

STATEMENT OF WORK

I. EXECUTIVE SUMMARY

The Indiana House and Senate have made lowering the price of healthcare in Indiana a priority for the past six years. Indiana's high healthcare costs are largely the result of high hospital prices, which are approximately 20 percent above the national average. During and following his election in 2024, Governor Braun committed to lowering the cost of healthcare for Hoosiers. Together, the Governor and the legislature made great strides forward in 2025, enacting legislation that should lead to lower hospital prices.

This is an outcomes-based procurement that wants to build on, and take advantage of, the work performed by Indiana's governing officials. The state's objective is to bring aggregate hospital facility prices — excluding physician and other professional fees — for the State Employee Health Plan, to at or below the national commercial average. The national commercial average for hospital prices, inclusive of professional services, is approximately 2.6 times Medicare rates. Hospital facility-only payments average closer to 2.8 times Medicare rates nationally. In Indiana, hospital facility payments exceed the national average by roughly 20 percent, while physician fees remain below national norms. To reduce costs, the State endeavors to establish a maximum allowable reimbursement level for hospital services, which must also be expressed as a multiple of Medicare rates, not to exceed the national average. The State Employee Health Plan is primarily funded with public dollars, and the State believes that a plan funded mostly by taxpayer dollars should not pay higher hospital prices relative to other states, particularly because the cost of living in Indiana is about ten percent below the national average.

The State Employee Health Plan believes consumers are capable of making informed decisions and should be able to shop for certain services (Shoppable Services) and, if they choose low-cost providers, share in the savings with the State. And if the more expensive services are chosen, the consumer should be willing to pay the difference. Accordingly, the State is looking to implement reference-based pricing at between the 50th and 60th percentile of allowed amounts for a set of shoppable services, including but not limited to the CMS list of shoppable services.

The State Employee Health plan should not pay more for services that are provided in a hospital outpatient setting than in a physician office or independent ambulatory surgical center. The State Employee Health Plan must include site-neutral payments for all services and procedures that Medicare does.

Additionally, tiered networks organize healthcare providers into different levels based on cost and quality, helping employees make informed choices about their healthcare while still saving money. Tiered Networks allow employees to access affordable, high-quality care that fits their budget and needs. The State is interested in expanding plan options to include multiple tiered network options for members to choose.

As one of the largest health plans in Indiana, the State Employee Health Plan is looking for a partner who is committed to the same goals: lower hospital prices, pricing based on a multiple of Medicare, more choice, and a focus on changing member consumption behaviors.

II. BACKGROUND AND CURRENT STATE

In aggregate, SPD spends approximately \$13M annually on Third-Party Administrative services for the State's self-insured medical plans and XX on Population Health Management. Since this number is based on past usage and may fluctuate up or down, the State is not in a position to guarantee that future spending will be at these levels. Nevertheless, this amount is provided as an aid to suppliers in responding to this RFP.

Current plan documents and other information about the State's Employee benefit offerings can be found at www.in.gov/spd/benefits.

III. SCOPE OF WORK

A. OBJECTIVES OF ENGAGEMENT

The successful respondent must demonstrate the ability to administer the State's self-funded medical plan including a PPO and CDHP medical plans (this does not include health savings account administration) including population health management with a wellness rewards platform for eligible employees and early retirees. The administrator must provide claims processing services, utilization management, disease management,

case management, account service and support, customer service, billing, benchmarking, reporting, appeals process, population health management, and other administrative services as fully described below. The respondent will also be expected to administer custom pricing arrangements between the State and in-network providers (referred to as “direct provider pricing arrangements”).

B. DELIVERABLES AND DEADLINES

a. General Responsibilities

- (1) Administer the State’s self-funded PPO medical plan and CDHPs for eligible employees, officers, and early retirees. Prescription drug benefits and related pharmacy benefit management of services have been “carved out” and are performed by a pharmacy benefits manager that may not be affiliated with Contractor. The Contractor does not insure or underwrite the liability of the State, participating School Corporations, Direct Billed entities, or individuals for these plans. The State retains the ultimate responsibility for claims made under these plans and all expenses incident to those plans, except for the performance of Contractor duties which shall be performed by the Contractor at the contract prices set forth herein.
- (2) Expand coverage as may be directed by the Indiana General Assembly.
- (3) Except to the extent of contractor duties as specified herein, the State retains full and final authority and responsibility for the Plans. The Contractor is empowered to act on behalf of the State in connection with the Plans only as expressly stated under this contract or as mutually agreed to in writing by the parties.
- (4) Each party shall notify the other party of any legal action against either party, which involves the Plan, or this Contract.

b. Administrative Responsibilities

- (1) The State of Indiana Personnel Department or State related organizations are responsible for the following functions:
 - (A) Enrollments (new and changed);
 - (B) Payroll deductions;
 - (C) Reimbursement of claims paid by the Contractor and payment of administrative charges as specified for the self-insured plans;
 - (D) In accordance with the requirements under COBRA, timely notification of the availability of continuation coverage to eligible Enrollees or dependents. However, each School Binder Agreement will provide that Contractor will administer specified COBRA requirements for the school corporation.
 - (E) Establishment of open enrollment periods;
 - (F) To provide to the Contractor, accurate information concerning employees newly eligible for enrollment, termination of enrollees, address changes and family status changes affecting enrollment, within 30 days of the event.
- (2) The Contractor, or its authorized Subcontractors, will perform the following functions in support of the health plans:

Hospital Pricing and Network Requirements

Consistent with the State's objectives for the State Employee Health Plan, the Contractor shall have the capability to implement and administer the following reimbursement and benefit-design requirements at the direction of the State:

- (A) Hospital Payment Limits. The Contractor shall implement and administer reimbursement arrangements under which aggregate hospital facility payments under the Plan do not exceed the national commercial average, including through reimbursement expressed as a multiple of Medicare rates. The Contractor shall administer such limits as directed by the State and provide the data and reporting necessary to measure the Plan's hospital prices relative to national benchmarks. Compliance with this requirement shall be evaluated at the individual claim level and not satisfied through an unweighted average across claims.
- (B) Reference Pricing for Shoppable Services. The Contractor shall implement and administer a reference-based pricing program for services designated by the State as Shoppable Services, including, but not limited to, services identified on the CMS list of shoppable services. Reference prices shall be established between the 50th and 60th percentile of allowed amounts for the applicable service. The Contractor shall support benefit designs that provide members with financial incentives to select providers priced at or below the reference price and that may require members selecting higher-priced providers to pay the amount above the reference price.
- (C) Site-Neutral Payments. The Contractor shall implement and administer site-neutral reimbursement for services and procedures. At a minimum, the Plan shall apply site-neutral payment policies to all services and procedures for which Medicare applies site-neutral payment policies. For services subject to site-neutral payment, the Contractor shall reimburse the service at the lower applicable amount without regard to whether the service is furnished in a hospital outpatient department, physician office, or other setting, as directed by the State.
- (D) Tiered Networks. The Contractor shall have the capability to establish and administer tiered provider networks that differentiate providers based on price, quality, or other criteria established by the State. The Contractor shall support multiple tiered-network plan options if directed by the State and shall administer differential member cost-sharing or other financial incentives designed to encourage utilization of high-quality, lower-cost providers.
- (E) Implementation and Reporting. The Contractor shall provide the State with the analyses, modeling, and implementation support necessary to establish reimbursement levels and benefit designs under this section. The Contractor shall provide the State with all claims, pricing, utilization, provider, and other data necessary to implement, monitor, and evaluate these requirements. At the State's direction, the Contractor shall report on hospital prices relative to national commercial and Medicare benchmarks; utilization and savings attributable to reference pricing; utilization shifts resulting from site-neutral payment policies; and enrollment, utilization, cost, and quality performance by network tier.

Claims Administration

- (A) Accurate processing of claims - Medical claims are received directly from enrollees and service providers and network discounts are applied. The Contractor will obtain and maintain all additional service provider or coordination of benefits information directly from service providers or other carriers. Payments and explanation of benefits forms (EOB's) are to be distributed directly to enrollees and service providers.
- (B) Contractor will be responsible for processing and paying health claims submitted to the Plans according the terms of this Contract and the Contractor's provider contracts, with payment for each claim made at the lesser of the actual billed amount submitted by the healthcare provider for the services rendered or the negotiated rate for such services as agree upon between the Contractor and the healthcare provider or as otherwise specified in any applicable provider agreement, rate schedule, or attachment to this Agreement. All payment shall comply with all applicable federal, state, and local laws, regulations, and guidelines, including those governing healthcare billing, coding, and reimbursement.
- (C) Contractor shall disclose and administer all clearinghouse, repricing, bundling, and other claims-pricing arrangements used in adjudication, including the identity and role of any repricer or affiliate; applicable pricing methodologies or algorithms, including uniform-payment or revenue-neutral programs and threshold-pricing arrangements; thresholds for alternative adjudication; and any provider-contract limitations on claim audits or adjudication edits.
- (D) Preparation and mailing to Enrollees homes of medical identification cards including information about the State's pharmacy benefit manager;
- (E) Preparation of claim forms that are available through mail or online format;
- (F) Provision of detailed explanation of benefits paid to each claimant;
- (G) Provision of an advanced explanation of benefits when requested by a plan member at least 72 hours in advance of the service being provided;
- (H) Notification to claimants of rejected claims and the reason for rejection;
- (I) Investigation of claims;
- (J) Performance of internal and external audits on a random sample basis of claim payments with results reported to State Personnel Department;
- (K) Delivery of information as necessary regarding coordination of benefits;
- (L) Administer coordination of benefits with Medicare, other employer group plans, property and casualty insurers, workers compensation programs, and other applicable payers.
- (M) Application of claims control procedures necessary for the effective implementation of the Plan;
- (N) Preparation of standard quarterly reports including, but not limited to, paid claims, membership, employee cost share, utilization by setting, utilization of Contractor programs and services, network updates, and regulatory and compliance updates;
- (O) Access to an online reporting portal with a suite of standard plan performance reports including at a minimum membership counts by type of enrollee and month, claims paid by setting, utilization by setting, large claims and lag reports;
- (P) Explanation of payment made directly to claimants;
- (Q) Use the pay and pursue method of Coordination of Benefits;
- (R) Administer third-party subrogation and disclose the use of any third parties, the fees or other compensation charged or retained, and the criteria used to select claims for subrogation.

- (S) Provide notice to the Enrollee and Provider if claim is pended and not adjudicated for more than thirty (30) days;
- (T) Maintain toll free telephone lines for pre-certification and to answer enrollee questions and assist with problems;
- (U) Make use of Contractor's health and legal consultants in handling claims and defending the propriety of Contractor's performance of its claims administration;
- (V) Make refund of contributions paid in error by retirees, COBRA participants or direct bill entities directly to the retiree, COBRA participant or entity;
- (W) When possible, maintain all claim administration records by Social Security Number, as directed by the State;
- (X) Use Contractor's funds to pay claims pending receipt of State remittances for the non-insured products;
- (Y) Provide onsite utilization review at hospitals within designated regional areas;
- (Z) Delegation by the State to Contractor of fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary to determine appeals of any adverse benefit determinations under the Plan. Contractor shall administer complaints, appeals and requests for independent review according to Contractor's complaint and appeals policy, and any applicable law or regulation unless otherwise provided in the Benefits Booklet. In carrying out this authority, Contractor is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Contractor shall be deemed to have properly exercised such authority unless a Member proves that Contractor has abused its discretion or that its decision is arbitrary and capricious. Contractor is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action.
- (AA) Utilization review of procedures of participating providers for quality, efficiency, and elimination of vendor over-utilization.
- (BB) Contractor is prohibited from engaging in cross-plan offsetting, defined as the practice whereby the Contractor will fail to pay the legitimate claims on behalf of one plan in order to recoup overpayments on behalf of a separate plan.
- (CC) Administer Direct Provider Pricing Arrangements established between the State and providers:
 - (i) Adjudicate claims at the lesser of the Direct Provider Pricing Arrangement amount and the Contractor's contracted amount;
 - (ii) For any Direct Provider Pricing Arrangement expressed as a multiple or percentage of Medicare, the applicable Medicare-based limit shall be applied at the individual claim level and not satisfied through an unweighted average across claims. Aggregate reporting may use a claims-weighted average of prices paid.
 - (iii) Apply Contractor's standard adjudication rules including, but not limited to, bundling, frequency limits, and non-covered services;
 - (iv) Claims from providers on a Direct Provider Pricing Arrangement will be adjudicated as in-network claims on the benefit tier designated by the State.
- (DD) If a provider agrees to a State of Indiana-specific custom contract based on a percentage of standard Medicare (e.g., a Medicare plus model), Contractor will administer said contract.

- (EE) Administer custom fee schedule for State Onsite clinic. The State hosts a “post-deductible” onsite medical clinic as a component of the State sponsored health plans. Significant benefits in the nature of medical care that are received at the onsite clinic are subject to the same annual deductible that apply to other outpatient medical care, under each plan. Under the terms of the Contract for Clinic Services, fair market pricing applies to services received at the onsite clinic. Consistent with Contractor’s duties as the medical TPA, Contractor will receive and process claims from the clinic. As TPA, Contractor will credit the amount patients are required to pay to their deductible and out of pocket maximums.
- (FF) Contractor shall perform the administration of independent dispute resolution processes for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the Consolidated Appropriations Act (CAA). Contractor shall disclose its Independent Dispute Resolution process under the No Surprises Act, report negotiation and arbitration outcomes for the Plan, and disclose any savings fee, cost-containment fee, percentage of savings, or other remuneration retained by Contractor or any affiliate or vendor in connection with such claims.

Contract Administration

- (A) Facilitate and administer the exchange of utilization information among vendors;
- (B) Standard direct claim system on medical benefits including:
 - (i) Toll-free direct enrollees counseling by contractor's claim staff to handle questions and problems on a routine basis;
 - (ii) Medical coverage verification by claim staff using information furnished by the State;
 - (iii) Benefit Plan Descriptions;
 - (iv) Prompt payment of proper claims;
- (C) Benefit Plan Descriptions, Benefit Summaries, and form letters tailored to the specifications of the State;
- (D) Maintenance of and reporting on eligibility records and eligibility listings by account.
- (E) Administer eligibility transactions, including electronic and manual actions, files, updates, and verifications, and maintain procedures for timely correction of eligibility records.
- (F) Preparation and delivery of individual billings to the following:
 - (i) COBRA participants
 - (ii) Quasi/Direct bill agencies
 - (iii) Early retirees
 - (iv) Participating School Corporations
- (G) Provide the State upon request, back up claim documentation and method of adjudicating claims;
- (H) Provide updates and analysis of state and federal legislation affecting the State Plan;
- (I) At least two (2) mailings to member’s homes per contract year will be provided to communicate plan benefits;
- (J) Provide representatives to meet quarterly with the State to review provider reports and resolve issues in the areas of claims, customer service, utilization, quality and others as may be requested by the State;
- (K) Contractor will respond to the merits of employee complaints brought through the Indiana Department of Insurance.

- (L) Administer the HIPAA certificate of creditable coverage and service participants exercising rights relative to PHI.
- (M) Administration of COBRA for plan participants, except that for State employees, the initial notification of COBRA rights and the notice of COBRA eligibility will be administered by the State. For school corporations, see the COBRA Administrative Service Agreement, Attachment X to the Exhibit B Adoption Agreement and Binder. The Contractor will be responsible for billing the COBRA participants as well as establishing and monitoring periods of eligibility, including duration of eligibility and secondary events.
- (N) Consultation on financial management, benefit design, and actuarial projections;
- (O) Periodic assistance with open enrollment, including on-site enrollment meetings for employees across the State of Indiana;
- (P) Contractor will provide State with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Contractor administers. State is solely responsible for ensuring that the SBC accurately reflects the benefits State will offer and for finalizing and distributing the SBC to Subscribers.
- (Q) Contractor will manage identification of Early Retirees and COBRA members who attain Medicare and terminate them as appropriate from the plans. The termination date of members who attain Medicare due to ESRD should extend out to the completion of their 30-month ESRD coordination period, even if age 65 is attained during this time.
- (R) Contractor will determine eligibility of disabled dependents, in accordance with the standard set forth by the State (<https://www.in.gov/spd/benefits/eligibility/eligibility-requirements-to-enroll>).
- (S) Administer unclaimed funds associated with the State's plans pursuant to unclaimed property or escheat laws.

Financial Administration

- (A) Benchmark medical plans to other employers by size, geography and industry and provide utilization reports;
- (B) Capability to break reporting into multiple groupings at the request of the State;
- (C) Accounting for rates and claims paid, claims denied, claims pending but not yet paid and administration services fees, for the fee for service plan, as indicated below:
 - (i) A detailed experience statement furnished no later than ninety days following the end of the Plan year. Administrative service fees are to be detailed as follows: total administrative fees, claim administration, contract administration, and other administrative costs;
 - (ii) A lag study furnished annually on the medical plans;
 - (iii) The State reserves the right to audit the claim files maintained by the Contractor or third-party administrator at any time and without additional charge;
 - (iv) Provide the State quarterly reports reflecting network discount savings to include, at a minimum: total submitted charges, total ineligible charges, total eligible charges, total network discounts, total coordination of benefits amounts, total member costs share, net paid claims
 - (v) A detailed financial accounting of all fees and charges related to fees and assessments related to out-of-network claims or inter-plan arrangements (as applicable). These fees may include, but are not limited to: access fees, administrative expenses allowance fees, and transaction fees;

- (vi) For out-of-network claims, Contractor shall identify any repricing vendor or affiliate used, including any vendor accessed through a clearinghouse; describe the methodology used to price such claims; disclose the calculation of all savings fees, cost-containment fees, or other remuneration; and provide information sufficient to reconcile the amount paid to the provider with the amount paid by the Plan.
- (vii) A detailed financial accounting of all fees and payments related to provider Performance Payments.
- (D) Underwriting/actuarial services including the rates (e.g. the suggestion of appropriate informational fees) and expected costs, benefit pricing for lag charges, calculation of incurred and unreported reserve liabilities, effects of changes in plan design, and annual experience report;
- (E) Use by the Contractor of its own funds to pay claims, pending receipt of remittances under this contract, for the fee for services plan.
- (F) Demonstrate application of accounting principles and claims cost controls that prevent loss of funds, abuse, fraud, and recovery of lost dollars.

Managed Mental Health Care Administrative Services

- (A) Inpatient and Outpatient Case Management for mental health and substance abuse;
- (B) Catastrophic (Individual) Case Management;
- (C) Network Development and management Services;
- (D) Full continuum of treatment services;
 - (i) Individual and group outpatient mental health treatment;
 - (ii) Individual and group outpatient chemical dependency treatment;
 - (iii) Intensive outpatient treatment;
 - (iv) Partial hospitalization and day and night treatment programs;
 - (v) Residential care;
 - (vi) Inpatient mental health and chemical dependency treatment;
 - (vii) Other treatment modalities, as appropriate;
- (E) Coordination of care with the Employee Assistance Program (EAP);
- (F) Intensive chemical dependency after care/follow up.

Prescription Drug Program

- (A) For the benefit of the enrollees and the State, coordinate with the carve-out Pharmacy Benefits Manager. These duties include activities such as:
 - (i) Providing the state's Pharmacy Benefit Manager with up to date (daily at a minimum) eligibility data that includes coordination of benefit information;
 - (ii) Receiving prescription drug claims and accumulator data feeds and accurately administering accumulators for the State's health plan participants;
 - (iii) Including the Pharmacy Benefit Manager name and customer service number on the member's medical ID card.
- (B) Pass through to the State 100% of rebates received from pharmaceutical manufacturers for claims for prescription drugs administered by Contractor and covered under the medical benefit portion of the Plan(s) ("Medical Drug Rebates").
- (C) COB coordination with the PBM.

Integrated Care and Data Management

- (A) Safeguard data in motion and at rest consistent with industry standards and all applicable laws and regulations;
- (B) Exchange data as needed for care coordination and plan administration with Pharmacy Benefits Manager, Employee Assistance Program, Dental Plan Manager, Vision Plan Manager, Population Health Manager, Worker's Compensation program, Disability program, and cafeteria plan administrator;
- (C) Electronically accept and integrate claim information as needed for care coordination and plan administration from, Pharmacy Benefits Manager, Dental Plan Manager, Vision Plan Manager, Population Health Manager, Worker's Compensation program, Disability program, and Employee Assistance program;
- (D) Apply a quantifiable predictive model to member records to assess risk;
- (E) Use integrated data for identification of member specific disease conditions;
- (F) Provide monthly data files to the State's data warehouse vendor in a mutually agreed upon file format including:
 - (i) Census data;
 - (ii) Claims data;
 - (iii) Clinical and disease management program participation;
 - (iv) Lab data;
- (G) Make available a mobile app for plan participants
- (H) Share information with the State's data warehouse in a mutually agreed upon file format.
- (I) Provide the State a detailed claims data dictionary identifying all delivered fields, delivery frequency, and format; provide requested X12 837 and X12 835 data fields; and submit data to and through the State's designated data warehouse, currently CedarGate, in the format and frequency directed by the State.

Disease Management

- (A) Offer disease management programs for high prevalence disease states;
- (B) Establish evidence-based practice guidelines for those conditions that will be managed;
- (C) Outreach to members identified with targeted diseases for enrollment in the disease management program;
- (D) Provide patient specific care recommendations and care gaps notifications to the member and their physician;
- (E) Provide education materials and disease-specific coaching to enrolled members; Measure outcomes including cost of care per unit risk, cost of care by setting, utilization by setting, medication adherence, and key clinical outcomes;
- (F) Provide enrollment, utilization and management reports to the State on a quarterly basis;
- (G) Provide outcomes reports to the State on an annual basis;
- (H) For disease management or other clinical services performed by a subsidiary, affiliate, or third party, Contractor shall disclose the arrangement, the parties' affiliations, and all fees, payments, or other compensation exchanged in connection with the services.

Transparency

- (A) Make available a provider search tool that is customized to the State's benefit plan design;
- (B) Integrate a provider search tool within the member portal that includes network status and quality data;

- (C) Provide a procedure specific search tool within the member portal that includes cost and quality data by provider;
- (D) Clearly designate all providers included in the State's preferred provider tier within the provider search tool including any preferred providers included as a result of the State contracting with providers on a Direct Provider Pricing Arrangement.

Utilization Management (UM)

Provide concurrent and retrospective UM programs to include the following:

- (A) Evaluate the appropriateness and medical necessity of health services, procedures and facilities according to evidence-based criteria or guidelines;
- (B) Administer programs to redirect care to the most appropriate lowest cost setting;
- (C) At a minimum, programs should be designed to address the following:
 - (i) Acute and Ancillary Care UM
 - (ii) Behavioral Health UM
 - (iii) Advanced Imaging UM
 - (iv) Specialty Drug (j-code) UM

Population Health Management

Provide population health management services to the State, the scope of which includes the following:

- (A) Provide three full-time health coaches to the State who work onsite at State facilities and locations. At least one coach will be stationed at minimum two days per week at the Indiana Government Center on-site clinic. Health coaches will provide support to wellness coordinator, wellness champions, and provide coaching to members of the State Employee Health Plan. Health coaches will also provide group and personal health coaching and lunch and learns. Health coaches must also be available to members by phone, digitally, and virtually when not on-site.
- (B) Provide telephonic coaching services to covered members.
- (C) Administer online Health Risk Assessments (HRA) for covered members over the age of 18.
- (D) Identify and engage individuals that would benefit from offered programs, utilizing Contractor's standard population health management processes.
- (E) Provide the State with a functional Member Engagement Platform with Personal Health Record (PHR)
- (F) Provide the State and its members with access to a functional mobile application to access Contractor's Member Engagement Platform.
- (G) Utilize a Care Engine analytic platform to identify and personalize experience.
- (H) Process physical claim forms received by members, record that data submitted on the form, and share that information with the State's Data Warehouse within a reasonable time.
- (I) Provide lifestyle risk reduction program that takes into account physical, behavioral health, and social health factors.
- (J) All services must comply with appropriate government regulations including, but not limited to, the Patient Protection and Affordable Care Act (PPACA),

Americans with Disabilities Act (ADA), Health Insurance Portability and Accountability Act (HIPAA), Health and Human Services (HHS), and Equal Employment Opportunity Commission (EEOC).

- (K) Program Data and Reporting – The Contractor will develop and submit monthly data reports for the data warehouse and quarterly standard program reports but will also include annual savings reports. These reports will include, at a minimum, the following:
 - (i) Participation in the Program;
 - (ii) Utilization of itemized services by service type;
 - (iii) Aggregate results from annual physicals and HRAs submitted by participants;
 - (iv) Levels of engagement of participants in targeted programs and coaching;
 - (v) Outcomes for health indicators for participants relative to the utilization of services; and
 - (vi) Return on investment calculations/predictions.
- (L) Ability for employees and dependents that have dual coverage, meaning eligibility to participate in the Contractor's program by two separate employers, to participate in the programs of both employers.
- (M) Provide member communication materials for the purposes of education and marketing.
- (N) Integrated Care, Data Management, and analytics
 - (i) Execute a monthly data feed to the State Health plan's contracted data warehouse which includes health risk assessment data, biometric data from the annual physical submissions, and program engagement by individual;
 - (ii) Permit extraction of reportable data on an individualized basis;
 - (iii) Exchange and integrate data among the Medical TPA, Pharmacy Benefits Manager, Onsite Clinic, Dental TPA, Vision TPA, and other Invest in Your Health programs.
 - (iv) Provide a weekly report to SPD that includes completed activities eligible for rewards and redeemed rewards by member.
- (O) Work constructively (and as seamlessly as possible), to integrate with the State "Invest in Your Health" strategy for care and data management.
- (P) Electronic Gift Card Fulfillment: Provide oversight and coordination for the State's wellness rewards, including issuing gift card rewards to members fulfilling the necessary terms to receive such a reward. This includes billing and tax record management.

c. Claim Payment

- (1) For benefits to be payable under the Plan, the Contractor must receive a claim with all information necessary to determine liability within 12 months following the date service was rendered. If the claim does not include enough information, the Contract shall ask for more details and it must be sent to the Contractor within 12 months or no benefits will be covered, unless otherwise required by

law (e.g. Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service.)

- (2) Often the provider of service will file the claim. If the servicing provider does not file, the Contractor will supply enrollees with claim forms.
- (3) The Contractor will pay benefits due under the Plan to the enrollee, or, at its sole discretion, to the provider of the service from which benefits are claimed, or to both the enrollee and the provider of service jointly. No enrollee or dependent may assign such payment.
- (4) If other parties have paid benefits due under the Plan, the Contractor may reimburse those other parties and be fully discharged from that portion of its liability. If any enrollee makes a material misrepresentation on a claim or application for this Plan's benefits, the Contractor, on behalf of the State, may cancel his/her Plan coverage, effective on or any time after the date of this claim.
- (5) If the Contractor makes any payment on behalf of the employer, that according to the terms of this Plan should not have been made, including payment made in error, the Contractor may recover that incorrect payment whether or not it was made due to Contractor's own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to an enrollee, the Contractor may deduct it when making future payment directly to that enrollee.
- (6) Paid Claims shall mean the amount charged to the State for covered services during the term of this Agreement. Paid Claims may also include any applicable interest passed through pursuant to the Medicare primary/secondary payment rules and any surcharges passed through pursuant to an assessment by a state or government agency (e.g., New York State facility use assessment).

The propriety amounts charged as Paid Claims can be ascertained by audit. The details of each plan/program will be made available to the State. Plan/program administration and cost are the same for the State as for Contractor's own insured book of business. Contractor will retain no margin on these payments to Provider or Vendor.

d. Subcontracting

- (1) The Contractor must obtain State Personnel Department and Department of Administration's approval before subcontracting all or any portion of this Contract. Any subcontract must be submitted at least six (6) months prior to the effective date of the subcontract. "Subcontractor" as used in the section does not include agreements between Contractor and its providers or subcontracts expressly authorized elsewhere in this document.
- (2) The foregoing provisions shall not apply to the following undertakings and/or conditions:
 - (A) Any purchase, acquisition, or procurement by the Contractor of supplies, equipment, and materials in the normal course of the Contractor's business.

- (B) Any purchase, acquisition or procurement by the Contractor, the principle purpose of which does not directly involve the performance of obligations under this Contract.
 - (C) Any purchase, acquisition or procurement precipitated by or arising from urgent program requirements which, in the exercise of prudent business judgment, compel immediate action by the Contractor to preserve and/or enhance the program or the interest of enrollees with coverage hereunder; provided that the State Personnel Department and Department of Administration give prior written approval for any purchase, acquisition or procurement which exceeds a 30 day period; however, all purchases, acquisitions or procurements shall be reported wherever possible and prior notice shall be given.
 - (3) The Contractor will be responsible for performance under the Contract, compliance with terms and condition of the Contract, and the requirements of federal and state equal opportunity and affirmative action statutes, rules, and regulations whether or not subcontractors are used.
- e. InterPlan Arrangements
- (1) Out of Area Services. [Detail provisions of Contractor's relationships with other affiliated providers that pass-through discounts and may involve additional fees/charges.]
 - (2) Non-Network Providers Outside Contractor's Service Area.
 - (A) Member Liability Calculation. When Covered Services are provided outside of Contractor's service area by non-Network Providers, the amount a Member pays for such services will generally be based on either the affiliated TPA's non-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the Non-Network Provider bills and the payment Contractor will make for the Covered Services as set forth in this paragraph.
 - (B) Exceptions. In some exception cases, Contractor may pay Claims from non-Network Providers outside of Contractor's service area based on the Provider's Billed Charges, such as in situations where a Member did not have reasonable access to a Network Provider, as determined by Contractor in Contractor's sole and absolute discretion or by applicable state law. In other exception cases, Contractor may pay such a Claim based on the payment it would make if Contractor were paying a non-Network Provider inside of Contractor's service area, as described elsewhere in this Agreement, where the affiliated TPA's corresponding payment would be more than Contractor's in-service area non-Network Provider payment, or in its sole and absolute discretion, Contractor may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-Network

Provider bills and the payment Contractor will make for the Covered Services as set forth in this paragraph.

IV. PROJECT MANAGEMENT

A. PROJECT MANAGEMENT PLAN

[Reserved]

B. KEY PERSONS

[Reserved]

C. OTHER PROJECT STAFF

[Reserved]

D. DOCUMENT MANAGEMENT

Vendor shall create, receive, maintain, store, transmit, retain, and dispose of Plan Documents, Participant Communications, Claims and Appeals Records, and related Compliance Evidence (“Plan Records”) in accordance with the HIPAA Privacy Rule and Security Rule, including 45 CFR Part 164 Subparts C and E. TPA will implement administrative, physical, and technical safeguards proportionate to the sensitivity of Plan Records, including documented risk analysis and risk management, role-based access controls, audit logging and activity review, and media protection controls for marking, storage, transport, sanitization, and destruction. TPA shall maintain procedures to ensure timely distribution of participant notices and retention of claims documentation to evidence compliance with applicable timeframes. Subcontractors shall be bound by Business Associate obligations and provide equivalent assurance, including SOC 2 Security criteria where applicable.

E. STATUS UPDATES AND REPORTING

Medical Reports

Report/Data Type	Frequency	Information Included
Standard Quarterly Plan Performance Report	Quarterly	Paid claims; membership counts; employee cost share; utilization by

		setting; use of programs; network & compliance updates.
Online Reporting Portal – Performance Reports	Ongoing	Membership by month; claims by setting; utilization metrics; large claims; lag reports.
Network Discount Savings Report	Quarterly	Submitted charges; eligible & ineligible charges; network discounts; COB amounts; member cost share; net paid claims.
Annual Lag Study	Annual	Lag differences between service date, claim submission, payment date.
Annual Experience Statement	Annual	Administrative fees; claim admin costs; contract admin costs; rates; claims paid, denied, pending.
Weekly Claims Expense Invoice	Weekly	Authorized claims paid; reconciled claim file; monthly admin charges.
Prescription Drug Rebate Report	Quarterly + Annual	Rebates received; additional collections; annual reconciliation.
Member Communications	Minimum 2 per year	Plan benefits; updates; health & wellness education; enrollment information.
Integrated Care & Data Management Feed	Monthly	Integrated data across PBM, dental, vision, clinic, wellness programs; predictive model outputs; disease identification data; care management participation.
Physical Claim Form Processing Feed	Monthly	Physical claim form data recorded and sent to data warehouse.
Federal & State Compliance (i.e. 1095 tax forms, IRS forms, PCORI)	Ad-Hoc	Custom extract based on need.

Disease Management Reports

Report/Data Type	Frequency	Information Included
Medical Management Report	Quarterly	Quality & efficiency reviews; utilization management metrics; outcomes.
Annual Disease Management Outcomes Report	Annual	Outcomes for disease programs; medication adherence; cost per unit risk; utilization metrics.
Performance Guarantee Results	Annual	Claims timeliness; financial accuracy; call center; diabetes tests; asthma/CAD metrics; ER visits; readmissions; network access; discount & trend guarantees.

Population Health Reports

Report/Data Type	Frequency	Information Included
Population Health – Data Warehouse Feeds	Monthly	HRA data; biometric screening data; physical claim form data; individual program engagement.
Population Health Rewards	Weekly	Completed wellness activities; redeemed rewards by member.
Population Health Program Report	Quarterly	Program participation; utilization; HRA results; targeted program engagement; health outcomes; ROI.
Population Health Annual Savings Report	Annual	ROI calculations; savings projections; participation & outcome trends.

V. INDEPENDENT VALIDATION AND VERIFICATION

In the event the State determines that any independent verification and validation ("IV&V") oversight is required by the State during the term of this Contract, the Contractor shall comply with any such oversight during the term of this Contract, pursuant to which an independent third-party review may be conducted by a reviewer selected by the State, for the purpose of verifying that the Contractor has performed its obligations in compliance with the terms of this Contract. In the absence of any such IV&V oversight, the Contractor shall comply with any other appropriate methods or means for verification and validation required by the State during the term of this Contract for the purpose of verifying and validating that the Contractor has performed its obligations in compliance with the terms of this Contract. The Contractor shall provide all information and documentation requested during the State's IV&V oversight or verification and validation efforts related to this Contract and in connection with any IV&V oversight or verification and validation efforts related to an initiative of which this Contract is a part.

VI. COMPLIANCE REQUIREMENTS**A. Fiduciary Duty**

- a. In accordance with SEA 3 effective July 1, 2025, Contractor owes fiduciary duties of loyalty, care and transparency to the Plan Sponsor when acting on its behalf, including but not limited to administering plan benefits, fee arrangements, vendor selection, provider network agreements, and claims processes.
- b. Contractor will act exclusively in the best interest of the Plan, avoid conflicts of interest, and disclose all direct and indirect compensation, referral fees, incentive

- payments, or financial arrangements that impact administration of the Plan or decision-making regarding provider reimbursement or network participation.
- c. Contractor will not enter into any contractual or financial arrangement with providers, subcontractors/sub-administrators, network vendors, or data providers that compromise its duties under this Section. Any such arrangement generating revenue or incentives must be fully disclosed and administered for Plan benefit only.
 - d. Contractor shall disclose any direct or indirect ownership interest, financial interest, or other economic relationship that Contractor or any affiliate has in a provider network proposed or used for the Plan.
 - e. Contractor shall provide to the Plan Sponsor, upon execution and annually thereafter, a comprehensive statement of all fees, charges, incentives, or revenue-sharing arrangements related to Plan administration in the prior year.
 - f. Any self-dealing, undisclosed arrangement, or breach of fiduciary duty discovered by Plan Sponsor shall be remedied immediately and may result in Plan Sponsorship direction to terminate the conflicting arrangement.
- B. Disclose plan data and financial information to government agencies and the public as required.
- C. Provide custom data extracts to the State to enable the State to comply with any mandated reporting requirements, for example PCORI and 1095-C tax forms.
- D. Contractor will disclose negotiated rates, allowed amounts, and other cost-sharing information to ensure the health plans' compliance with the federal transparency-in-coverage rules.
- E. Gag Clause Compliance and Attestation
Contractor guarantees no downstream agreements contain gag clause restrictions per the CAA and will support the Plan's attestation timeline and data access needs as required.
- F. Pricing Transparency/TiC Obligations – Contract shall produce and publicly host monthly MRFs and maintain a fully functional participant price comparison tool, in compliance with federal 2024 requirements and foreseeable CMS updates.
- G. Prescription Drug Data Collection (RxDC) – Although pharmacy is separately administered, Contractor will assist PBM by providing necessary medical encounter information for the June 1 filing.
- H. No Surprises Act/Provider Directories – Contract confirms support for director verification every 90 days, 2-day update turnaround, transitional care implementation, and readiness for AEOB processes.
- I. MHPAEA NQTL Analysis Support – Contractor shall furnish plan methodology and data for comparative analysis, audits, and fiduciary certifications related to mental health parity under the CAA.
- J. Contractor shall monitor Indiana fiduciary law, CAA, NSA, TiC, RxDC, and MHPAEA developments and notify Plan Sponsor of impactful changes within 15 days. The parties agree to update obligations, systems, and reporting without additional fees unless the change adds material scope beyond industry standard.

VII. KEY PERFORMANCE INDICATORS/PERFORMANCE GUARANTEES

The State will use Key Performance Indicators (KPIs) to measure performance and outcomes of the Contract. The specific KPIs and their targets will be defined and agreed upon by the State and the Contractor during the initial phases of the requirements under the Contract.

At a minimum the following KPIs should be included:

Performance guarantee	Requirement	Measurement	Reporting period and Dollars at Risk	Notes/Clarifications
Implementation	Post-implementation validation of benefits setup accuracy			
Network Discount				
Trend				
Network access				
Account Management satisfaction				
Claims processing timeliness				
Claims financial accuracy				
Call center – First call resolution				
Integration with PBM				
Accumulator accuracy				
Integration/collaboration with other State vendors				