overpayment Identified; 6. Collection Activity, including letter and phone date(s); and 7. Date Debt Discharged.
Year-End Credit Balance Recovery Report	Annually	Detailed report including the number of claims detected during the year, the number of claims recovered within 365 days, percentage of claims recovered within 365 days, and percentage of claims not recovered within 365 days.
Past Due Detail Report	Monthly – by the 10th of the month following the previous month	Detailed report showing employer units with past due premiums.
Premium Billing and Account Reconciliation Report	Monthly – by the 10th of the month following the previous month	Detailed report containing any premiums received for reconciliation purposes.
Public Employees' Retirement System (PERS) System Billing Report	Monthly – by the 10th of the following month's premiums.	Detailed report sent to PERS on retirees whose health and/or life premiums are deducted by PERS that includes the minimal participant identifiable information and premium amount (medical and life).
Prescription Rebate Report	Quarterly – 30 calendar days after the quarter ends	Report detailing all prescription rebate information.
Enrollment Report	Monthly – by the 10th of the month following the previous month	Detailed report of all enrolled participants and dependents.
COBRA and Retiree Termination List Report	Monthly – by the 10th of the month following the previous month	Detailed list of all COBRA and retiree terminations.
Monthly Meeting Recap	Monthly – by the 10th of the	Detailed summary of each monthly meeting between the TPA

	month following the previous month	and OI.
MDFA Issue Tracking Log	Continuously updated	Detailed log of all issues being worked. This log should provide status and updates through completion of all issues.
Statement on Standards for Attestation Engagements Number 18 (SSAE 18)	Annually	Detailed SSAE 18 report or equivalent prepared by a Certified Public Accountant at the TPA's own expense.
Data Transfer Error Report	Per occurrence	Detailed report of all error transactions from the data transferred to (Board's) vendors which were corrected and returned to vendors.
Performance Guarantee Tracking Log	Quarterly	Detailed report of performance guarantee tracking to include scores/percentages per quarter and any missed guarantees and associated penalty assessment.
System Enhancement and Modification Progress Report	Weekly status through completion of project	Detailed report of system enhancements and modifications requested by OI. The report will initially include an outline of the change, projected implementation date, estimated hours and an overview of the work performed and to be performed. Once the project is initiated, the report will also combine weekly status updates.
Advanced Explanation of Benefits (EOB) Report	Monthly – by the 10th of the month following the previous month	Detailed report to include Advanced Explanation of Benefits including verification of timely notice.
Standard/Ad Hoc Reporting	Per Board request	Detailed report will be provided at the Board's request in a hard copy and/or electronic media format. The TPA shall provide web-based reporting tools that allow the Board to view, print and download reports to spreadsheet software.

Exhibit D - The TPA Contractor's Response to the Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Third Party Administration Services, Dated January 12, 2022

Exhibit E - Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Third Party Administration Services, dated November 17, 2021