



**State of Delaware
Office of Management & Budget
Statewide Benefits Office**

STATE EMPLOYEE BENEFITS COMMITTEE

Request for Proposal for COBRA/HIPAA Administration Services for The State of Delaware Group Health Insurance Program

March 18, 2013

**Intent to Bid Deadline –
April 1, 2013, no later than 4:00 p.m. EST**

OMB13001-COBRAAdmin

500 W. Loockerman Street, Suite 320 • Dover, DE 19904
Phone (302) 739-8331 Fax (302) 739-8339 www.ben.omb.delaware.gov

Table of Contents

Request for Proposal for COBRA/HIPAA Administration Services For the State of Delaware Group Health Insurance Program

Section	Page
I. Introduction	3
A. Background and Overview	3
B. Proposal Objectives.....	5
C. Scope of Services	5
D. Timetable/Deadlines	7
E. Evaluation Process	8
II. Terms and Conditions	11
A. Proposal Response Requirements	11
B. General Terms and Conditions	11
C. Other Terms and Conditions	14
III. Minimum Requirements	16
Technical Standards and Security Requirements	20
IV. Questionnaire	24
A. Company History and Financial Profile.....	24
B. Organizational Experience and References.....	27
C. COBRA Administration.....	28
D. Customer Service to Participants.....	29
E. Account Management	31
F. Quality Assurance.....	31
G. Computer System and Support.....	31
H. HIPAA.....	34
I. Reporting Capabilities.....	35
J. Implementation and Transition Issues	35
K. Performance Guarantees	36
V. Cost Quotation Questionnaire	37
Table 1 – Summary of Fees	38

Table 2 – First Year Set Up Fees	39
Appendix A – Officer Certification Form.....	40
Appendix B – Transaction Volumes for 2012.....	41
Appendix C – Performance Guarantees	42
Appendix D – Business Associate Agreement	44
Appendix E – HIPAA Privacy Notice	53
Appendix F – Eligibility and Enrollment Rule (Effective March 1, 2013)	58
Appendix G – List of Reports.....	75
Appendix H – Account Management Team Survey.....	76
Appendix I – Technical Standards and Security Requirement Forms	82

I. Introduction

The State Employee Benefits Committee (SEBC) is seeking COBRA/HIPAA administration services for the State of Delaware (State). The SEBC is soliciting proposals from vendors who will partner with the SEBC and its contracted vendors to provide exemplary services. This Request for Proposal (RFP) is issued pursuant to Title 29 Delaware Code, Chapter 69, Sect. 6981 and 6982.

Important Dates (A full timeline is included in Section I.D.)

Contract Effective Date:	January 1, 2014
Intent to Bid Due:	Monday, April 1, 2013, by 4:00 p.m. EST
Proposal Submissions Due:	Monday, April 29, 2013, by 4:00 p.m. EST

A. Background and Overview

Organization Description

The SEBC is chaired by the Director of the Office of Management and Budget (OMB). The Controller General, Insurance Commissioner, State Treasurer, Secretary of Health and Social Services, Secretary of Finance and Chief Justice of the Supreme Court comprise the remainder of the SEBC. The SEBC controls and manages benefits to approximately 36,000 active employees and approximately 25,000 retirees.

The Statewide Benefits Office (SBO) is a division within the OMB. The SBO functions as the administrative arm of the SEBC responsible for the administration of all statewide benefit programs with the exception of pension and deferred compensation benefits. These programs include, but are not limited to, health, prescription, dental, vision, disability, group life, flexible spending accounts, wellness and disease management programs, and pre-tax commuter benefits.

Background Information

The SBO administers the Group Health Insurance Program (GHIP). The GHIP offers health insurance to active employees of the State and their dependents, as well as individuals who have retired from State employment and their dependents, including individuals who are disabled and their dependents. The State also provides health insurance to a number of non-State entities, such as municipalities and fire companies. The health insurance component of the program is self-insured and currently provides services to an estimated 115,000 covered lives. Highmark Delaware (BCBSD) insures approximately 95% of the members and Aetna covers the remaining 5%.

Eligible participants include the State's active employees which include school district, charter school, university, and community college employees and their dependents, non-Medicare and Medicare retired employees and their dependents, non-State groups and their dependents; and COBRA participants. By statute, employee unions cannot negotiate for benefits. The GHIP participants are primarily located within the State, although a small number of participants reside in other states and countries. There are multiple employer units¹ located in three counties throughout the State, with each exercising a high degree of independence.

The State offers a comprehensive benefits package to its employees and retirees that includes:

- Medical Program
 - Aetna HMO
 - Aetna CDH Gold with HRA
 - Highmark Delaware (BCBSD) First State Basic
 - Highmark Delaware (BCBSD) Comprehensive PPO
 - Highmark Delaware (BCBSD) Blue Care HMO
 - Highmark Delaware (BCBSD) CDH Gold
 - Highmark Delaware (BCBSD) Special Medicfill (Medicare Retirees Only)
 - Highmark Delaware (BCBSD) Port POS Plan (available to Wilmington Port Authority employees only)
- Prescription Drug Program
 - Express Scripts (formerly known as Medco)
 - Express Scripts Medicare PDP (Eff. 1/1/13 for Medicare Retirees Only)
- Dental Program
 - Delta Dental Premier PPO
 - Dominion Dental DHMO
- Health Care FSA
 - ASI/ Central Bank
- Vision Insurance
 - EyeMed Vision Care

The State utilizes multiple electronic human resource programs and vendor databases at separate locations in various formats to collect and store participant personal health data. The State currently contributes 96% of the First State Basic Plan health insurance premium for employees regardless of the tier they choose. The optional health benefit plans are PPO (Preferred Provider Organization), HMO (Health Maintenance Organization), and CDHP (Consumer Directed Health Plan). The State contributes 86.75%, 93.5%, and 95.0% of the

¹ For the purpose of COBRA/HIPAA administration, "employer units" refer to each group – such as an agency, charter school, and non-State entities – that need a secure remote access to the vendor's website for administrative entries of qualifying events. Therefore, the State of Delaware's account is essentially one employer with 165 separate business units.

premiums respectively. Non-state groups are responsible for 100% of the premium for any health plan plus applicable monthly and annual administration fees. The dental and vision benefit plans are 100% employee pay-all.

You may view all information specific to the programs governed by the SEBC at the following web site: <http://ben.omb.delaware.gov/>.

B. Proposal Objectives

The SEBC desires to contract with an organization specializing in providing COBRA/HIPAA administration services to large self-insured health and prescription programs in addition to a variety of other programs for which the SEBC has oversight. The organization must have prior experience directly related to the services requested in this RFP.

C. Scope of Services

The State currently contracts with an organization to provide COBRA/HIPAA administration services to eligible employees and retirees (and their eligible dependents), and desires to continue to outsource these services. The services outlined in this RFP apply to all health plans offered by the State, including medical, dental, FSA and vision.

In 2012, there were approximately 2,450 qualifying events. There are approximately 165 employer units with a total of 300 local benefit representatives involved in the day to day administration who will need secure, role-based remote access to the selected vendor's system. It is a minimum qualification that the vendor have experience with a client with a similar organization of separate employer units. All requests for Qualifying Event packages, New Hire Notifications, and HIPAA Only Certifications are requested via the vendor's website. An initial file feed of all eligible members will not be provided. On-going eligibility feeds are also not provided. A weekly electronic COBRA enrollment feed is required to be sent to Highmark Delaware (BCBSD), whereas all other enrollment reports are to be sent to SBO for forwarding to Aetna and the dental, vision and FSA vendors.

Cyber Security and Data Integrity: The selected vendor shall ensure that State information is protected with reasonable security measures, promote and maintain among its employees and agents an awareness of the security needs of the State's information, safeguard the confidentiality, integrity, and availability of State information, and ensure that appropriate security measures are put in place to protect internal systems from intrusions and other attacks.

The selected organization is required to perform the following services²:

1. Provide a New Hire Notice to newly enrolled/covered participants³ of their COBRA rights and obligations as they become covered under the State's plans;
2. As required by the State, provide a HIPAA Privacy Notice to newly enrolled participants (see Appendix E);
3. Process Qualifying Event Certifications;
4. Issue HIPAA Creditable Coverage Certificates to participants;
5. Provide COBRA continuation coverage notices to participants and their qualified dependents upon notice of a Qualifying Event;
6. Mail individual premium invoices on a monthly basis for qualified participants, and for those participants that are not current in their payments, mail an invoice that details the grace period, and, if applicable, a letter of impending end of coverage;
7. Collect premiums and forward the amount of paid premiums (less the 2% administrative charge) to the State;
8. On a weekly basis, provide one electronic COBRA enrollment report to Highmark Delaware (BCBSD). For all other benefits, send daily updates and new enrollments via secure email or fax to SBO. On a monthly basis, provide a reconciliation of the daily emails or faxes;
9. Distribute termination of continuation coverage letters;
10. Provide a compliance review process to address any written request for review and provide a determination.
11. As applicable, distribute conversion notices at end of COBRA continuation coverage periods;
12. Submit to SBO a monthly electronic listing of all participants;
13. Provide the SBO with a mailing address list of current participants for annual open enrollment notification;

² This is a general list of services. More detail can be found in the minimum qualifications and questionnaire sections.

³ For the purposes of this RFP, the term *participant* is being used interchangeably with an eligible beneficiary that receives a service from the vendor such as the mailing of a HIPAA notice to be mailed to a new employee as required by the State.

14. If selected as the new vendor, accept electronic transfer of information from the State's incumbent vendor, as part of the transition process, including information for participants in waiting status;
15. Provide administrative reports as described in this RFP, see Appendix G;
16. Mail to the corresponding benefit representative notice of unavailability letters (such as *Cannot Reach COBRA Participant, Bad Address, etc.*);
17. Provide COBRA coverage rate projections to the SEBC annually for each plan and their corresponding four election tiers – employee, employee and spouse, employee and children, and family;
18. Send all COBRA and other notices by first-class mail (certified mail is not required);
19. Establish a toll-free phone number and access to Customer Service Representatives from, at a minimum, 8:00 a.m. to 5:00 p.m. EST, Monday through Friday (except holidays);
20. Provide secure on-line remote access to approximately 300 benefit representatives and non-payroll groups to update information for their own employees/participants' information (they must be able to see a list of only their group's employees). Additionally, SBO designated staff would have central/all access;
21. Ensure that State information is protected with reasonable security measures, promote and maintain among its employees and agents an awareness of the security needs of the State's information, safeguard the confidentiality, integrity, and availability of State information, and ensure that appropriate security measures are put in place to protect internal systems from intrusions and other attacks; and
22. Provide a flexible administration system and operational procedures that can accommodate the State's coverage rules (i.e., end of month termination date vs. day after QE date for divorce cases, etc.) per the State's Eligibility and Enrollment Rules, Appendix F.

D. Timetable/Deadlines

The following timetable is expected to apply during this RFP process:

Event	Target Date
RFP Release/Advertisement Dates	March 18, 2013 and March 25, 2013
Deadline for Intent to Bid notice	April 1, 2013 by 4:00 p.m. EST
Vendor's Deadline to Submit Questions	April 8, 2013 by 4:00 p.m. EST
Responses to Questions Sent to Vendors	April 19, 2013
Deadline for RFP Responses/Bids	April 29, 2013 by 4:00 p.m. EST

Notification of Finalists*	Week of May 20, 2013
Finalist Interviews	Week of June 10, 2013
Selection of Vendor	End of August 2013
Contract Effective Date	January 1, 2014

**The SEBC will require each of the finalists to make a presentation in Dover, Delaware. The presentation will be at the expense of the proposing firm.*

E. Evaluation Process

Proposal Review Committee

All proposals submitted in response to the RFP will be reviewed by the Proposal Review Committee (PRC). The PRC shall be comprised of representatives from each of the following offices:

- Office of Management and Budget
- Controller General’s Office
- Department of Finance
- Department of Health and Social Services
- State Insurance Commissioner’s Office
- State Treasurer’s Office
- Chief Justice of the Supreme Court

The PRC shall determine the firms that meet requirements pursuant to selection criteria of the RFP and procedures established in 29 Del.C. §6981 and 6982. The PRC shall interview at least one of the qualified firms.

The minimum requirements are mandatory. Failure to meet any of the minimum requirements outlined in the RFP will result in disqualification of the proposal submitted by your organization.

The PRC shall make a recommendation regarding the award of contract to the SEBC who shall have final authority, in accordance with the provisions of this RFP and 29 Del.C. §6982, to award a contract to the successful firm or firms as determined by the SEBC in its sole discretion to be in the best interests of the State of Delaware. The SEBC may negotiate with one or more firms during the same period and may, at its discretion, terminate negotiations with any or all firms. The SEBC reserves the right to reject any and all proposals or award to multiple vendors.

Evaluation Criteria

All proposals shall be evaluated using the same criteria and scoring process. The following criteria shall be used by the PRC to evaluate proposals:

- Cost – Cost for requested services as detailed in the RFP in relation to other competitive proposals.

- Depth of Organization's Experience and Ability – Depth of the organization's experience and ability to be responsive to the needs of the SEBC. Proven ability and infrastructure to perform the services as outlined in the Scope of Work for multiple employer units.
- Depth of Experience and Ability of Personnel – Qualifications and experience of the organization's personnel to perform excellent administrative services as outlined in the Scope of Work. Additionally, have a demonstrated flexibility to facilitate anticipated and unanticipated regulatory and process changes.
- Account Management – Demonstrated ease of access to personnel, ability to provide reports and complete all services within required timeframes, and comply with Performance Guarantees. Additionally, if applicable, proven ability for implementation and transition of services.
- Customer Service – Demonstrated ability to provide excellent customer service to participants.

The SEBC will use the information contained in your proposal to determine whether you will be selected as a finalist and for contract negotiations. The proposal the SEBC selects will be a working document. As such, the SEBC will expect the proposing firm to honor all representations made in its proposal.

It is the proposing firm's sole responsibility to submit information relative to the evaluation of its proposal and the SEBC is under no obligation to solicit such information if it is not included with the proposing firm's proposal. Failure of the proposing firm to submit such information in a manner so that it is easily located and understood may have an adverse impact on the evaluation of the proposing firm's proposal.

The proposals shall contain the essential information for which the award will be made. The information required to be submitted in response to this RFP has been determined by the SEBC and the PRC to be essential in the evaluation and award process. Therefore, all instructions contained in this RFP must be met in order to qualify as a responsive contractor and to participate in the PRC's consideration for award. Proposals that do not meet or comply with the instructions of this RFP may be considered non-conforming and deemed non-responsive and subject to disqualification at the sole discretion of the PRC.

RFP Award Notifications

After review by the PRC a recommendation will be made to the SEBC for award of the contract. The contract shall be awarded to the vendor whose proposal is determined by the SEBC to be most advantageous, taking into consideration the evaluation factors set forth in the RFP. It should be explicitly noted that the SEBC is not obligated to award the contract to the vendor who submits the lowest bid or the vendor who receives the highest total point score, rather the contract will be awarded to the vendor whose proposal is determined by the SEBC to be the most advantageous. The award is subject to the appropriate State of Delaware approvals. After a final selection(s) is made, the winning vendor will be invited to negotiate a contract with the State; remaining vendors will be notified in writing of their selection status.

Award of Contract

The final award of a contract is subject to approval by the SEBC. The SEBC has the sole right to select the successful vendor(s) for award, to reject any proposal as unsatisfactory or non-responsive, to award a contract to other than the lowest priced proposal, to award multiple contracts, or not to award a contract, as a result of this RFP. Notice in writing to a vendor of the acceptance of its proposal by the SEBC and the subsequent full execution of a written contract will constitute a contract, and no vendor will acquire any legal or equitable rights or privileges until the occurrence of both such events.

Confidentiality of Documents

The OMB is a public agency as defined by state law, and as such, it is subject to the Delaware Freedom of Information Act, 29 Del. C. Ch. 100 (FOIA). Under the law, all the State's records are public records unless otherwise declared by law to be not public and are subject to inspection and copying by any person. Organizations are advised that once a proposal is received by the State, a decision on contract award is made and the contract awarded, its contents will become public record and nothing contained in the proposal will be deemed to be confidential except proprietary information. Pricing information and fee structures are not considered confidential and cannot be included as proprietary information.

Proposing firms must submit one hard copy of any information the firm is seeking to be treated as proprietary in a separate, sealed envelope labeled "Proprietary Information" with the RFP name included (COBRA/HIPAA RFP). The envelope must contain a letter from the proposing firm's legal counsel describing the documents in the envelope, representing in good faith that the information in each document is not public record as defined by FOIA at 29 Del. C. § 10002(d) and state the reasons that each document meets the said definitions. The documents must also be provided electronically on a separate CD from the bidding documents. In order to submit a complete electronic copy, you must scan the letter as the first page so that the file is clearly designated.

Upon receipt of a proposal accompanied by such a separate, sealed envelope, the State will open the envelope to determine if the procedure described above has been followed. Such requests will not be binding on the SEBC to prevent such a disclosure but may be evaluated under the provisions of 29 Del.C. Chapter 100. Any final decisions regarding disclosure under FOIA shall be made at the sole discretion of the OMB.

All documentation submitted in response to this RFP and any subsequent requests for information pertaining to this RFP shall become the property of the State of Delaware, OMB and shall not be returned to the proposing firm. All proposing firms should be aware that government solicitations and responses are in the public domain.

II. Terms and Conditions

A. Proposal Response Requirements

Your proposal must conform to the requirements set forth in this RFP. The SEBC reserves the right to deny any and all exceptions taken to the RFP requirements. General RFP information can be obtained by emailing Ms. Laurene Eheman at laurene.eheman@state.de.us.

Please provide complete answers and explain all issues in a concise, direct manner. Please do not refer to another answer if the question appears duplicative, but respond in full to each question. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. “Will discuss” and “will consider” are not appropriate answers. All information requested is considered important. If you have additional information you would like to provide, include it as an appendix to your proposal.

B. General Terms and Conditions

1. **Completeness of Proposal** – The proposal must be complete and comply with all aspects of the specifications. Any missing information could disqualify your proposal. Proposals must contain sufficient information to be evaluated and, therefore, must be complete and responsive. Unless noted to the contrary, we will assume that your proposal conforms to our specifications in every way. Failure to respond to any request for information may result in rejection of the proposal at the sole discretion of the SEBC.
2. **Intent to Bid** – You must indicate your intent to bid via email to Ms. Laurene Eheman at laurene.eheman@state.de.us by April 1, 2013, no later than 4:00 p.m. EST.
3. **Questions** – The SEBC anticipates this will be an interactive process and will make every reasonable effort to provide sufficient information for vendor responses. Vendors are invited to ask questions during the proposal process and to seek additional information, if needed. **All proposing vendors must submit their questions electronically, and only electronically, to Ms. Laurene Eheman no later than April 8, 2013, at 4:00 p.m. EST.** The SBO will then put all questions received and the responses into one document and send to all vendors who confirmed their intention to bid. Do not contact any member of the SEBC about this RFP or the COBRA/HIPAA administration services selection process. All questions regarding this proposal should be directed only, and by email only, to Ms. Laurene Eheman at laurene.eheman@state.de.us.

Submission of Proposal

4. **Format** - For each requirement or question, retain the numbering/lettering convention, copy the item and state your answer below it. Please completely answer the question even

if you must restate information provided in a minimum requirement or in another question.

Please tab your proposal with a separate section for each of the following:

- Minimum Requirements;
- Technical Standards and Security Requirements;
- Questionnaire;
- Cost Quotation; and
- Appendices or Exhibits.

In each section, and for each attachment or appendix you reference, clearly separate the corresponding materials with a tab. Please include a table of contents for the appendices.

Information deemed Proprietary and Confidential must be submitted in hard copy and electronic format. See the *Confidentiality of Documents* section for a complete explanation of the required elements.

5. **Hard Copies** – Please submit six (6) complete hard copies - binders are preferred instead of spiral bound - of your proposal to Ms. Laurene Eheman at the following address:

Ms. Laurene Eheman, RFP and Contract Coordinator
Office of Management and Budget
Statewide Benefits Office
500 W. Loockerman Street, Suite 320
Dover, DE 19901
Phone: (302) 739-8331
Fax: 302) 739-8339
laurene.eheman@state.de.us

Complete means that it includes all information you may deem proprietary and confidential. In other words, the information deemed proprietary and confidential must not be redacted or separated from the rest of the information and therefore would require the SEBC to manually merge the documents in order to read the material in the order and format requested.

6. **Electronic Copies** – Please include a complete electronic copy of your proposal in a PDF format on a CD. You must scan all the documents; for example, a signed cover letter, the signed Officer's Statement and any appendices. Please divide the PDF into manageable sections for easier readability. Please label and carefully package the CD.

Please see the table at the end of this section for a recap of the required formats of the hard copies, electronic copies, and confidential and proprietary copies.

7. **Proposal Submission Date** – Both hard and electronic copies of your complete proposal must be received at the above address no later than **4:00 p.m. EST on April 29, 2013**. Any proposal received in the same package after this date and time shall not be

considered and will be returned to the proposing firm unopened. The proposing firm bears the risk of delays in delivery.

8. **Officer Certification** – All vendors participating in this RFP will be required to have a company officer attest to compliance with RFP specifications and the accuracy of all responses provided. See Appendix A for a copy of this form.
9. **Vendor Errors/Omissions** – The SEBC will not be responsible for errors or omissions made in your proposal. You will be permitted to submit only one proposal. You may not revise or withdraw submitted proposals after the applicable deadline.
10. **General Modifications to RFP** – The SEBC reserves the right to issue amendments or change the timelines to this RFP. All firms who submitted an Intent to Bid notice will be notified in writing via e-mail of any modifications made by the SEBC to this RFP.
11. **Modifications to Submitted Proposal** – Changes, amendments or modifications to proposals shall not be accepted or considered after the time and date specified as the deadline for submission of proposals.
12. **Time for Acceptance of Proposal** – The bidder agrees to be bound by its proposal for a period of at least 180 days, during which time the State may request clarification or correction of the proposal for the purpose of the evaluation.
13. **Incurred Costs** – This RFP does not commit the SEBC to pay any costs incurred in the preparation of a proposal in response to this request and vendor/bidder agrees that all costs incurred in developing its proposal are the vendor/bidder's responsibility.
14. **Basis of Cost Proposal** – Your proposal must be based on your estimated cost of all expenses for the services and funding arrangements requested.
15. **Certification of Independent Price Determination** – By submission of a proposal, the proposing firm certifies that the fees submitted in response to the RFP have been arrived at independently and without – for the purpose of restricting competition – any consultation, communication, or agreement with any other proposing firm or competitor relating to those fees, the intention to submit a proposal, or the methods or factors used to calculate the fees proposed.
16. **Improper Consideration** – Bidder shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or any items of value to any officer, employee, group of employees, retirees or agent of the SEBC in an attempt to secure favorable treatment or consideration regarding the award of this proposal.
17. **Representation Regarding Contingent Fees** – By submission of a proposal, the proposing firm represents that it has not retained any person or agency to solicit or secure a contract for the services described herein upon an agreement or understanding for a commission or a percentage, brokerage, or contingent fee. The SEBC will not pay any brokerage fees for securing or executing any of the services outlined in this RFP.

Therefore, all proposed fees must be net of commissions and percentage, contingent, brokerage, service, or finder's fees.

18. **Confidentiality** – All information you receive pursuant to this RFP is confidential and you may not use it for any other purpose other than preparation of your proposal.

C. Other Terms and Conditions

Rights of the PRC

- The PRC reserves the right to:
 - Select for contract or negotiations a proposal other than that with lowest costs.
 - Reject any and all proposals received in response to this RFP.
 - Make no award or issue a new RFP.
 - Waive or modify any information, irregularity, or inconsistency in a proposal received.
 - Request modification to proposals from any or all vendors during the review and negotiation.
 - Negotiate any aspect of the proposals with any organization.
 - Negotiate with more than one organization at the same time.
 - Select more than one contractor/vendor to perform the applicable services.

- Right of Negotiation – Discussions and negotiations regarding price, performance guarantees, and other matters may be conducted with organizations(s) who submit proposals determined to be reasonably susceptible of being selected for award, but proposals may be accepted without such discussions. The PRC reserves the right to further clarify and/or negotiate with the proposing organizations following completion of the evaluation of proposals but prior to contract execution, if deemed necessary by the PRC and/or the SEBC. The SEBC also reserves the right to move to other proposing firms if negotiations do not lead to a final contract with the initially selected proposing firm. The PRC and/or the SEBC reserves the right to further clarify and/or negotiate with the proposing firm(s) on any matter submitted.

- Right to Consider Historical Information – The PRC and/or the SEBC reserves the right to consider historical information regarding the proposing firm, whether gained from the proposing firm's proposal, question and answer conferences, references, or any other source during the evaluation process.

- Right to Reject, Cancel and/or Re-Bid – The PRC and/or the SEBC specifically reserve the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or re-bid the services requested.

Contract/Rate Guarantee Periods

The State plans to enter into a three (3) year contract with the selected vendor effective January 1, 2014, with the State having the option to renew the contract for two (2) additional one-year extensions. The vendor must guarantee the contract period rates and fees through

December 31, 2016, with a rate cap for two (2) additional optional one-year periods that may be exercised at the discretion of the SEBC. The rate caps must be expressed in a percentage as an increase from the previous year. Use the Cost Quotation form in Section V.

Performance Guarantees

The State expects exceptional client account management and participant customer service from their COBRA/HIPAA administration vendor and is interested in evaluating financial and non-financial performance guarantees. The State reserves the right to negotiate both financial and non-financial performance guarantees. Please refer to Appendix C.

Required Reporting

One of the primary goals in administering this contract is to keep accurate records regarding its actual value. This information is essential in order to update the contents of the contract and to establish proper bonding levels if they are required. The integrity of future contracts revolves around our ability to convey accurate and realistic information to all interested bidders. Therefore, be advised that a Monthly Usage Report will be filed with the State’s Contracting Office that discloses the fee paid to the successful vendor for the administration of this contract.

In accordance with Executive Order 14 and 29 – Increasing Supplier Diversity Initiatives within State Government and Ensuring Representation of Veteran-Owned Businesses, the State is committed to supporting its diverse business industry and population. The successful Vendor will be required to report quarterly on the participation by a certified minority, woman, or veteran owned business for subcontracted services that are provided for the administration of this contract.

Recap of Proposal Copy Formats:

(See Pages 10 & 12 for Detailed Descriptions)	Hard Copies	PDF Copies (on separate CDs)
Confidential and Proprietary documents: Only those documents and the attorney’s cover letter	1 (In marked envelope)	1
Complete bid <u>with</u> redacted sections	1	1
Complete bid <u>without</u> redacted sections	6	1

III. Minimum Requirements

The following minimum requirements are mandatory. Failure to meet any of these proposal criteria will result in disqualification of the proposal submitted by your organization.

1. As an introduction, please provide the firm's name, home office address and telephone number, and the address and telephone number of additional offices, if any, that would provide the services requested under this RFP. Also provide the name and information for the primary contact, including email address, for this RFP.
2. The selected vendor must have at least five (5) years experience as an organization in providing the type and scope of COBRA/HIPAA administration services to be procured through this competitive RFP process. Please confirm that you have reviewed the plan information and COBRA rate structures included in this RFP and that you have provided the COBRA/HIPAA administration services outlined in the RFP for other clients. The determination of the length of time an entity has provided these services will be based upon the initial date the entity established a contractual relationship to provide such administration services. The proposing organization must provide sufficient detail to demonstrate it has significant experience in working with programs similar in size and complexity to the GHIP. Because more detailed questions follow, please provide only a broad outline here of the organization's years of experience and qualifications for the services listed in the Scope of Services.
3. The individual who will act as the SEBC's primary contact shall be, at a minimum, a senior level manager and shall have at least ten (10) years experience providing COBRA/HIPAA administration services, of which three (3) years experience must have been in providing administration services to self-insured health plans consisting of at least 100,000 covered lives. Please provide a statement detailing such experience and a resume.
4. Please confirm that your company can maintain Health Information Technology for Economic and Clinical Health (HITECH) standards for the encryption of confidential information for transmission via non secure methods, which include File Transfer Protocol or other use of the internet.
5. Please confirm that your organization has, or will establish, and maintain an encryption solution that you provide clients for exchanging e-mails containing ePHI. Please describe the system.
6. Please confirm your acceptance that any payments made by the State will be by Automated Clearing House (ACH) as per its ACH processing procedures.
See <https://w9.accounting.delaware.gov/?OpenForm> for the required information.
7. Please confirm that your organization will not use the names, home addresses or any other information obtained about participants of the GHIP for the purpose of offering for sale any property or services that are not directly related to services negotiated in the RFP without the express written consent of the State.

8. Please confirm that your organization has strict policies and procedures in place for the protection of client and member Protected Health Information (PHI) and to avoid security breaches under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. Please describe in detail your program, policies and procedures.
9. Please confirm that your organization will maintain a security program, policies and procedures that meet or exceed industry best practices and comply with the HIPAA, HITECH and National Institute of Standards and Technology (NIST) standards. Also, please confirm that you will:
 - a) Ensure that State information is protected with reasonable security measures;
 - b) Promote and maintain among your employees and agents an awareness of the security needs of the State's information;
 - c) Safeguard the confidentiality, integrity, and availability of State information; and
 - d) Ensure that appropriate security measures are put in place to protect your internal systems from intrusions and other attacks.
10. Please confirm that you will act as Plan Administrator as defined by federal regulations and your processes, notices, systems and reporting will be in full compliance with COBRA and HIPAA federal and state continuation requirements. Also confirm that any fines related to non-compliance will be your sole responsibility.
11. Verify that the primary contact and/or lead personnel assigned to a transition team and account management team will be part of any interview team.
12. Provide a copy of an errors and omissions professional liability insurance coverage in the amount, at a minimum, of \$1,000,000 per person and \$3,000,000 per occurrence.
13. Confirm that your system is able to handle multiple coverage termination rules depending on the type of Qualifying Event (QE). Please describe your capabilities in this area. The State requires that coverage terminates at the end of the month for all QEs except:
 - a. Coverage terminates the day after the effective date of a divorce; and
 - b. Coverage for the ex-spouse of a retiree covered by a Medicare supplement plan with or without prescription coverage will terminate on the last day of the month in which the divorce is final.
14. Additionally, confirm that your system is able to administer all other Eligibility and Enrollment Rules (see Appendix F). Please describe your capabilities in this area.
15. Please confirm that your organization can maintain separate, secured, and individual access to your online portal by benefit representatives for each employer group/unit. In other words, a benefit representative would be able to see only their group's employees and covered dependents along with a "waiting" or "enrolled" status. Additionally, SBO designated staff must have central/all access.

16. Please confirm that your organization has online capability to accept qualifying event notices electronically (via web-based services) from the State and that remote access will be provided to the State's benefit representatives (approximately 300) to update information and enter qualifying event notices.
17. Your company must have proven ability to perform the services to multiple employer units as described in this RFP. Of your company's current clients, list one (1) or more that qualify. Can they be contacted during reference checks? Include the following information:
 - a) Client name
 - b) Principal location
 - c) Location servicing account, if different
 - d) Number of covered participants
 - e) Client contact including name, title address, email and phone number
 - f) List of services provided (Please be specific)
 - g) Effective date of contract
18. Please confirm that if you are the awarded vendor, you would be able to successfully implement COBRA/HIPAA administration services for the State effective January 1, 2014.
19. Confirm that your proposal is valid for 180 days subsequent to the date of submission.
20. Please confirm that you will sign the Business Associate Agreement in Appendix D to ensure your compliance with the HIPAA Privacy and Security rules as it pertains to Protected Health Information as well as HITECH.
21. Please confirm that State data (along with other relevant documentation such as procedure manuals and system access) will be made available to the State or its authorized agents for purpose of an audit.
22. Please confirm that all record documents and data shall be the property of the State, not the administrator, and will not be stored off-shore (outside of the United States).
23. Please confirm you are willing to accept the State's performance guarantees and fees at risk, at minimum, as listed in Appendix C.
24. Please confirm your willingness to negotiate financial and non-financial performance guarantees.
25. Please confirm that your processes, systems and reporting are in full compliance with HIPAA.
26. Please confirm that in the event of contract termination, you agree to transfer to the State (or to a successor administrator) within thirty (30) days of termination notice all data and participant records necessary for the continued administration of the plan. Your organization must agree to continue operations until the transfer of data has been completed.

27. The term of the contract between the successful organization and the State will be for three (3) years and may be renewed for two (2) additional one-year extensions at the discretion of the SEBC. The State will be the only party to have termination for convenience rights. Should the vendor terminate for cause, the State will require 180 days written notice. Please confirm your acceptance.
28. The RFP and the executed Contract between the State and the successful organization will constitute the Contract between the State and the organization. In the event there is any discrepancy between any of these contract documents, the following order of documents governs so that the former prevails over the latter; contract and RFP. No other documents will be considered. These documents contain the entire agreement between the State and the organization. Please confirm your acceptance.
29. The payment of an invoice by the SEBC shall not prejudice the SEBC's right to object or question any invoice or matter in relation thereto. Such payment by the SEBC shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. Vendor's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the SEBC, on the basis of audits, to not constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices. Please confirm your acceptance.
30. The SEBC reserves the right to deduct from amounts that are or shall become due and payable to the vendor under this contract between the parties any amounts which are or shall become due and payable to the SEBC by the vendor. Please confirm your acceptance.
31. Please confirm that your organization will not use the State's name, either express or implied, in any of its advertising or sales materials without the State's express written consent.
32. Vendor shall indemnify and hold harmless the State, its agents and employees, from any and all liability, suits, actions or claims, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (A) the negligence or other wrongful conduct of the vendor, its agents or employees, or (B) vendor's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided as to (A) or (B) that (i) vendor shall have been notified in writing by the State of any notice of such claim; and (ii) vendor shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise. Please confirm your acceptance.

Vendor shall indemnify and hold harmless the State, its agents and employees, from any and all liability, suits, actions or claims, including any claims or expenses with respect to the resolution of any data security breaches/ or incidents, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (A) the negligence or other wrongful conduct of the Vendor, its agents or employees, or (B) vendor's breach of this Agreement, provided as to (A) or (B) that (i) vendor shall have been notified promptly in writing by the State of any notice of such claim; and (ii) vendor shall have control of the defense of any action on such claim and all negotiations for its settlement or compromise. Please confirm your acceptance.

TECHNICAL STANDARDS AND SECURITY REQUIREMENTS – ACKNOWLEDGEMENT REQUIRED

(Though some items are similar or duplicative to other requirements or questions, please respond to each question completely.)

33. TERMS AND CONDITIONS:

The State is taking a very deliberate approach to cloud-based engagements because of concerns around the protection of our data, access control, and the lack of mature standards in the industry. It is for this reason that explicit details of the cloud solutions are required, including an item-by-item acknowledgement from the candidate vendor. **Proposals must contain the form in Appendix I – Acknowledgement of the Terms and Conditions for Cloud Contracting and External Hosting. All of the Terms and Conditions (T&C) must be signed (acknowledged) and only the Statement of Work (SOW) that the solution accommodates should be signed.**

34. CONFIDENTIALITY AND DATA INTEGRITY:

The Department of Technology and Information is responsible for safeguarding the confidentiality and integrity of data in State computer files regardless of the source of those data or medium on which they are stored; e.g., electronic data, computer output microfilm (COM), tape, or disk. Computer programs developed to process State Agency data will not be modified without the knowledge and written authorization of the Department of Technology and Information. All data generated from the original source data, shall be the property of the State. The control of the disclosure of those data shall be retained by the State and the Department of Technology and Information.

The Contractor is required to agree to the requirements in the **CONFIDENTIALITY AND INTEGRITY OF DATA STATEMENT**, attached at Appendix I, and made a part of this RFP. Contractor employees, individually, may be required to sign the statement prior to beginning any work. Please confirm.

35. SECURITY:

Computer, network, and information security is of paramount concern for the State and the Department of Technology and Information. The State wants to ensure that computer/network hardware and software does not compromise the security of its IT infrastructure. The SANS Institute and the FBI have released a document describing the Top 20 Internet Security Threats. The document is available at www.sans.org/top20.htm for your review. The Contractor is guaranteeing that any systems or software provided by the Contractor are free of the vulnerabilities listed in that document.

The awarded vendor shall maintain network security policy compliance in accordance with Secure File Transport to secure data classified as confidential or higher per the Data Classified Policy when moving data. References to the policy documents are provided in Question 39. Please confirm.

36. Electronic information storage devices (hard drives, tapes, diskettes, compact disks, USB, multifunction peripherals, etc) shall be disposed of in a manner compliant to Delaware

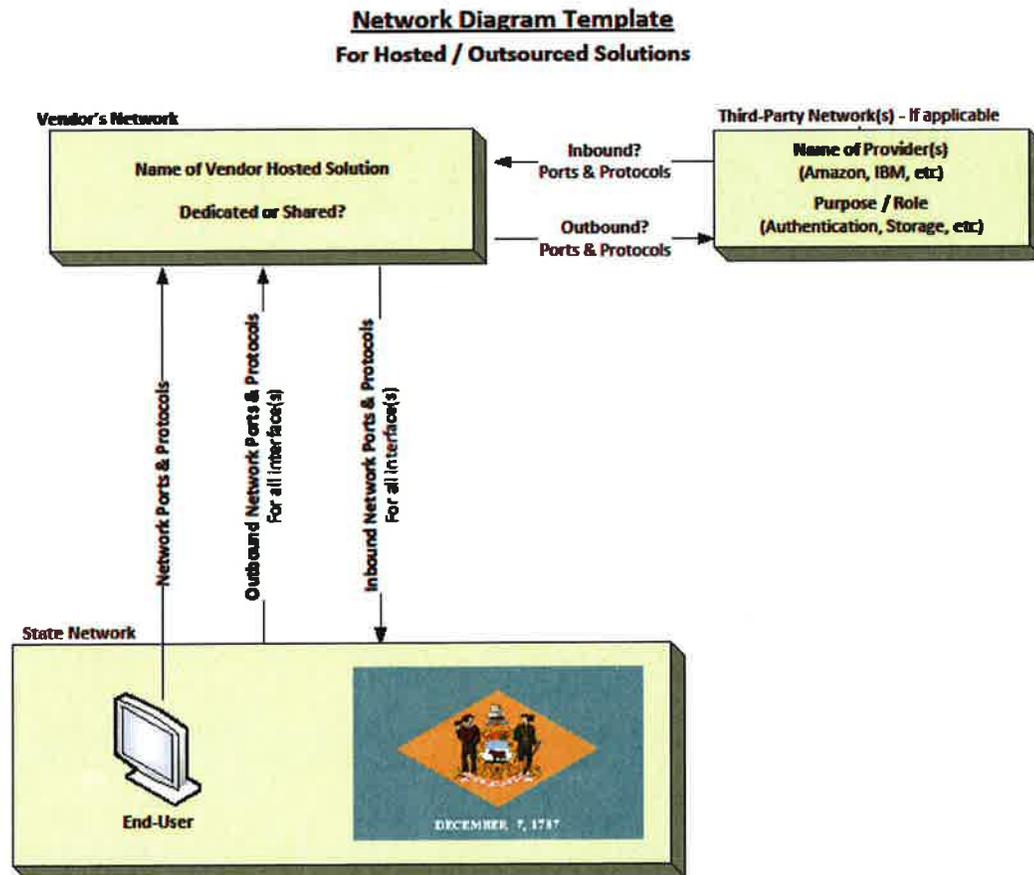
Department of Technology and Information policy DTI-005.01, Disposal of Electronic Equipment/Storage Media. Reference to the policy document is provided in Question 39. Please confirm.

37. CYBER SECURITY LIABILITY:

It shall be the duty of the Vendor to assure that all products of its effort do not cause, directly or indirectly, any unauthorized acquisition of data that compromises the security, confidentiality, or integrity of information maintained by the State. Vendor’s agreement shall not limit or modify liability for information security breaches, and Vendor shall indemnify and hold harmless the State, its agents and employees, from any and all liability, suits, actions or claims, together with all reasonable costs and expenses (including attorneys’ fees) arising out of such breaches. In addition to all rights and remedies available to it in law or in equity, the State shall subtract from any payment made to Vendor all damages, costs and expenses caused by such information security breaches that have not been previously paid to Vendor. Please confirm.

37. Architectural Documentation Requirements

a. Network Diagram - A network diagram of the proposed solution is required that clearly documents the user’s interaction with the solution and the State. The network diagram should follow this example:



- b. **Software Inventory** - A software inventory of the proposed solution is required that list any software **that the State needs**. For example, a certain web browser (IE) or web service technology for an interface. Software inventories should use the format included in Appendix I – Software Inventory Template. (Feel free to create the same form in an excel document.)
- c. **Database Dictionary or Data model** - A data dictionary OR a conceptual data model for state-owned business data must be provided to the state. The data dictionary or conceptual data model does not have to be submitted with a vendor response to this RFP, but must be submitted once the design of the solution is complete or prior to implementation of the solution. The submitted data dictionary or conceptual data model must include at least the following items: entity names and descriptions, entity relationships and descriptions, attribute names, attribute descriptions, attribute data type, attribute lengths, and primary identifier for each entity.

Data dictionaries must be submitted in Excel or in a .csv file. The directions for how to format the Excel workbook is explained in the first section of the Data Model Samples document. If a data model is submitted, it must be in either Sybase PowerDesigner or CA ERwin format. Any submission by a vendor to comply with these requirements that necessarily includes data that the vendor wishes to claim as proprietary must be submitted and labeled “Proprietary Information” with the RFP/Contract number. The envelope must contain a letter from the Vendor’s legal counsel describing the documents in the envelope, representing in good faith that the information in each document is not “public record” as defined by 29 Del. C. § 10002(d), and briefly stating the reasons that each document meets the said definitions. The vendor's counsel must also acknowledge what elements of the submission are not claimed as proprietary and are subject to release upon request. Additional guidance is in Appendix I.

38. Business Case Requirement

Please confirm your understanding that a vendor selected for an interview may be required to provide a Business Case model.

See <http://extranet.dti.state.de.us/information/itic/tools.shtml>

39. Mandatory Standards

The following State technology standards and/or policies have been identified as being related to this solution. Please confirm your ability to meet these requirements:

- a. Data Classification Policy
<http://dti.delaware.gov/pdfs/pp/DataClassificationPolicy.pdf>
- b. Data Management Policy
<http://dti.delaware.gov/pdfs/pp/DataManagementPolicy.pdf>

- c. State of Delaware Information Security Policy (DISP)
<http://dti.delaware.gov/pdfs/pp/DelawareInformationSecurityPolicy.pdf>
- d. Secure File Transport
<http://dti.delaware.gov/pdfs/pp/SecureFileTransport.pdf>
- e. Strong Password Standard
<http://dti.delaware.gov/pdfs/pp/StrongPasswordStandard.pdf>
- f. Web Application Security
<http://dti.delaware.gov/pdfs/pp/WebApplicationSecurity.pdf>
- g. Terms and Conditions for Cloud Contracting and External Hosting
<http://dti.delaware.gov/pdfs/pp/Cloud-External-Hosting.pdf>
- h. Data Modeling Standard
<http://dti.delaware.gov/pdfs/pp/DataModelingStandard.pdf>
- i. Disposal of Electronic Equipment and Storage Media Policy
<http://dti.delaware.gov/pdfs/pp/DisposalOfElectronicEquipmentAndStorageMedia.pdf>
- j. Data Center Policy
<http://dti.delaware.gov/pdfs/pp/DataCenterPolicy.pdf>
- k. Data Integration Standard
<http://dti.delaware.gov/pdfs/pp/DataIntegrationStandard.pdf>

IV. Questionnaire

Failure to respond to any request for information may result in rejection of the proposal in the sole discretion of the State. Whenever applicable, you must clearly and succinctly indicate how your standard procedures would be modified in order to accommodate any specific requirements of the State that deviate from your standard procedures. Generic responses or stock answers that do not address State-specific requirements will be deemed unresponsive.

A. Company History and Financial Profile

1. State the full name and home office address of your organization.
2. Describe your organizational structure (e.g., publicly held corporation, private non-profit, partnership, etc.). If it is incorporated, include the state in which it is incorporated. List the name and occupation of the individuals serving on your organization's Board of Directors, and list the name of any person/entity owning 10% or more of your company.
3. How long has your company been operational?
4. Is your company a division or subsidiary of a parent firm? If yes, please indicate the name and address of the parent firm.
5. Include a statement of your company's history, management, business objectives and financial structure, including ownership and general financial condition.
6. Describe any pending contracts to merge or sell your company.
7. What are your company's growth plans for the next three (3) years?
8. How many employees does your company currently have? What was your company's average number of employees for calendar year 2011 and 2012?
9. What is the annual turnover rate by year for the last three (3) years for each of the following departments/units: account management, administrative staff, customer service staff and compliance managers/attorneys?
10. List the offices that will service the State's account. If it is (they are) located at a different address than the home office, provide the complete address and phone number. Also indicate what services under this RFP would be provided from each office.
11. Will the office in charge of the State's account have access to resources/staff in other offices? If so, please describe those resources.
12. Does your company anticipate any internal reorganizations or system changes/upgrades that could impact the services requested under this RFP?

13. Designate the individual(s) with the following responsibilities. Include the name, title and address of each individual, along with a brief description of his/her qualifications and experience. Please provide a copy of their resume as an exhibit or appendix.
 - a) The individual(s) representing your company during the proposal process
 - b) The individual(s) who will be assigned to manage the account
 - c) The individual(s) responsible for management of the customer service unit
14. Do you plan to sub-contract any portion of the services required to another firm? If "Yes", answer the following:
 - a) Describe the services.
 - b) Will any sub-contracted services be provided by firms that are outside or have service operations outside the United States?
 - c) Will you take responsibility for the quality, timeliness and accuracy of these sub-contracted services?
 - d) Describe how your staff will interface with the staff of the sub-contractor(s).
 - e) Would there be an expectation that member systems and/or participants would interface with any sub-contractor?
15. Please confirm that you are licensed to do business in the State and provide a copy of your Delaware business license.
16. Confirm that State data will be made available to the State or its authorized agents for purpose of an audit. What, if any, restrictions would apply?
17. Provide the latest annual report or other financial reports (including audited financial statements) that indicate the financial position of your organization. If your company is privately held, list owners with five (5) percent or more of equity.
18. Please indicate your company's most recent ratings by Standard and Poors, Fitch, A.M. Best and Moody's, as applicable. If one or more of these agencies does not rate your company, explain why not.
19. Has your firm ever been subject to a legal action brought by a client or former client for the proposed services within the past ten (10) years? If so, please explain the nature and current status of the action(s).
20. Are there any outstanding legal actions pending that would affect your ability to provide the requested services? If yes, please explain.
21. Has your company, its affiliates or any of its staff, principals or owners ever been subject to a governmental or criminal investigation involving the requested services or any other services offered by your organization? Please describe.

22. Please confirm that you will not use any staff (including sub-contractors) who has been convicted of a felony or class A misdemeanor to fulfill the obligations of the contract with the State.
23. In the last five (5) years, has your company, its affiliates or any of its principals or officers ever been subject to bankruptcy proceeding, been declared bankrupt or been placed into involuntary bankruptcy, whether directly related to the services requested in this RFP or not? If so, please provide details including dates and outcomes.
24. Please describe any security breaches in the last seven (7) years including type, extent, notifications, remedies and the policies or procedures implemented to minimize the chance for future breaches. These include occurrences such as laptops being stored in unsecure places such as vehicles or flash drives with PHI used on unsecure computers.
25. Please describe any type of external audits performed of your operations including but not limited to SSAE-16 (SAS-70) and the frequency of these audits. Please include a copy of your most recent SSAE-16/SAS-70 (or other external audit).
26. Has your firm or any client administered by your firm ever sustained a fidelity loss or claim? If yes, please provide details.
27. State if your company currently provides any services, directly or indirectly, to any of the following vendors or SEBC members. If so, provide a full description of services provided and whether or not you feel they represent a conflict of interest or potential conflict of interest.
 - a) Highmark Delaware (Blue Cross Blue Shield of Delaware)
 - b) Aetna
 - c) Dominion Dental
 - d) Delta Dental
 - e) Truven Health Analytics, Inc. (formerly Thomson Reuters)
 - f) Application Software, Inc. dba "ASI" or "ASI Flex"
 - g) Minnesota Life Insurance Company
 - h) The Hartford
 - i) Human Management Services, Inc. dba "HMS"
 - j) Express Scripts, Inc. (formerly Medco Health Services, Inc.)
 - k) Alere Health Improvement Co. dba "Alere"
 - l) EyeMed Vision Care
 - m) SEBC Members:
 - Ann Visalli, Director, Office of Management and Budget
 - Mike Morton, Controller General
 - Karen Weldin-Stewart, Insurance Commissioner
 - Chipman "Chip" Flowers, Jr., State Treasurer
 - Rita Landgraf, Secretary of Health and Human Services

- Thomas J. Cook, Secretary of Finance
- The Honorable Carolyn Berger, Justice, Delaware Supreme Court

B. Organizational Experience and References

28. How long has your firm been providing COBRA/HIPAA administration services?
29. For how many clients do you currently provide COBRA/HIPAA administration services? How many additional clients are expected during the next year?
30. How many governmental clients do you serve in total?
31. Of your company's current clients, what five (5) would be viewed as peer groups for the services requested by the State? Can they be contacted during reference checks? Include the following information:
- a) Client name
 - b) Principal location
 - c) Location servicing account, if different
 - d) Number of eligible participants (i.e., covered lives)
 - e) Client contact including name, title address, email and phone number
 - f) List of services provided (Please be specific)
 - g) Effective date of contract
32. If at least one (1) governmental/public sector client was not listed in the references provided above, list an additional one or more governmental client references.
33. If at least one (1) client that requires a termination of coverage on the day after divorce is not listed in the references provided above, list an additional one or more client references with this requirement.
34. Has any client terminated COBRA/HIPAA administration services provided by your firm during the last five (5) years? If so, please provide the names along with the reason for each termination (please limit your response to former clients who had similar services to the ones requested by the State). May they be contacted? If so, provide the information as requested above.
35. Describe how your company keeps its staff apprised of both federal and state legislative updates. Indicate the scope of your company's technical research ability, including staff and access to legal resources.
36. Describe how your company keeps its clients abreast of both federal and state legislative updates and on-going changes within your industry.
37. Do you offer other optional, value-added services that support COBRA/HIPAA Administration? If so, please describe these services and the associated costs (add these

optional fees to the Fee Table in Section IV of this RFP). Specifically, please describe any services/products you offer in support of annual open enrollment activities.

C. COBRA Administration

38. What would you require from the State to prepare COBRA notifications?
39. Provide sample copies of your notices as follows and include any routine form notices or letters not listed below:
- a) New Hire Notice to newly enrolled/covered participants of their COBRA rights and obligations as they become covered under the State's plans;
 - b) Qualifying Event Certifications;
 - c) HIPAA Creditable Coverage Certificates;
 - d) COBRA continuation coverage notices;
 - e) Individual premium invoices;
 - f) Collect premiums and forward the amount of paid premiums (less the 2% administrative charge) to the State;
 - g) Enrollment report to SBO for forwarding to other State vendors;
 - h) Termination of continuation of coverage letters; and
 - i) Conversion notices at end of COBRA continuation coverage periods.
40. Please confirm that you are able to provide the following COBRA/HIPAA administration and reporting services, including a description of the procedures, timelines and all functions that are automatically tracked and/or processed through your COBRA system:
- a) COBRA notification for new hires
 - b) Notification of qualifying event from State or qualified beneficiary
 - c) Sending COBRA notice of rights following a qualifying event
 - d) Receipt of election notice/enrollment applications
 - e) Premium billing, both initial and ongoing
 - f) Premium collection and tracking
 - g) Premium remittance to State or carriers
 - h) Reporting eligibility to State and carriers (electronic and paper)
 - i) Multiple Qualifying Events
 - j) COBRA termination letters, including early termination
 - k) Sending notice of conversion privileges, if applicable
 - l) Mail to the corresponding benefit representative notice of unavailability letters (such as *Cannot Reach COBRA Participant, Bad Address, etc.*);
 - m) Mailing of HIPAA Privacy Notice (see Appendix E)
 - n) Mailing of HIPAA Creditable Coverage Certificate
 - o) Mailing of rate change letters

- p) Providing COBRA coverage rate projections to the State annually (for four tiers – employee, employee and spouse, employee and children, family)
- q) Updating of system for new plan year's rates and provision of mailing lists to the State for communicating plan design changes
- r) Distribution of unavailability of COBRA coverage

41. Please confirm that all COBRA and other notices will be sent by first class mail.
42. How are COBRA premiums collected and deposited? Do you offer any online/electronic premium payment options?
43. Describe your procedures related to when a qualified participant:
- a) Submits excess premium payments
 - b) Submits insufficient premium payments
 - c) Declines COBRA coverage then later desires to revoke declination and enroll in COBRA coverage
44. What types of COBRA administration reports do you provide on a routine basis that are not listed in Appendix G? Please provide samples.
45. Describe your procedures for the issuance of HIPAA Certificates of Creditable Coverage, noting that the State carriers/vendors do not issue these Certificates. Do you automatically issue HIPAA Certificates when COBRA coverage ceases?
46. Are you able to send electronic eligibility files directly to Highmark Delaware (BCBSD)? Are you able to issue file feeds in the standard HIPAA 834 format and/or the vendor's proprietary format?

D. Customer Service to Participants⁴

47. Provide a brief overview of the customer service office you would propose for the State. What is the location and hours of operation of the office that would provide day-to-day service? How long has it been operational? What types of services does it provide?
48. Describe the staffing of the proposed customer service office. How many employees work in that location? What is the average number of years of experience of these employees?
49. Indicate how many full time and part time customer service representatives (by position type and level) and whether they would be dedicated or designated to the State's account. What percentage of time would the designated representatives be dedicated to the State?
50. Describe the customer service center's supervision function. Who would be responsible for daily ongoing administrative issues? How would the account management services for the

⁴ Not *account management* for the State's account. See Section E.

State be coordinated? If your firm is selected, do you anticipate hiring additional staff? If so, how many and in what category?

51. Confirm that a toll-free number will be made available to participants to handle inquiries.
52. Confirm that the telephone line will be staffed by customer service representatives from 8:00 a.m. to 5:00 p.m. EST. Would the telephone line be staffed additional hours? (Please do not include hours the telephone line will be staffed by an answering service.) Include weekend hours, if applicable.
53. Describe your phone system and the call routing capabilities. How do you handle incoming calls during non-business hours?
54. Indicate the ways in which your organization is able to accommodate any telephonic special needs of participants. (*Check all that apply*)
- No special accommodations
 - Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired
 - Accommodate non-English speaking enrollees by contracting with an independent translation company
 - Maintain customer service staff with the ability to translate Spanish
 - Maintain customer service staff with the ability to translate the following languages:
-
55. The State is interested in the customer service performance of the administrative office that you would propose for the State. Please provide your most recent performance statistics for the following categories:

	Statistic
Percent of calls answered within a specified number of seconds	_____ % within _____ secs.
Abandoned call rate	
Frequency in which callers receive a busy signal	
Of calls requiring additional research, percentage responded to within 48 hours	

56. How is your staff trained in customer service?
57. Do you accept email communications from participants?
58. Do you currently offer, or would you agree to offer, a web site that would provide general COBRA eligibility and payment information to eligibles and participants?

59. Please provide information on any enhancements currently underway in your customer service department.
60. Do you conduct customer satisfaction surveys? If yes, please provide the satisfaction percentage for the last two (2) years on your Book of Business. If not, will you be willing to conduct surveys on behalf of the State if you are selected?
61. Do you have an appeal process for the participants? If so, describe.

E. Account Management

62. Please describe what online services are available to State's account management staff in the SBO for reviewing eligibility, account balances and payment transactions. Can standard and/or ad/hoc reports be accessed online? If so, what are they?
63. Please describe what online services would be available to the 300 benefit representatives relevant only to their employer group?
64. Are you willing to attend a yearly on-site account management meeting in Dover, Delaware, at no cost to the State?
65. From a list of Benefit Representatives that have access to the on-line portal, will you be able and willing to send periodic educational and reminder emails?
66. Provide a copy of a sample invoice that would be presented to the State for payment of administrative services.

F. Quality Assurance

67. Describe your quality assurance program.
68. Describe your internal and external audit procedures, including frequency of audits.
69. Describe your process to ensure COBRA participants are eligible at initial enrollment, ongoing coverage, and open enrollment periods.
70. How do you monitor turnaround time to ensure that COBRA notifications are sent to COBRA qualified participants within the required fourteen (14) day time frame? Also conversion/continuation timeframes?
71. Will your organization allow the State (or its authorized representatives) to audit your procedures and records?

G. Computer System and Support

72. What COBRA activities are automated systematically? What COBRA activities are performed manually?

73. Please describe all data elements that your COBRA administration system can capture and track. Can reports be queried by any of these data elements?
74. Confirm your ability to provide “super user” access or similar administrator type access to the State’s 300 benefit representatives. Describe how you would provide role-based access and security to ensure that these individuals can access and update information for their unit’s employees only, and what type of functions would be restricted (e.g., would have to be escalated to the vendor for handling).
75. What is the up-time of your system? Are you willing to provide performance guarantees related to the up-time of your systems and applications? If so, please list the guarantee and fees at risk you would include in Appendix C. If systems must be taken offline to perform system maintenance, please describe how frequently maintenance is performed and how long systems would be down or offline.
76. How long do you maintain beneficiary eligibility, enrollment and premium payment records online?
77. How do you maintain COBRA history (e.g., hard copy, online)? How do you access COBRA history?
78. What system modifications, if any, do you expect to implement in order to accommodate the State’s required services accurately and on a timely basis?
79. Please indicate in the chart below what components of the computer application were (a) developed in-house, (b) purchased, or (c) licensed. If software is purchased or licensed, please indicate from whom.

Function	Developed In-House	Purchased	Licensed	Year of Last Major Modification	Name of Software Vendor
COBRA Administration					
Accounting/Billing					
Imaging/Scanning					
Workflow					
Customer Service					
Other: _____					

80. For licensed software, are you authorized to modify it or must you receive permission from the licensor?

81. If your software was developed in-house, what language are your application programs written in? Please describe the operation of the software and characterize the major features, e.g., on-line? Real time update? Batch processing?
82. Do you have any plans to change your system over the next three (3) years?
83. Do you have programmers on staff? If so, please describe the staffing of your IT department.
84. How would you securely destroy the State's data if the State selects another service provider in the future? Are you required to store copies of the State's data and if so, for how long? Please describe how you store and secure data for terminated clients.
85. Are any of your applications or services provided via the cloud? If so, which ones? Do you use the cloud for data storage? Do you encrypt all data in transit to the cloud?
86. Has your organization adopted the ISO/IEC 27001 standards for information security management systems? Have you received a certification of compliance with these standards? If so, please provide proof of your certification.
87. Do you have a system and data file backup policy? If yes, please outline.
88. Please confirm that the State's backed-up data will not be comingled with any other customer data.
89. Describe your disaster recovery program and business resumption strategy. Please include a description of your recovery time objectives (RTOs).
90. Is all data stored/retained on a secure server environment that uses firewall and other advanced technology to prevent interference or access from non-authorized users; requires unique login ids; and meets at a minimal a level 7 data center rating as outlined in the Delaware Data Center Policy? <http://dti.delaware.gov/pdfs/pp/DataCenterPolicy.pdf>
91. Does the solution provide audit reports (SOC 2, etc) that capture user level interaction such as login/logoff with the system?
92. Will dedicated server resources be used for the solution that are not shared with other customers (i.e. dedicated web hosting, dedicated databases)?
93. Will the solution have the ability to run on mobile devices using the State's Mobile Device encryption protocols?
94. Will the solution encrypt all State non-public data on all vendor devices including mobile?
95. Will the solution restrict direct user access to the database layer of the solution?
96. Will there be end-user access logs to the solution? For example, John Doe logged in at 4:55 p.m. on Saturday and accessed these specific records.

H. HIPAA

97. Describe the process used by your company to comply with HIPAA EDI, Privacy, and Security requirements. Have you received external or independent certification regarding your HIPAA compliance?
98. Who is the key individual in your organization responsible for compliance with the HIPAA Administrative Simplification provisions? Please identify that individual by name and title and provide a copy of his or her resume.
99. Have you arranged for additional vendors, subcontractors, or other entities to assist you in complying with the HIPAA Administrative Simplification provisions? If yes, please identify the entities, their address, and their role.
100. Describe your HIPAA EDI compliance solution. Does your system have the ability to send and receive all types of HIPAA X12 electronic transmissions? Are you using a clearinghouse as part of your solution? If so, which one(s)?
101. Are you actively conducting EDI transactions at the present time? Have you implemented version 5010? If so, which transactions are you presently conducting? If not, what is preventing you from sending and/or receiving EDI transactions?
102. If you would consider yourself the plan's HIPAA Business Associate, have any of your clients ever terminated a HIPAA Business Associate Agreement with you (or an underlying Services Agreement) for cause, due to material breach or violation of the HIPAA Business Associate Agreement? If so, please describe the breach or violation and your efforts to remedy the situation.
103. How is security set up in the system? What are the different levels of security? Have you conducted a HIPAA Privacy and Security assessment?
104. Is your staff trained on all Privacy and Security requirements? Please describe your HIPAA training program and enforcement policy.
105. Have you conducted an analysis of the risks and vulnerabilities to protected enrollment and claims information in your system and networks?
106. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?
107. What types of HIPAA administration reports do you provide on a routine basis that are not listed in Appendix G? Please provide samples.
108. Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file attachments? Please describe.

109. Do you encrypt data at rest? Describe your encryption methodology and tools using industry standard key management.
110. Please describe your procedures for securing, encrypting, and/or destroying PHI that may be stored in fax transmissions and copy machine hard drives.

I. Reporting Capabilities

111. Please confirm you can provide the reports set forth in Appendix G and provide a sample if currently available.
112. Will you provide a dedicated unit or individuals that would be responsible for generating standard and ad-hoc reports?
113. Please provide a list and samples of all reports included in your standard package. Please indicate for each:
 - a) The frequency (monthly, quarterly, annually); and
 - b) How soon are they available after the close of the reporting period.
114. Describe any other reports you would be able to supply to the State regularly at no additional charge and the frequency with which they could be provided.
115. What information/reports are available to the State and SEBC staff via on-line self-service access?
116. Please confirm that you will provide the State with a list of mailing addresses for current participants for annual enrollment notification.
117. Would you provide ad-hoc data reports at the State's request? If so, please describe your ad-hoc data reporting capabilities. Would there be additional fees for these reports? If so, please describe and include all additional fees in the Cost Quotation form.

J. Implementation and Transition Issues

118. Would you agree to guarantee complete implementation within 120 days of being awarded the contract? What is the minimum amount of time recommended to ensure a clean transition into the proposed program?
119. Do you have a special team assigned to handle the transition of new clients? Who would be on your "State Team" if you are the selected bidder? Please include the titles and credentials of this team if applicable.
120. Describe your implementation process and provide a proposed implementation plan and timetable, beginning with the award of business to effective date of coverage. Include:
 - a) Steps required to implement the program
 - b) Role played by the State/vendor
 - c) Eligibility feeds

- d) Contacts and personnel assigned to each step of the implementation process
 - e) The qualifications and experience of the proposed Project Manager
 - f) Your approach to project communications and outreach
 - g) Your proposed data migration strategy
 - h) Your approach to risk and issue management, scope control, and quality assurance
 - i) Establishment of bank accounts
121. Explain how you would transition COBRA administration from the current administrator.
122. How would you communicate the change in administrator to State employees and COBRA participants? Please attach sample communication materials and indicate the cost, if any, on the Cost Quotation form. Are customized communications available?
123. Please describe in detail all implementation costs included and excluded on the Cost Quotation form.
124. Based upon past experience from other cases you have implemented, what can the State expect as far as the transition process is concerned?

K. Performance Guarantees

125. The State's performance guarantees listed in Appendix C and the fees at risk are a minimum requirement. Are there any additional performance guarantees you would be willing to include in a contract with the State? If so, copy the chart here and highlight your revisions.
126. How do you measure satisfaction with your guaranteed quality and customer service levels?
127. Do you provide periodic reports to your clients indicating satisfaction or failure to meet quality and service levels?

V. Cost Quotation

Directions:

- A. Please complete the following fee tables. Fees for each of the five (5) years must be included. Fees should include all COBRA/HIPAA administration services outlined in this request for proposal. The rate caps for optional years four and five must be expressed in a percentage as an increase from the previous year. For example, a rate cap of 3% in Year 4 would be calculated from Year 3's rate. If the increase is contracted for 2%, Year 5's rate is calculated from Year 3 plus 2%, not 3%. Any special fees or charges of any kind for services or supplies that will not be covered must be described and disclosed in your proposal.
- B. In providing fee estimates please keep in mind the following:
- Please use the transaction volumes provided in Appendix B for your calculations;
 - Any set-up fees to transfer records from the current vendor's system and/or manual records to your recordkeeping system should be listed in Table 2; and
 - Fees must include the cost of a customer service toll-free line, routine faxes, printing of notices, and first class mailing for notices and monthly premium billings. The State will not pay for itemized costs of these routine services.

Questionnaire:

1. Please confirm your understanding that the SEBC may or may not elect to contract for the optional services requested and identified as such on the Cost Quotation form, along with any additional optional services your organization can provide that you quote on the form.
2. Please confirm that fees are payable at the end of a 30-day grace period.
3. Detail your reconciliation responsibilities and procedures. The State will require that all reconciliations be performed by the selected vendor.
4. Describe how you handle the banking arrangements for the participants' premiums and distribution. What type of accounts you would propose for the State and what is your strategy for eliminating or minimizing banking fees?
5. In the event of cancellation of the Contract, confirm that you guarantee a post-termination administrative fee of no more than your last month's monthly fee. Additionally, confirm that the transfer of all records to the State or the successor administrator within thirty (30) days of termination in a form that is acceptable to the successor administrator will be at no cost. If not, please so indicate and describe on the Cost Quotation form.

Table 1 – Summary of Fees

Service	Administration Fees				
	Year 1	Year 2	Year 3	Opt Year 4 % Rate Cap	Opt Year 5 % Rate Cap
1. Qualifying Event Notification (Each) (First class mail notification, proof of mailing, billing, collecting, and reporting)					
2. Takeover (each) (Billing, collecting, reporting)					
3. Annual Renewal (Required system updates for rate and plan changes)					
4. HIPAA Certificate of Creditable Coverage (Each)					
5. HIPAA Privacy Notice (Each) (Required by the State)					
6. HIPAA “Per Loss of Coverage” (Each)					
7. New Hire Notices (Each)					
8. Current Employee And Dependent Notices (each) (Via first class mail, proof of mailing, document archiving)					
9. Carrier Eligibility Reporting (per HIPAA 834 EDI file)					
10. Carrier Eligibility Reporting (Per hard copy report)					
11. Reports listed in Appendix G					
List of fees and optional services not included in the fees and services above (Add rows as necessary):					
1. Ad hoc reporting					
2. Other (Describe)					

Table 2 – First Year Set Up Fees

Service	Set-Up Fees (Year 1 Only)
1. Initial Set-Up Charge	
2. Development of Communication Materials (e.g., transition announcement letters, etc.)	
3. Other (Specify)	
Total Set-Up Fees	

Note: Please expand the table to detail included and excluded services.

Appendix A – Officer Certification Form

Please have an Officer of your company review and sign this worksheet to confirm the information is valid. Please include completed form with proposal.

OFFICER'S STATEMENT	
Company's Legal Name	
Company's Marketing Name (if different)	
Street Address	
City	
State	
Zip	
Phone Number	
Fax Number	
Email Address	
Name of Officer Completing Statement	
Title of Officer Completing Statement	
Phone Number of Officer Completing Statement	
Email Address of Officer Completing Statement	

I certify that our response to the State of Delaware's RFP (Request for Proposal) is complete and accurate to the best of my knowledge and contains no material omissions or misstatements. I acknowledge that the State of Delaware will rely upon the information included in our response to make decisions concerning consulting services for benefit programs that are offered to their employees.

Officer's Signature

Date Signed

Appendix B – Transaction Volumes for 2012

The following are the transaction volumes provided by the current COBRA administrator from January 1, 2012 through December 31, 2012.

Transaction	Count/Volume
Number of Eligible Employees	33,820
Number of Qualifying Events Processed	2,450
Qualifying Event Rate	7%
Number of Elections Processed	161
Number of General Notices of COBRA Rights Processed (New Hire Notices and HIPAA Privacy Notices, Appendix E)	2,623
HIPAA Loss of Coverage Events (Notice of Creditable Coverage)	
COBRA Certificates Issued	172
Non-COBRA Certificates Issued	2,545
Total Number of Certificates Issued	2,717
Cancellations (due to late election or failure to pay premiums timely)	109
Monthly Average Number of COBRA Continuants	134
Average Length of Time on COBRA	
18 Month Qualifying Event	8.61 Months
36 Month Qualifying Event	14.58 Months
Number of Qualifying Events Requiring Special Handling	3
Number of Dependent Changes (added and dropped)	59
Number of Telephone Calls Received	347
Average Length of Call	4.9 Minutes
Number of Monthly Invoices Sent to Continuants	1,465
Number of Grace Letters Sent to Continuants	255
Number of COBRA Premium Checks Processed	1,147

Appendix C – Performance Guarantees

The following are the minimum performance guarantees the State requires. However, the State reserves the right to negotiate both financial and non-financial performance guarantees with the selected vendor.

Vendor shall perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, May 15 for the first quarter of the calendar year – January 1 to March 31). Quarterly results shall be averaged on an annual basis and penalty payments, if any, shall be made annually within six (6) months of the end of the plan year. In no instance shall measurement or penalties apply to any period less than a full quarter.

Item	Description	Service Standard	Administrative Fee at Risk
Customer Service Service Level	Percentage of calls answered by a CSR within a certain time threshold	80% within 90 seconds calculated based on Book of Business	\$1,000
Customer Service Abandonment Rate	Call abandoned prior to getting to a CSR (excludes call completed in IVR)	Less than 5% calculated based on Book of Business	\$1,000
Customer Service Quality	Based on quarterly call center quality scores	90% or more CSR rating calculated based on Book of Business (Scale of 1 – 100)	\$1,000
Account Management Account Management Team Survey (See Appendix H)	Quarterly review of service based on SBO review	Overall average rating of "3" "Somewhat Agree" or lower	\$2,000
Account Management System Availability: On-Going	The Benefit Representative's web portal shall be available from 8:00 a.m. to 5:00 p.m. EST.	At least 99% - calculated as an average of each calendar month per quarter.	\$2,000
Account Management System Availability – Notification	SBO will be notified of unexpected problems or unscheduled outages of the web portal that occur during the period of 8:00 a.m. to 5:00 p.m. EST, within 24 hours or sooner.	Notification to SBO within 24 hours or sooner.	\$2,000

Item	Description	Service Standard	Administrative Fee at Risk
Account Management System Availability – Site Maintenance	Vendor must make every effort to perform site maintenance requiring downtime during non-business hours.	Notification to SBO for site maintenance requiring downtime during the hours of 8:00 a.m. to 5:00 p.m. EST of no less than seven (7) business days advance notice, at least 95% of the time.	\$2,000
Processing Election Processing	Paper election forms manually entered into the system (DE only)	95% within 5 business days from receipt of a valid election	\$2,000
Processing Election Processing	Electronic election forms (DE only)	95% within 2 business days from receipt of a valid election	\$2,000
Processing Preparation of Initial Invoices for Billing	Participant invoice for initial election premium (DE only)	95% prepared within 5 business days from receipt of complete data or within invoicing date	\$2,000
Processing Preparation of Monthly Invoices for Billing	Participant invoice for monthly premium (DE only)	95% prepared within 5 business days from receipt of complete data or within invoicing date	\$2,000
Processing Premiums Receipt Processing	Adjudicating timelines and completeness of premium payments and then crediting participant records (DE only)	95% posted within 5 business days from receipt of full premium (posted daily)	\$2,000
Processing Management Reports (Monthly)	Produce standard reports as required for State (DE only)	Report will be sent no later than 15 calendar days after the close of the respective month	\$2,000
Reporting Proof of Compliance with Federal COBRA and HIPAA Regulations	Detail what the federal requirement is and how compliance was met (DE only)	Quarterly – no later than the 15 th day of the month following the quarter	\$2,000

Appendix D – Business Associate Agreement

This Business Associate Agreement (“BA Agreement”) is undertaken pursuant to the parties’ performance of a certain contract (“Contract”) dated as of _____, 20__ by and between the State of Delaware by and through the State Employee Benefits Committee (“Plan Sponsor”), on its own behalf and on behalf of the group health plan it sponsors for employees or other covered persons (the “Plan”), and _____ (“Contractor”).

In the performance of services on behalf of the Plan pursuant to the Contract, and in order for Contractor to use, disclose or create certain information pursuant to the terms of the Contract, some of which may constitute Protected Health Information (“PHI”) (defined below), Contractor is a Business Associate of the Plan as that term is defined by the Health Insurance Portability and Accountability Act of 1996, including the modifications required under the American Recovery and Reinvestment Act of 2009 (“ARRA”), and its implementing Administrative Simplification regulations (45 C.F.R. §§142, 160, 162 and 164) (“HIPAA”). Accordingly, Contractor, the Plan and Plan Sponsor mutually agree to modify the Contract to incorporate the terms of this BA Agreement to comply with the requirements of HIPAA, and to include additional provisions that Plan Sponsor, the Plan and Contractor desire to have as part of the Contract.

Therefore, in consideration of the mutual covenants contained herein and for other good and valuable consideration, the parties agree as follows:

I. DEFINITIONS

- A. Covered Entity.** “Covered Entity” shall mean the Plan.
- B. Individual.** “Individual” shall have the same meaning as the term “individual” in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- C. Required By Law.** “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR 164.501.
- D. Secretary.** “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.
- E. Protected Health Information.** “Protected Health Information” or “PHI” shall mean individually identifiable information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or mental health or condition of an individual, provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any other form or medium. “PHI” shall be limited to the information created or received by Contractor from or on behalf of Covered Entity.
- F. Standard Transactions.** “Standard Transaction(s)” shall mean a transaction that complies with the standards set forth at 45 C.F.R. §162.
- G. Designated Record Set.** “Designated Record Set” shall have the meaning given to such term in 45 C.F.R. §164.501.

- H. **Covered Person.** "Covered Person" means the Covered Employee and the Covered Employee's legal spouse and/or unmarried dependent children as specified in the Plan or elsewhere in the Contract as Employee or Insured.
- I. **Summary Health Information.** "Summary Health Information" means information, which may be PHI, (1) that summarizes the claims history, claims expenses, or types of claims experienced by Covered Persons for whom a Plan Sponsor has provided health care benefits under the Plan, and (2) from which the identifiers specified in 45 CFR §164.514(b)(2)(i) have been deleted (except that the zip code information described in 45 CFR §164.514(b)(2)(i)(B) may be aggregated to the level of a five (5) digit zip code).
- J. **Electronic PHI.** "Electronic PHI" shall mean PHI that is subject to the Security Rule, limited to such information created, received, maintained, or transmitted electronically.
- K. **Security Incident.** "Security Incident" shall have the same meaning as "security incident" in 45 CFR 164.304, limited to any such incident involving Electronic PHI.
- L. **Security Rule.** "Security Rule" shall mean the Security Standards for the Protection of Electronic PHI at 45 CFR §§160, 162 and 164.
- M. **Breach.** "Breach" shall mean an unauthorized acquisition, use or disclosure of protected health information (PHI) which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. For purposes of this definition, "compromises the security or privacy of such information" means poses a significant risk of financial, reputational or other harm to individual.
- N. **Secured PHI.** "Secured PHI" shall mean PHI when it is rendered unusable, unreadable, or indecipherable. Methodologies that render PHI secure are as follows:
 - Encryption of electronic data per National Institute Standards and Technology guidelines
 - Destruction of electronic media as per NIST Standards
 - Destruction or shredding of paper, film or other hard copy media
- O. **Unsecured PHI.** "Unsecured PHI" is "unsecure" when it is not rendered unusable, unreadable or indecipherable to authorized individuals through the use of a technology or methodology specified by the Department of Health and Human Services.
- P. All other capitalized terms used in this BA Agreement shall have the meanings set forth in the applicable definitions under the HIPAA Privacy/Security Rule or the Standards for Electronic Transactions.

II. **PERMITTED USES AND DISCLOSURES BY CONTRACTOR**

- A. During the continuance of the Contract, Contractor will perform services necessary in connection with the Plan as outlined in the Contract. These services may include Payment activities, Health Care Operations, and Data Aggregation as these terms are defined in 45 CFR §164.501. In connection with the services to be performed pursuant to the Contract, Contractor is permitted or required to use or disclose PHI it creates or receives for or from the Plan or to request PHI on the Plan's behalf as provided below.
- B. **Functions and Activities on the Plan's Behalf.** Unless otherwise limited in this BA Agreement, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Plan as specified in the Contract. Contractor may decide in its own reasonable discretion

what uses and disclosures of PHI are required for it to perform administrative services for the Plan as outlined in this BA Agreement and in the Contract as well as in accordance with the law.

1. Use for Contractor's Operations. Contractor may use PHI it creates or receives for or from the Plan for Contractor's proper management and administration or to carry out Contractor's legal responsibilities in connection with services to be provided under the Contract.
2. Disclosures for Contractor's Operations. Contractor may disclose the minimum necessary of such PHI for Contractor's proper management and administration or to carry out Contractor's legal responsibilities, but only if the following conditions are met:
 - a. The disclosure is required by law; or
 - b. Contractor obtains reasonable assurance, evidenced by written contract, from any person or organization to which Contractor will disclose such PHI that the person or organization will:
 - i) Hold such PHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person or organization or as required by law; and
 - ii) Promptly notify Contractor (who will in turn promptly notify the Plan) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.
3. Minimum Necessary Standard. In performing functions and activities in connection with the Contract, Contractor agrees to make reasonable efforts to use, disclose or request only the minimum necessary PHI to accomplish the intended purpose of the use, disclosure or request.

C. Data Aggregation Services. The Plan agrees and recognizes that Contractor performs Data Aggregation services for the Plan, as defined by the HIPAA Privacy Rule. In the course of performing normal and customary services under the Contract, this data aggregation is an essential part of Contractor's work on behalf of the Plan under the Contract. Accordingly, Contractor can perform these data aggregation services in its own discretion, subject to any limitations imposed by the Contract. The term "Data Aggregation" is defined under the HIPAA Privacy Rule to mean, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a covered entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

D. Prohibition on Unauthorized Use or Disclosure

1. Non-permitted Use and Disclosure of PHI. Contractor will neither use nor disclose PHI it creates or receives for or from the Plan or from another Business Associate of the Plan, except as permitted or required by the Contract and this BA Agreement, as required by law, as otherwise permitted in writing by the Plan, as authorized by a Covered Person.
2. Disclosure to the Plan and the Plan Business Associates. To the extent permitted or required by the Contract and this BA Agreement, Contractor will disclose PHI to other Business Associates of the Plan which the Plan has identified in a writing provided to Contractor. Contractor shall only disclose such PHI to such Business Associates, in their capacity as Business Associates of the Plan. Other than disclosures permitted by this Section II or as otherwise specifically identified in the Contract, Contractor will not disclose Covered Persons' PHI to the Plan or to a Business Associate of the Plan except as directed by the Plan in writing.

3. No Disclosure to Plan Sponsor. Contractor will not disclose any Covered Persons' PHI to Plan Sponsor, except as permitted by and in accordance with Section VIII or as otherwise specifically identified in the Contract.

III. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR

- A. Contractor will develop, document, implement, maintain and use appropriate administrative, technical and physical safeguards to preserve the integrity and confidentiality of, and to prevent non-permitted use or disclosure of, PHI created or received for or from the Plan.
- B. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this BA Agreement.
- C. Contractor agrees to report to Covered Entity, without unreasonable delay and in any event within sixty (60) days, any use or disclosure of the PHI not provided for by this BA Agreement or otherwise in writing by the Plan. Contractor shall maintain a written log recording the date, name of Covered Person and description of PHI for all such unauthorized use or disclosure and shall submit such log to the Plan Sponsor semiannually and by request.
- D. Contractor will require that any agent, including a subcontractor, to whom it provides PHI as permitted by this BA Agreement (or as otherwise permitted with the Plan's prior written approval), agrees to the same restrictions and conditions that apply through this BA Agreement to Contractor with respect to such information.
- E. Contractor agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- F. Contractor agrees to implement administrative, physical, and technical safeguards (as set forth in the Security Rule) that reasonably and appropriately protect the confidentiality and integrity (as set forth in the Security Rule), and the availability of Electronic PHI, if any, that Contractor creates, receives, maintains, or transmits electronically on behalf of Covered Entity. Contractor agrees to establish and maintain security measures sufficient to meet the safe harbor requirements established pursuant to ARRA by making data unreadable, indecipherable, and unusable upon receipt by an unauthorized person. Contractor agrees to provide adequate training to its staff concerning HIPAA and Contractors responsibilities under HIPAA.
- G. Contractor agrees to report to Covered Entity any Security Incident of which Contractor becomes aware.
- H. Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Electronic PHI, agrees to implement reasonable and appropriate safeguards to protect such information.
- I. Contractor agrees to directly provide notice to any effected participants in the event of a Breach and to send a written log each such Breach and notice to participants to the covered entity within thirty (30) days of notification. Contractor agrees to notify participants in accordance with the guidelines and standards set forth by the Department of Health and Human Services under the American Reinvestment & Recovery Act and the HITECH Act.

IV. INDIVIDUAL RIGHTS OBLIGATIONS

- A. Access.** Contractor and the Plan agree that, wherever feasible, and to the extent that responsive information is in the possession of Contractor, Contractor will provide access to PHI as required by 45 CFR §164.524 on the Plan's behalf. Contractor will provide such access according to its own procedures for such access. Contractor represents that its procedures for such access comply with the requirements of 45 CFR §164.524. Such provision of access will not relieve the Plan of any additional and independent obligations to provide access where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Covered Person (or the Covered Person's personal representative), any PHI about the Covered Person created or received for or from the Plan in Contractor's custody or control contained in a Designated Record Set, so that the Plan may meet its access obligations under 45 CFR §164.524. All fees related to this access, as determined by Contractor, shall be borne by Covered Persons seeking access to PHI.
- B. Amendment.** Contractor and the Plan agree that, wherever feasible, and to the extent that responsive information is in the possession of Contractor, Contractor will amend PHI as required by 45 CFR §164.526 on the Plan's behalf. Contractor will amend such PHI according to its own procedures for such amendment. Contractor represents that its procedures for such amendment comply with the requirements of 45 CFR §164.526. Such amendment will not relieve the Plan of any additional and independent obligations to amend PHI where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will amend such PHI contained in a Designated Record Set, in accordance with the requirements of 45 CFR §164.526. Upon receipt of written or electronic notice from the Plan, Contractor will amend or permit the Plan access to amend any portion of the PHI created or received for or from the Plan in Contractor's custody or control, so that the Plan may meet its amendment obligations under 45 CFR §164.526.
- C. Disclosure Accounting.** So that the Plan may meet its disclosure accounting obligations under 45 CFR §164.528, Contractor and the Plan agree that, wherever feasible and to the extent that disclosures have been made by Contractor, Contractor will provide the accounting that is required under 45 CFR §164.528 on the Plan's behalf. Contractor will provide such accounting according to its own procedures for such accounting. Contractor represents that its procedures for such accounting comply with the requirements of 45 CFR §164.528. Such provision of disclosure accounting will not relieve the Plan of any additional and independent obligations to provide disclosure accounting where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will provide an accounting as set forth below.

1. Disclosure Tracking

Starting as of the Effective Date of the Contract, Contractor will record each disclosure of Covered Persons' PHI, which is not exempted from disclosure accounting that Contractor makes to the Plan or to a third party.

The information about each disclosure that Contractor must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Contractor made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure.

For repetitive disclosures of Covered Persons' PHI that Contractor makes for a single purpose to the same person or entity (including the Plan), Contractor may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency,

periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

2. Exceptions from Disclosure Tracking

Contractor is not required to record disclosure information or otherwise account for disclosures of PHI that this BA Agreement or the Plan in writing permits or requires: (i) for the purpose of the Plan's payment activities or health care operations, (ii) to the individual who is the subject of the PHI disclosed, or to that individual's personal representative; (iii) to persons involved in that individual's health care or payment for health care; (iv) for notification for disaster relief purposes, (v) for national security or intelligence purposes, (vi) to law enforcement officials or correctional institutions regarding inmates; (vii) pursuant to an authorization; (viii) for disclosures of certain PHI made as part of a limited data set; (ix) for certain incidental disclosures that may occur where reasonable safeguards have been implemented; (x) for disclosures prior to April 14, 2003; or (xi) as otherwise excepted under 45 CFR §164.528.

3. Disclosure Tracking Time Periods

Contractor will have available for the Plan or for Covered Persons the Disclosure Information required for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information (except Contractor will not be required to have Disclosure Information for disclosures occurring before April 14, 2003).

D. Right to Request Restrictions and Confidential Communications

So that the Plan may meet its obligations to evaluate requests for restrictions and confidential communications in connection with the disclosure of PHI under 45 CFR §164.522, Contractor and the Plan agree that, wherever feasible and to the extent that communications are within the control of Contractor, Contractor will perform these evaluations on behalf of the Plan. Contractor will evaluate such requests according to its own procedures for such requests, and shall implement such appropriate operational steps as are required by its own procedures. Contractor represents that its procedures for evaluating such requests comply with the requirements of 45 CFR §164.522. Such evaluation will not relieve the Plan of any additional and independent obligations to evaluate restrictions or implement confidential communications where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will evaluate requests for restrictions and requests for confidential communications, and will respond to these requests as appropriate under Contractor's procedures.

V. OBLIGATIONS OF THE COVERED ENTITY

- A. Covered Entity shall provide Contractor with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Contractor's permitted or required uses and disclosures.
- B. Covered Entity shall notify Contractor of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522.
- C. Covered Entity shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except as provided in this BA Agreement. In no event shall Covered Entity request Contractor to disclose to Covered Entity or agents of Covered Entity any PHI unless such disclosure is the minimum necessary disclosure that satisfies the request and that such disclosure is solely for the purpose of treatment, payment or plan operations.

VI. BREACH OF PRIVACY OBLIGATIONS

Without limiting the rights of the parties under the Contract, the Plan will have the right to terminate the Contract if Contractor has engaged in a pattern of activity or practice that constitutes a material breach or violation of Contractor's obligations regarding PHI under this BA Agreement and, on notice of such material breach or violation from the Plan, fails to take reasonable steps to cure the breach or end the violation.

If Contractor fails to cure the material breach or end the violation after the Plan's notice, the Plan may terminate the Contract by providing Contractor written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Such termination shall be effective sixty (60) days from this termination notice.

A. Effect of Termination.

1. Return or Destruction upon Contract End

Upon cancellation, termination, expiration or other conclusion of the Contract, Contractor will if feasible return to the Plan or destroy all PHI, in whatever form or medium (including in any electronic medium under Contractor's custody or control), that Contractor created or received for or from the Plan, including all copies of such PHI that allow identification of any Covered Person who is a subject of the PHI. Contractor will complete such return or destruction as promptly as practical after the effective date of the cancellation, termination, expiration or other conclusion of the Contract.

Following notice, Contractor shall pay the costs incurred in returning or destroying such PHI unless Plan Sponsor agrees to reimburse Contractor for reasonable costs following good faith negotiation between Contractor and Plan Sponsor subject to the requisite appropriation by the Delaware General Assembly as required by Title 29 Delaware Code Chapter 65 and Article 8, Section III of the Delaware Constitution.

2. Disposition When Return or Destruction Not Feasible

The Plan recognizes that in many situations, particularly those involving data aggregation services performed by Contractor for the Plan and others, that it will be infeasible for Contractor to return or destroy PHI. Accordingly, where in Contractor's discretion such return or destruction is infeasible, for any such PHI, upon cancellation, termination, expiration or other conclusion of the Contract, Contractor will limit its further use or disclosure of the PHI to those purposes that make their return to the Plan or destruction infeasible.

VII. PLAN SPONSOR'S PERFORMANCE OF PLAN ADMINISTRATION FUNCTIONS

A. Communication of PHI. Except as specifically agreed upon by Contractor, the Plan and Plan Sponsor, and in compliance with any requirements imposed by this Section VIII, all disclosures of PHI from Contractor pursuant to the Contract shall be made to the Plan, except for disclosures related to enrollment or disenrollment in the Plan.

B. Summary Health Information. Upon Plan Sponsor's written request for the purpose either to, (a) obtain premium bids for providing health insurance coverage for the Plan, or (b) modify, amend or terminate the Plan, Contractor is authorized to provide Summary Health Information regarding the Covered Persons in the Plan to Plan Sponsor.

- C. **Plan Sponsor Representation.** Plan Sponsor represents and warrants (A) that the Plan has been established and is maintained pursuant to law, (B) that the Plan provides for the allocation and delegation of responsibilities for the Plan, including the responsibilities assigned to Contractor under the Contract, (C) that the Plan includes or incorporates by reference the appropriate terms of the Contract and this BA Agreement, and (D) that the Plan incorporates the provisions required by 45 CFR §164.504.
- D. **Plan Sponsor's Certification.** Contractor will not disclose Covered Persons' PHI to Plan Sponsor, unless and until the Plan authorizes Contractor in writing to disclose the minimum necessary Covered Persons' PHI to Plan Sponsor for the plan administration functions to be performed by Plan Sponsor as specified in the Plan.
- E. **Contractor Reliance.** Contractor may rely on Plan Sponsor's certification and the Plan's written authorization, and will have no obligation to verify that the Plan complies with the requirements of 45 CFR §164.504 or this BA Agreement or that Plan Sponsor is complying with the Plan.
- F. **The Plan Amendment.** Before the Plan will furnish Plan Sponsor's certification described above to Contractor, the Plan will ensure (1) that its Plan establishes the uses and disclosures of Covered Persons' PHI consistent with the requirements of 45 CFR §164 that Plan Sponsor will be permitted and required to make for the plan administration functions Plan Sponsor will perform for the Plan, and (2) that Plan Sponsor agrees to all the applicable conditions imposed by §164.504 on the use or disclosure of PHI.

VIII. **MISCELLANEOUS**

- A. **Regulatory References.** A reference in this BA Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
- B. **Survival.** The respective rights and obligations of Contractor under Section IV of this BA Agreement shall survive the termination of this BA Agreement.
- C. **Interpretation.** Any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule. Except to the extent specified by this BA Agreement, all of the terms and conditions of the Contract shall be and remain in full force and effect. In the event of any inconsistency or conflict between this BA Agreement and the Contract, the terms and provisions and conditions of this BA Agreement shall govern and control. Nothing express or implied in this BA Agreement and/or in the Contract is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever. This BA Agreement shall be governed by and construed in accordance with the same internal laws that are applicable to the Contract.
- D. **Duration.** This BA Agreement will continue in full force and effect for as long as the Contract remains in full force and effect. This BA Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the Contract.
- E. **Term.** The Term of this BA Agreement shall be effective as of the date appearing on the signature page, and shall terminate when all of the PHI provided by Covered Entity to Contractor, or created or received by Contractor on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this BA Agreement.
- F. **Amendment.** Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of HIPAA applicable to this BA Agreement or to the Contract, this BA Agreement will automatically

amend such that the obligations imposed on Plan Sponsor, the Plan and Contractor remain in compliance with such regulations, unless (1) Contractor elects to terminate the Contract by providing Plan Sponsor and the Plan notice of termination in accordance with the Contract at least thirty (30) days before the effective date of such final regulation or amendment to final regulations; or (2) Contractor notifies the Plan of its objections to any such amendment. In the event of such an objection, the parties will negotiate in good faith in connection with such changes or amendment to the relevant final regulation.

- G. Conflicts.** The provisions of this BA Agreement will override and control any conflicting provision of the Contract. All nonconflicting provisions of the Contract will remain in full force and effect.
- H. Independent Relationship.** None of the provisions of this BA Agreement are intended to create, nor will they be deemed to create any relationship between the parties other than that of independent parties contracting with each other as independent parties solely for the purposes of effecting the provisions of this BA Agreement and the Contract.
- I. Rights of Third Parties.** This BA Agreement is between Contractor and the Plan and the Plan Sponsor and shall not be construed, interpreted, or deemed to confer any rights whatsoever to any third party or parties.
- J. Notices.** All notices and notifications under this BA Agreement shall be sent in writing by traceable carrier to the listed persons on behalf of Contractor, the Plan and Plan Sponsor at the addresses indicated on the signature page hereof, or such other address as a party may indicate by at least ten (10) days' prior written notice to the other parties. Notices will be effective upon receipt.
- K. Expenses.** Unless otherwise stated in this BA Agreement or the Contract, each party shall bear its own costs and expenses related to compliance with the above provisions. Any additional expenses incurred by Contractor in connection with services to be provided pursuant to this BA Agreement shall be included in the Contract.
- L. Documentation.** All documentation that is required by this BA Agreement or by the HIPAA Privacy Rule must be retained by Contractor for six (6) years from the date of creation or when it was last in effect, whichever is longer.

AGREED By and between the undersigned Parties this ___ day of _____ 20__.

For State of Delaware:

For Contractor:

By: _____

By: _____

Title: _____

Title: _____

Printed Name

Printed Name

Address for Notices:

Address for Notices:

Statewide Benefits Office, OMB
Attention: Brenda Lakeman, Director
500 W. Loockerman Street, Suite 320
Dover, DE 19904

Appendix E – HIPAA Privacy Notice

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you on behalf of:

**The State of Delaware Employee Health Care Plan
The State of Delaware Employee Dental Care Plan
The State of Delaware Employee Assistance Program
The State of Delaware Employee Flexible Benefits Plan
The State of Delaware Employee Pharmacy Care Plan
The State of Delaware Employee Vision Care Plan**

These plans comprise what is called an “Affiliated Covered Entity,” and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we’ll refer to these plans as a single “Plan.”

The Plan’s Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future physical or mental health or condition, including genetic information, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required by law to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required by law to follow the privacy practices described in this Notice currently in effect, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other manner. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan’s Privacy Official, described below), and will be posted on the website maintained by State of Delaware that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative, e.g., a person who is your custodian, guardian, or has

your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Authorization.**
 - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
 - **Payment:** Another important function of the Plan is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
 - **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage.
- **Other Uses and Disclosures of Your PHI That Do Not Require Your Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
 - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as State of Delaware) who sponsor or maintain for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. For example, PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits; The State Insurance Department for the purpose of reviewing the state's insured plans.
 - **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in the course of judicial or administrative proceedings. Your PHI may be disclosed for law enforcement purposes under some conditions. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.
 - **National Priority Uses and Disclosures:** When permitted by law, the Plan may use or disclose medical information for various activities that are recognized as "national priorities." In other words, the Federal government has determined that under certain circumstances (described below) it is so important to disclose medical information that it is acceptable to disclose it without the individual's authorization. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law:

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
 - **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
 - **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
 - **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research. Research means a systematic investigation designed to develop or contribute to generalized knowledge.
 - **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
 - **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Written Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked in writing at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
 - **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose PHI about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. We may also provide PHI about your location, general condition, or death to assist in the notification of a family member, or personal representative or other person responsible for your care. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and/or disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).
 - **Uses and Disclosures of genetic information for underwriting purposes.** The Plan is prohibited from using or disclosing PHI that is genetic information about you or your dependents for underwriting purposes. Genetic information for purposes of this prohibition means information about (i) your genetic tests; (ii) genetic tests of your family members; (iii) family medical history.

Breach of Unsecured PHI. You must be notified in the event of a breach of unsecured PHI. A “breach” is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. PHI is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information. To exercise these rights, please submit a written request to the Privacy Official identified below:

- **To request a copy of this Notice:** You have a right to request a copy of this Comprehensive Notice of Privacy Policy and Procedures at any time. In addition, a copy of this Notice is available on the State of Delaware website at www.ben.omb.delaware.gov.
- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law. In addition, you have the right to restrict disclosure of PHI to the Plan for payment or healthcare operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, the Plan is required to implement the restrictions that you request.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but it may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not part of the Plan's records that you may inspect and copy. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your personal representative. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the

Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against by the Plan, its vendors or the State if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Plan's Privacy Official (see below).

Privacy Official.

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:
Director, Benefits Administration, Office of Management and Budget (OMB)
500 W. Loockerman St., Suite 320, Dover, DE 19904
Telephone Number: (302) 739-8331

The Plan's Deputy Privacy Official(s) is/are:
Human Resources Specialists, Statewide Benefits Unit, OMB,
500 W. Loockerman St., Suite 320, Dover, DE 19904, (302) 739-8331

Information Systems Manager, PHRST, 802 Silver Lake Blvd, Suite 200, Dover, DE 19904 (302) 739-2260

Human Resources Manager, PHRST Benefits, 802 Silver Lake Blvd, Suite 200, Dover, DE 19904 (302) 739-2260

Organized Health Care Arrangement Designation.

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

The State of Delaware Employee Health Care Plan

The State of Delaware Employee Dental Care Plan

Dominion Dental Services, Inc.

Delta Dental

The State of Delaware Employee Assistance Program

The State of Delaware Employee Flexible Benefits Plan

The State of Delaware Employee Pharmacy Care Plan

The State of Delaware Employee Vision Care Plan

Appendix F – Eligibility and Enrollment Rules **(Effective March 1, 2013)**

STATE OF DELAWARE STATE EMPLOYEE BENEFITS COMMITTEE GROUP HEALTH INSURANCE PLAN (Effective March 1, 2013)

ELIGIBILITY AND ENROLLMENT RULES

1.00 Pursuant to the authority vested in the State Employee Benefits Committee (SEBC) by 29 Del. C. §5210(4) and §9602(b)(4), the SEBC adopts these eligibility and coverage rules for the State of Delaware Group Health Insurance Program (“State Plan”). In the event of a conflict between these rules and the *Delaware Code*, the *Delaware Code* takes precedence over these rules.

1.01 An employee or pensioner must meet one of the following definitions to be eligible for enrollment in the State Plan:

- a. a permanent full-time employee (regularly scheduled 30 or more hours per week or 130 or more hours per month);
- b. an elected or appointed official as defined by 29 Del. C. §5201;
- c. a permanent part-time employee (regularly scheduled to work less than 130 hours per month);
- d. a limited term employee (as defined by Merit Rule 10.1);
- e. a pensioner receiving or eligible to receive a pension from the State;
- f. a per diem or contractual employee of the Delaware General Assembly who has been continuously employed for 5 years;
- g. a temporary employee (regularly scheduled 30 or more hours per week or 130 or more hours per month) as defined by 29 Del. C. §5207.

38.

Enrollment in State plan is not indicative of eligibility to receive State Share contributions.

1.02 Those employees who meet the definition outlined in rule 1.01(a), (b),(d) and (e) are considered “regular officers and employees” or “eligible pensioners” as provided by 29 Del. C. §5202 and are to receive State Share contributions.

1.03 Short term disability beneficiaries receiving benefits under 29 Del. C. §5253(b) will be treated as “regular officers and employees” under these regulations. Long term disability beneficiaries receiving benefits under 29 Del. C. §5253(c) will be treated as “eligible pensioners” under these regulations.

1.04 Casual and seasonal and substitutes are not eligible for the State Plan.

1.05 Newly employed school teachers become eligible employees when they start employment not when they sign their contract. (Review the Eligibility Table, see Appendix “A”, for coverage start date - dependent upon the September hire date). Temporary teachers who are re-hired in September are

eligible to elect coverage when re-hired. Temporary teachers who are re-hired in the next contract year are eligible to elect coverage when re-hired without fulfilling another 3-month waiting period.

1.06 Pensioners who are enrolled in a Medicare Part D prescription plan which is not administered by the State of Delaware may not be enrolled in the State of Delaware's Medicare Part D prescription plan for Medicare eligible retirees.

DEPENDENTS ELIGIBLE TO PARTICIPATE

In compliance with the Civil Union and Equality Act of 2011, 13 Del. C., Chapter 2, effective January 1, 2012 at 10 A.M., regular officers, employees, and pensioners who are party to a civil union in the State of Delaware shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship as they appear in the Groups Health Eligibility and Enrollment Rules. The same proof of relation required of "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", will be required of employees and pensioners who are party to a civil union.

The Spousal Coordination of Benefits Policy will apply to parties to a civil union or same-sex marriage performed in other jurisdictions as recognized by Delaware law.

2.01 Dependents must meet one of the following definitions to be eligible for enrollment in the State Plan:

A regular officer's or employee's or eligible pensioner's:

- a. legal spouse or civil union partner (Delaware law does not recognize common law marriage). Ex-spouses and ex-civil union partners may not be enrolled in the State's Plan - even if a divorce decree, dissolution decree, settlement agreement or other document requires an employee or pensioner to provide coverage for an ex-spouse or ex-civil union partner.;

IMPORTANT NOTE: Spousal Coordination of Benefits Policy has been in effect since 1/1/93 and revised 7-1-11. The policy applies to a spouse who is eligible for health coverage through his/ her own employer or former employer (when spouse is retired). Spouses who work full-time or who are retired and are eligible for health coverage through their current or former employer, but do not enroll under that employer's health plan, will have a reduction in benefits under the State Plan. A new Spousal Coordination of Benefits form must be completed each year during Open Enrollment or anytime throughout the year the spouse's employment or health insurance status changes. Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at <http://ben.omb.delaware.gov/>.

- b. child/ren under age 26 born to or legally adopted or lawfully placed for adoption by a regular officer, or employee or eligible pensioner or a regular officer's or employee's or pensioner's legal spouse;
- c. child/ren who do not meet the requirements of section (b) above, who is unmarried, under age 19 (age 24 if a full-time student), residing with a regular officer or employee or eligible pensioner in a regular parent-child relationship, and dependent upon the regular officer or employee or eligible pensioner for at least fifty (50) percent support, and who would be considered the regular officer's or employee's or pensioner's "dependent" under Section 105(b) of the Internal Revenue Code. A statement of support form must be completed by the regular officer or employee or eligible pensioner and forwarded to the employee's Benefit Representative or Human Resources Office with the request for coverage together with a copy of the legal guardianship, permanent guardianship or custody order for the dependent child. If a natural parent resides in the same household as the insured regular officer or employee or eligible pensioner, it will be deemed that a regular parent-child relationship does

not exist unless the regular officer or employee or eligible pensioner has legal guardianship documents or has legally adopted the dependent child.

- d. unmarried dependent child/ren who meet the criteria of section (b) above, but who is age 26 or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 26. The child/ren must have been covered under employee's contract immediately preceding age 26.
- e. unmarried dependent child/ren who meet the criteria of section (c) above, but who is age 19 (age 24 if full-time student) or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 19 (age 24 if full-time student). The child/ren must have been covered under employee's contract immediately preceding age 19 (age 24 if full-time student).

IMPORTANT NOTES: The Administration of Dependent Coverage to Age 26 policy became effective July 1, 2011 and provides for coverage of adult dependents until age 26 under the State Plan. As a "grandfathered" health care plan, the State Plan shall exclude adult dependents who are eligible to enroll in an employer-sponsored plan available through the adult dependent's employer until the plan year beginning July 1, 2014. The Adult Dependent Coordination of Benefits form must be completed by the regular officer, employee, or eligible pensioner on an annual basis at Open Enrollment or anytime throughout the year that the adult dependent's employment or health care status changes, except if enrolled in one of the non-grandfathered Consumer-Directed Health Plans.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

2.02 Eligible dependent child/ren covered under the health insurance plans of both parents will be primary to the parent's plan whose birthday is the first to occur during the calendar year. In the event the parents' birth dates are the same, the dependent child will be primary to the parent with the longest employment service. In the event birth dates and length of service are the same, the dependent child will be primary to the mutual choice of the parents.

2.03 Employing agencies shall maintain files that include such documents as SEBC determines appropriate to administer the State Plan; files shall be subject to audit by the SEBC.

2.04 In accordance with 29 Del. C., §5202(h) any spouse receiving a survivor's pension benefit from the State Employee Pension Plan, the State Police Pension Plan(s) or the Judiciary Pension Plan may not include a new spouse in the State's pension group health insurance plan effective June 1, 2012.

COVERAGE

3.01 Coverage of an eligible regular officer or employee and his/her eligible dependents will become effective on the first of the month following date of hire provided the employee submits a signed application within 30 days of the employee's date of hire or within 30 days of the employee becoming eligible for the State Share. Refer to Eligibility Table for specific coverage date options for employees who elect coverage when eligible for State Share.

Coverage may become effective on date of hire provided the employee submits a signed application within 30 days of the employee's date of hire. Premiums are not pro-rated.

IMPORTANT NOTES: Spousal Coordination of Benefits Policy became effective 1/1/93 and revised 7-1-11 for a spouse who is eligible for health coverage through his or her own employer or former employer when spouse is retired. Spouses who work full-time and are eligible for health coverage through their employer or spouses who are retired and eligible for health coverage through their former employer, but do not enroll under their former employer's health plan, will have a reduction in benefits under the State

Plan.. Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at <http://ben.omb.delaware.gov/>

Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

3.02 Employees of the State of Delaware who are enrolled in a health insurance benefit plan must re-enroll in a plan of their choice during the Open Enrollment period as determined by the SEBC. Should such employee(s) neglect to re-enroll in the allotted time, said employee/s and any spouse or dependents shall be automatically re-enrolled in their previous plan as long as verification of employment is provided by the employee and the Statewide Benefits Office.

3.03 Employees or pensioners who cover their spouse on the State Plan must complete a Spousal Coordination of Benefits Policy Form during each annual Open Enrollment period as well as anytime there is a change in the spouse's employment or an insurance status change. Failure to supply the Spousal Coordination of Benefits form shall result in the spouse's medical claims being sanctioned, which reduces health care claims to be processed at 20 percent with the remainder becoming the responsibility of the employee or pensioner; prescriptions must be paid in full at the pharmacy and a claim submitted to the State's pharmacy benefit manager to be reimbursed at the allowable charge (20 percent minus the applicable copay).

3.04 Any employee or pensioner who elects not to enroll in the State Plan must complete and sign an application/enrollment form acknowledging the desire not to enroll by noting "waive" on the appropriate form.

3.05 Eligible employees or pensioners who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire, their date of eligibility for State Share or their date of retirement may not join the State Plan until the next open enrollment period (usually May), unless the employee or pensioner meets the requirements of Eligibility and Enrollment Rule 3.06.

3.06 Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for him or herself or their dependent/s (including the spouse) because of other health insurance coverage and later involuntarily loses the coverage, the State employee and/or spouse may be eligible to join the State Plan, without waiting for the next Open Enrollment period, as long as the request to enroll is made within 30 days of the loss of coverage. Necessary forms must be completed within 30 days of the request to enroll. If such a change is not made in the time period specified, the eligible employee/and or spouse must wait until the next Open Enrollment period.

The following list includes examples of loss of coverage or loss of eligibility for coverage rules under which an employee may request enrollment for him/her-self and for dependent/s:

- a. Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment;
- b. Loss of eligibility for coverage provided through a Health Maintenance Organization (HMO) because the individual no longer resides, lives, or works in an HMO service area (regardless of whether the choice of the individual) and no other benefit package is available to the individual;
- c. Loss of eligibility for coverage due to the cessation of dependent status;

- d. Loss of coverage because an individual incurs a claim that meets or exceeds a lifetime limit on *all* benefits under the plan;
- e. A plan discontinues a benefit package option and no other option is offered;
- f. If the employer ceases making contributions toward the employee's or dependent's coverage, the employee or dependent will be deemed to have lost coverage and does not need to drop coverage to have special enrollment rights;
- g. Exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, except that an employee/dependent losing coverage under another plan is not required to elect COBRA under that plan before using their special enrollment rights to enroll with the State.

An increase in employee contribution, change of benefits or change of carrier of the spouse's plan shall not constitute loss of coverage, except where the other plan terminates employer contributions. Employees should contact their Benefit Representative or Human Resources Office and pensioners should contact Pension Office to ask specific questions about eligibility.

3.07 If an employee declines enrollment for him/her-self or his/her dependents (including the spouse) and later has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll him/her-self and his/her dependents provided that he/she request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Necessary forms must be completed within 30 days of the request to enroll. Please see Eligibility and Enrollment Rule 2.04 for exception for new spouses of surviving pensioners.

3.08 The eligible employee who is currently enrolled in a group health plan, may change his/her benefit plan upon the dependent's involuntary loss of coverage, pursuant to Eligibility and Enrollment Rule 3.06, and addition to the State's Plan, provided the request for enrollment is made within 30 days of the loss of dependent's coverage and necessary form must be completed within 30 days of the request. In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may change his/her benefit plan upon the addition of the dependent to the State Plan provided the request for enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption and the necessary paperwork is completed within 30 days of the request.

3.09 When two active eligible regular officers, employees, or pensioners and all eligible dependents elect to be covered under "employee and spouse" or one "family" contract then the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. A change of agency is considered re-enrollment. (In the event the birth dates are the same, length of service, and mutual choice of parents will be applied as described in Eligibility and Enrollment Rule 2.02). Beginning with the effective date, May 2003, of these rules, State Share contributions for all new enrollment will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and children or family coverage. Enrollment prior to February 1990 shall continue to be charged to the agency or organization as was previously determined.

Each eligible regular officer, employee, or pensioner may elect to enroll under a separate contract, but no regular officer or employee or eligible pensioner may be enrolled more than once under the State Plan. Eligible dependents may be enrolled under either contract, but no dependent shall be enrolled more than once under the State Plan.

The increment of cost of the contracts selected by the two regular officers or employees, or eligible pensioners who were hired and married on or before December 31, 2011, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012, a charge of \$25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each

contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 31, 2011.

Any regular officer, employee, and pensioner who marries or whose civil union is legal with another regular officer, employee, or pensioner on or after January 1, 2012, shall pay the applicable employee premium associated with the chosen contract/s.

3.10 When the spouse of an eligible regular officer or employee is a retired State of Delaware employee receiving a pension, and enrolled under separate individual contracts, the employing agency and the Pension Office will carry the coverage for their respective employee/pensioner. If an Employee & Spouse, or a Family contract is chosen, the coverage will continue to be carried through the active employee's agency until such time that the Pensioner turns 65. The over age 65 spouse may continue to have the State Plan as primary payor of benefits with the contract to continue under the active employee's agency, or the spouse may choose Medicare as the primary payor through the Pension Office. Also see Eligibility and Enrollment Rules 4.08 and 4.12.

CHANGES IN COVERAGE

4.01 An eligible employee who elects to be covered on his/her EMPLOYMENT COVERAGE DATE may change health insurance (medical) coverage when the employee first becomes eligible for the State Share payment. (Examples: (1) An employee who at hire enrolls in the "First State Basic" plan may change to "Comprehensive PPO" (or another optional coverage) when beginning State Share contribution, without waiting for the next open enrollment period. (2) An employee who at hire enrolls for "Employee" coverage may change to "Employee and Child/ren", "Employee and Spouse", or "Family" coverage when he/she begins to receive State Share, without waiting for the next open enrollment period. The employee who elects coverage to dental and/or vision coverage on his/her EMPLOYMENT COVERAGE DATE may not make changes to dental and/or vision coverage until the next open enrollment period unless the employee meets the requirements of Eligibility and Enrollment Rule 3.06.

4.02 When a covered regular officer or employee or eligible pensioner marries, or enters into a civil union, coverage for the spouse or civil union partner will become effective on the date of marriage or civil union, or first of the month following the date of marriage or civil union provided the regular officer, employee, or eligible pensioner requests enrollment of the new spouse or civil union partner within 30 days of the date of the marriage or civil union and provides the necessary paperwork within 30 days of the request to enroll. A copy of valid marriage license or civil union certificate must be provided. (Delaware law does not recognize common law marriage.) A Spousal Coordination of Benefits Policy form must be completed when adding a spouse or civil union partner to coverage. The Spousal Coordination of Benefits Policy form must be completed on-line (a copy of certification should be printed and provided to your Benefits Representative/HR Office.

4.03 Coverage for a child/ren born to a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of birth provided a request to enroll the child is made within 30 days of the date of birth and provided the necessary paperwork is received within 30 days of the request to enroll. A copy of a valid birth certificate must be provided. Premiums are paid on a monthly basis and not pro-rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child/ren. For an employee who has an existing Employee and Child, or Family type contract, the 30-day time period does not apply. However, the application to add the newborn child/ren must be made within a reasonable time period and copy of valid birth certificate provided.

IMPORTANT NOTES: Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

4.04 Coverage for a child/ren legally adopted or placed for adoption with a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of adoption or placement for adoption provided a request to enroll for the child/ren is made within 30 days of the date of adoption or placement for adoption and provides the necessary paperwork within 30 days of the request to enroll.

A copy of a valid legal document attesting to the adoption or placement for adoption must be provided. Premiums are paid on a monthly basis and not pro-rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child. For an employee who has an existing Employee and Child/ren, or Family type contract, the 30-day time period does not apply. However, the application to add the newly adopted child must be made within a reasonable time period.

4.05 Coverage for an eligible dependent, other than a newborn child/ren, who becomes an eligible dependent after the employee has been enrolled, becomes covered on the first day of the month following eligibility provided the regular officer or employee or eligible pensioner requests enrollment within 30 days of eligible status. The necessary paperwork must be completed within 30 days of the request for enrollment. A copy of valid documentation of dependent status must be provided, i.e. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.

4.06 An employee who transfers to another agency or school district may change his/her plan and coverage without waiting until the next Open Enrollment period if the transfer impacts the employee contribution to health benefits provided the employee makes the required change within 30 days of the transfer.

4.07 Changes in coverage can only be made at the annual Open Enrollment period, except:

- a. A regular officer or employee or eligible pensioner is making a change due a qualifying event or Special Enrollment Right as previously outlined in Eligibility and Enrollment Rules 3.06 through 3.08;
- b. In the case of divorce, if there is a "qualifying event" under Eligibility and Enrollment Rules 3.06 through 3.08, the regular officer or employee or eligible pensioner's coverage status may change, but the plan cannot unless Double State Share (DSS) is applicable;
- c. The spouse of a regular officer or employee or eligible pensioner has become a State of Delaware employee entitled to State Share in which case the plan may be changed if an Employee and Spouse or Family contract is chosen;
- d. A regular officer or employee or eligible pensioner may change coverage and/or plan if no longer entitled to DSS, provided application is made within 30 calendar days of the qualifying event; or
- e. A regular officer or employee or eligible pensioner electing to drop health coverage or drop one or more dependents (including the spouse of such regular officer, employee, or eligible pensioner) from health coverage may drop coverage of dependents, under the following limited circumstances as per Section 125 of the Internal Revenue Service Code:
 1. Change in status.
 - (i) Due to death of spouse.

- (ii) Due to changes in employment status of the employee, the employee's spouse or dependent (e.g., commencement of employment, change of worksite or return from an unpaid leave of absence).
 - (iii) Change in the eligibility conditions for coverage under the spouse's or dependent's employer's plan.
 - (iv) Events that cause the employee's dependent to cease to satisfy the plan's eligibility requirements. (e.g. age, student status or similar circumstance).
 - (v) Change in the place of residence of the employee, spouse or dependent provided that in each of the circumstances described in subparagraphs (i) through (v), inclusive, the cessation of coverage for the dependent is on account of and corresponds with a change in status that affects eligibility for coverage under the plan.
2. Judicial Order, Decree, or Judgment. Health coverage for one or more of dependent children may be dropped if a judicial order, decree, or judgment permits the cancellation of dependent child coverage, provided that the spouse, former spouse or another individual is required to cover such child and such coverage is in fact provided.
 3. Medicare or Medicaid Eligibility. If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291) or Title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the regular officer, employee or eligible pensioner may for themselves or for their dependents make a prospective election change to cancel or reduce coverage of that employee or dependent under the health plan.
 4. Change in Costs or Coverage. If the cost charged to an employee for health coverage significantly increases during a period of coverage, the regular officer, employee or eligible pensioner may make a corresponding change in election under the plan, including commencing participation in an option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other health plan option providing similar coverage is available. (For purposes of this paragraph, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees).

4.08 An eligible regular officer or employee or a legal spouse (eligible to receive State Share) who reaches age 65 and becomes eligible for Medicare shall continue to be covered under the State Plan as the primary payor of benefits.

- a. Regular officers or employees and dependents eligible for Medicare, by reason of age or disability, must apply for Medicare Part A when first eligible regardless of their coverage under the State Plan. Also see Eligibility and Enrollment Rule 3.10.
- b. If an employee or dependent covered under the State Plan becomes eligible for Medicare Parts A and B due to End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS) the covered individual must enroll in Medicare Parts A and B and these plans will be

primary to the State Plan for the period of time as outlined in the Medicare guidelines. Employees with ESRD or ALS should contact their State Plan insurance carrier to discuss coverage options.

4.09 An employee who becomes eligible for pension or Long-Term Disability (LTD) may change their plan at the onset of receiving pension or LTD and must enroll in Medicare Parts A and B upon eligibility.

4.10 A regular officer or employee or eligible pensioner who is required by Court or Administrative Order to provide health insurance coverage for a child/ren shall be permitted to enroll under family or employee and child/ren coverage, any child/ren who is eligible for such coverage (without regard to any Open Enrollment restriction). If the employee is enrolled, but fails to make application to obtain coverage of the child/ren, the child/ren shall be enrolled under such family or employee and child/ren coverage upon application by the child/ren's other parent, the Division of Child Support Enforcement or Division of Social Services. The employee shall not disenroll (or eliminate coverage of) any child/ren unless the employer is provided satisfactory written evidence that:

1. The Court or Administrative Order is no longer in effect, or
2. The child/ren is or will be enrolled in comparable health coverage, which will take effect no later than the effective date of such disenrollment.

4.11 When a covered regular officer or employee or eligible pensioner divorces, coverage for the ex-spouse will terminate on the day following the date of divorce. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee contribution for the plan, which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or 30 days following the date of divorce. If DSS terminates as a result of the divorce, the regular officer or employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred.

4.12 Pensioners and dependents eligible for Medicare, by reason of age or disability, must also enroll in Medicare Part A and B when first eligible for these plans and may enroll in the Medicare Supplement plan provided by the State through the Pension Office. If a pensioner or their dependent eligible for Medicare does not enroll, or remain enrolled, in Medicare Part A and B, they will not be eligible to enroll in the Medicare Supplement Plan. In this instance, they must remain enrolled in a non-Medicare plan until the next available opportunity to enroll in Medicare Part A and B. Coverage in the non-Medicare plan will be reduced and paid as if secondary coverage at 20 percent (20%) of allowable charges for both medical and prescription claims. Also see Eligibility and Enrollment Rule 3.10.

COST OF COVERAGE

Used to determine the amount of State Share contributed toward an employee's coverage and the amount of employee contributions required, if any.

5.01 "Regular officers and employees" begin earning State Share contributions on the first of the month following three full months of employment. See Eligibility Table for specific information regarding State Share payments and employee payroll deductions for employees who elect coverage when eligible for State Share.

5.02 Permanent part-time (regularly scheduled to work less than 130 hours per month), temporary per diem and contractual employees of the General Assembly as described in Eligibility and Enrollment Rule 1.01 are eligible to participate in the State Plan, but are not eligible for State Share. Therefore, any such employee joining the State Plan must pay the full cost of the health plan selected. Payment must be collected by the organization and forwarded to the Statewide Benefits Office by the first day of the month for which the employee's coverage becomes effective.

If an existing full-time state employee takes a limited term position, State Share shall continue.

Casual and seasonal employees and substitutes are not eligible to participate in the State Plan, nor are they eligible for State Share.

5.03 When a husband and wife are both permanent full-time active employees or pensioners employed and married on or before December 31, 2011, they shall earn State Share contributions in accordance with the following as of July 1, 2012:

- a. If they elect to enroll in two separate contracts, a charge of \$25 per each contract per month, or the employee premium associated with the contract (whichever is less), will be assessed to each contract chosen by the individuals and deducted by OMB from salary, pension, or disability check.
- b. If they elect to enroll in one employee and spouse or family contract, one charge of \$25 per contract per month shall be deducted by OMB from salary, pension, or disability payments.

If a husband and wife who are both permanent full-time active employees or pensioners and married to each other on or before December 31, 2011 leave State Service, on authorized unpaid leave of absence (no longer eligible for State Share), or stop collecting a pension, on or after January 1, 2012, they will be eligible to earn State Share as indicated above if they return or are permanent full-time active employees or pensioners at a future date as long as they are married to the same spouse who is also a regular officer or employee or pensioner.

5.04 When the spouse of an eligible employee is a retired State of Delaware employee receiving a monthly pension or a Disability Insurance Program (DIP) LTD beneficiary receiving an LTD check on or before December 31, 2011 each may enroll as two separate contracts, employee, and spouse contract or a family contract. The increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments until June 30, 2012. (A notation should be made in the employee's file that the spouse is a State of Delaware pensioner or DIP LTD beneficiary). The Pension Office should be notified when the active employee terminates State Service. Effective July 1, 2012 a charge of \$25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 30, 2011.

5.05 An eligible employee who elects to be covered prior to becoming eligible for State Share must pay the full cost of coverage, State Share and employee share, until State Share begins.

5.06 If a regular officer, employee, eligible pensioner, or beneficiary selects coverage under any plan, the employee or pensioner is responsible for paying the monthly employee premium cost for the selected plan and coverage class (individual, employee & child, employee & spouse, or family).

5.07 A regular officer or employee or eligible pensioner who is eligible for the State Share contribution may not receive the cash equivalent in lieu of the coverage itself.

5.08 Health coverage premiums are collected on a lag basis. (Example: January coverage is paid by deduction in the second pay of January plus deduction in the first pay of February). Each agency/school district/sub-group is responsible for reconciling premiums to ensure that proper payment has been remitted. Payments, other than those made through OMB's automated payroll system, and all adjustments must be submitted in a timely manner to the Statewide Benefits Office. The State Plan will not be responsible for payment of premiums and/or claims if a signed enrollment form/confirmation statement/waiver is not in the employee file.

5.09 An eligible employee who returns from an authorized unpaid leave of absence is entitled to State Share payments upon return without fulfilling another three month waiting period. The employee must

request enrollment by contacting their Human Resources Office within 30 days of return from leave of absence. State Share and coverage (if it has lapsed) begin on the date of return from leave of absence.

5.10 Any regular officer or employee or eligible pensioner who fails to make payment for his/her share of the cost of health coverage when he/she is eligible to continue coverage and does not have sufficient salary from which payment can be deducted will have coverage canceled on the first day of the month that a regular officer or employee or eligible pensioner fails to pay the required share for the coverage selected.

Family and Medical Leave Act (FMLA) regulations provide that employees have a 30-day grace period for late premium payments. The employer's obligation to maintain health coverage ceases if an employee's premium payment is more than 30 days late. Benefit Representative or Human Resources Offices should continue the employee's health coverage for the 30-day period provided under FMLA. The Benefit Representative or Human Resources Offices can then do a retroactive cancellation if the required employee contribution was not paid by the end of the 30-day grace period. (See Eligibility and Enrollment Rule 5.22 for additional FMLA considerations.)

5.11 An employee who has a break in active employment due to authorized leave of absence, suspension, termination or unauthorized leave of absence without pay for a full calendar month, shall not be eligible for State Share for that calendar month and any subsequent calendar month that the employee is in a non-pay status for the entire calendar month. In the case of an authorized leave of absence, an intermittent return to work or use of paid leave of less than five full days in one month, the employee shall not be entitled to State Share contributions. Full payment must be made for the month in order to retain coverage. Upon return, the employee is eligible for State Share without fulfilling another three month waiting period, provided the break was the result of any of the following:

- a. an authorized leave of absence;
- b. a suspension without pay;
- c. termination or unauthorized leave of absence for a period less than 30 calendar days.

Coverage begins on the date of employee's return to work.

A LTD recipient whose LTD benefits have terminated and who returns to active employment with the State as a regular officer or employee is entitled to State Share without fulfilling a three month waiting period provided the return to work was less than 30 days after the last day of their LTD benefits. If the time period between the termination of LTD benefits and return to work is 30 days or more, a three month waiting period will apply.

5.12 State Share will be paid for employees drawing Workers' Compensation, provided the employee is not eligible for coverage from a subsequent employer. Such an employee must submit payment for the share of the coverage that would normally be deducted from his/her salary.

5.13 State Share will be paid for employees who are approved for Short Term and/or Long Term Disability through the State's DIP.

- a. Employee's share of premium shall be deducted by OMB from employee's salary or DIP LTD check.
- b. Employees whose STD claims are in a pending status are entitled to receive State Share. If STD claim is denied, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending status.

- c. Employees who are appealing a STD termination and/or benefit denial are eligible to receive State Share. If the appeal results in a denial, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending appeal status.

5.14 Any refund of State Share or employee share is subject to the following requirements:

- a. An employee who has paid the State Share in order to insure continuation of health coverage and then later is found to have been eligible for receipt of State Share, is to be refunded the amount that was not paid by the State. The employee must make application for the refund within one calendar year of the date the employee paid the State Share to be refunded;
- b. An employee who has paid the employee share then later is found to have been eligible for receipt of DSS is to be refunded the amount paid for employee share for a period not to exceed one calendar year. The employee seeking a refund must make application for the refund within one year of the date the employee paid the employee share to be refunded;
- c. An employee who has paid the employee share for an ineligible dependent (for example following a divorce, death or exceeding the dependent age limits) is to be refunded the amount paid for employee share for a period not to exceed 60 days, provided that the employee seeking a refund must make application for the refund within 60 days of the date the employee paid the employee share to be refunded and further that the employee shall be liable for any amounts paid by the State Plan on behalf of the ineligible dependent until the employee provides notice to the Statewide Benefits Office of the dependent's ineligibility;
- d. If an employee is terminated from employment and does not pay the employee share for the second half of the month in which terminated, coverage under the Plan is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days.
- e. In any event, refunds of less than \$1.00 will not be made.

5.15 Teachers who are granted a sabbatical leave of absence are eligible for State Share while they are on such leave. Also see Eligibility and Enrollment Rule 6.03.

5.16 All employees whose positions are involuntarily terminated after they have been employed for a full calendar year who return to full-time State employment within 24 months of their termination will be eligible for State Share without fulfilling another three month qualification period.

5.17 A temporary, casual, seasonal employee, or substitute who becomes a "Regular Officer or Employee" shall have his/her unbroken temporary, casual, seasonal, or limited term, provisional or permanent part-time "Aggregate State Service" applied toward the three month qualification period for State Share contributions. The "Aggregate State Service" must immediately precede becoming a "Regular Officer or Employee". The temporary, casual- seasonal employee, or substitute must have worked each pay cycle for the three months prior to hire to be eligible for State Share or last three full months of the school year prior to September hire.

5.18 State Share shall continue for a "Regular Officer or Employee" who is temporarily appointed to a position that results in a dual incumbency.

5.19 Any regular officer, employee or pensioner who is also receiving a survivor's pension through the State of Delaware is also entitled to State Share for the survivor's pension. The increment of cost of the contract selected by the regular officer or employee or eligible pensioner who is also receiving a survivor's pension, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012 a charge of \$25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an

employee only plan), will be assessed to the contract chosen by regular officer, employee, or pensioner who is also receiving a survivor's pension.

5.20 A regular officer or employee called to active duty with the National Guard or Reserve for other than training purposes shall continue to receive state share toward health insurance coverage for a period of up to two years. Employee's share must be remitted to Benefit Representative or Human Resources Office for further processing.

5.21 In the event that the State has paid the employee share or any co-pays, coinsurance, deductibles or other amounts that OMB determines should have been paid by the regular officer or employee or covered spouse or dependent of the regular officer or employee, upon prior written notice to such regular officer or employee (which shall not be less than sixty (60) days), the State, to the extent permissible under applicable law, may recover such amounts from such regular officer or employee by deducting the amount paid by the State from the after tax pay due to the regular officer or employee, (i) the regular officer or employee shall be provided an opportunity to dispute such amounts owed to the State to the Statewide Benefits Office and (ii) if the amount owed by the regular officer or employee exceeds \$1,000 then the regular officer or employee shall be provided an opportunity to have the amount owed deducted in monthly installments over a period of time not less than twelve (12) months.

5.22 Family and Medical Leave Act (FMLA) regulations provide that employees who fail to return to work after their FMLA leave entitlement has been exhausted shall be responsible for repayment of the State Share under the group health plan unless they fail to return to work due to their own or eligible family member's serious health condition, or for some other reason beyond their control.

CONTINUATION OF COVERAGE

6.01 To continue coverage, a covered employee must pay the difference between the State Share contribution and the cost of the coverage selected. Coverage will be terminated on the first day of the month employee did not make required payment.

6.02 An employee granted an unpaid authorized leave of absence can maintain membership in the group health plan by paying the full cost of coverage (State Share plus employee share) during the period of the leave as long as that leave of absence does not exceed two years. An employee who returns from an authorized leave of absence, whether he/she maintains coverage or not while on leave of absence, is authorized to receive State Share immediately upon return. (Eligibility for State Share begins upon return without fulfilling another three-month qualification period). An employee on FMLA leave is entitled to have pre-existing health insurance benefits (including the State Share) maintained while on an FMLA leave. If an employee was paying State Share and/or employee share of the premium payments prior to leave, the employee would continue to pay the same share during the leave period. Failure to make such payment within 30 days of the due date will result in termination of coverage.

6.03 Coverage continues for teachers who are granted sabbatical leave provided they make the required payments for their share of the cost of their coverage; otherwise, their coverage is terminated effective the last day of the month in which the employee share of the premium was received. State Share continues while employee is on sabbatical leave provided that the teacher on sabbatical leave makes the required payments for their share of the cost of coverage. Also see Eligibility and Enrollment Rule 5.15.

6.04 Employees leaving State employment, except for termination due to gross misconduct or whose application for LTD benefits under the DIP has been approved, are eligible for continuation under COBRA. Employees should contact their Benefits Representative or Human Resources Office for details of this continuation option.

6.05 An eligible employee or eligible dependent that loses coverage under the State Plan may continue coverage under COBRA. If a COBRA qualifying event occurs, the employee or the employee's dependent(s) must notify the employee's Benefit Representative or Human Resources Office or the State's COBRA Administrator to provide notice of the qualifying event within 60 days of its occurrence.

6.06 Upon expiration of the covered individual's COBRA eligibility, the individual may apply directly to the insurance company for a direct billed health insurance contract.

TERMINATION OF COVERAGE

7.01 Coverage ends on the last day of the month in which the employee terminates employment. A public school or higher education employee (less than 12 month employee) whose employment during a school year continues through the last scheduled work day of that school year shall retain coverage through August 31 of the same year so long as the required employee share has been paid. In the event an employee fails to make the required payment for any optional coverage selected, coverage will be terminated. If an employee works one day in the month in which he/she terminates, he/she shall earn State Share for the entire month. Coverage will be terminated on the first day of the month employee did not make required payment.

7.02 Coverage (and dependent coverage, if applicable) ends as of the end of the month in which the employee ceases to be an eligible employee for coverage (due to some change such as a reduction in the number of hours the employee works).

7.03 Coverage of dependents, except for dependents of pensioners and dependents eligible for a survivor's pension, ends as of the last day of the month of the employee's death. Dependents who lose coverage as a result of the employee's death are eligible for continuation under COBRA. Contact the State's COBRA administrator for details of this continuation option.

7.04 Ex-spouses not employed by the State of Delaware are not eligible for coverage under the State Plan - even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex-spouse.

- a. Coverage for the ex-spouse of an active employee or pensioner covered by a non-Medicare plan will terminate on the day after the date of divorce.
- b. Coverage for the ex-spouse of a pensioner covered by a Medicare supplement plan with or without prescription will terminate on the last day of the month in which the divorce is final.
- c. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee share for the plan which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or the date of divorce. If DSS terminates as a result of the divorce, each regular officer, employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred. The State Plan will not be responsible for payment of claims when a dependent is no longer eligible for coverage 30 days following.

7.05 Coverage for a dependent child/ren will end the earlier of the following:

- a. the end of the month in which the dependent child/ren as defined in Section 2.01 b attains age 26;
- b. the end of the month in which the dependent child/ren as defined in Section 2.01 c marries, or attains age 19 (or age 24 if full time student); or

- c. the date the child/ren ceases to be dependent on the regular officer or employee or eligible pensioner for at least fifty (50) percent support per Sections 2.01c, d, and e.

7.06 Coverage for a LTD recipient will end as of the end of the month in which their LTD benefits are terminated.

REINSTATEMENT OF COVERAGE

8.01 Once a regular officer or employee or eligible pensioner has requested that his/ her coverage be canceled, he/she cannot rejoin the State Plan until the next annual Open Enrollment period unless such regular officer or employee or eligible pensioner qualifies for re-enrollment under the applicable exceptions to these Eligibility and Enrollment Rules.

8.02 An employee who returns from an authorized leave of absence not exceeding 24 months in duration who does not maintain coverage while on leave of absence, is permitted to enroll immediately upon return without waiting for the next Open Enrollment period, provided the employee requests enrollment within 30 days of return and completes the necessary paperwork required to enroll within 30 days of the request. Coverage will begin as of the date the employee returns from leave following completion of the necessary paperwork and payment of any required employee share. Premiums are paid on a monthly basis and are not prorated.

8.03 Employees whose positions are *involuntarily* terminated after they have been employed for a full year (or full school year) will be eligible for State Share immediately if they return to full-time State employment within 24 months of termination.

MISCELLANEOUS

9.01 It is the responsibility of the regular officer, employee or eligible pensioner to keep his/her Benefit Representative or Human Resources Office informed of any change of address or change in status which results in the adding or dropping of dependent/s (marriage, divorce, birth, death, adoption, etc.) that affects his/her health care coverage. In turn, it is the responsibility of the Benefit Representative or Human Resources Office to make the necessary changes in the appropriate payroll system, or to notify the Statewide Benefits Office of these changes. Failure to do so may affect eligibility of coverage or extent of coverage for any participant and could impose an extreme hardship on a regular officer or employee or eligible pensioner. The State Plan will not be responsible for payment of premiums and/or claims in the event of ineligibility and/or the absence of a signed enrollment form/confirmation statement in the regular officer or employee or eligible pensioner's file.

9.02 If any provision of these Rules and Regulations or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or application of the Rules and Regulations which can be given effect without the invalid provision or application, to that end the provisions of these Rules and Regulations are declared to be severable.

DENTAL AND VISION PLANS

10.01 Employees electing to pay for and receive coverage under one of the Dental and/or Vision Plans should be aware of the following terms:

- a. Dental and Vision Plans are not affected by Double State Share (DSS);

39.

- b. Employees may enroll in a Dental and/or Vision plan during the first of month after being hired, becoming eligible, or 90 days after the first of the following month after being hired;

- c. The Dental and Vision Plans' effective date is always the first of the month and not on event date as for the health plan;
 - d. Dental and Vision Plans' refund rules are limited to 60 days or less because the Dental and Vision Plans are fully insured;
 - e. Dental and Vision Plans' term dates are limited to 60 days or less;
 - f. Dental and/or Vision Plan will be terminated in the event that employee is 60 days delinquent in payment of Dental and/or Vision Plans' premium and any paid claims in the same period will be reversed;
 - g. If an employee is terminated from employment and does not pay the Dental and/or Vision Plans' premium for the second half of the month in which terminated, coverage under the Dental and/or Vision Plans is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days;
 - h. School district employees (except those of Delaware Technical and Community College) who are offered school district dental and vision coverage are not eligible for coverage under the State Dental or Vision Plans;
 - i. Terminations in Dental and/or Vision coverage can only be made during the annual Open Enrollment period, except that a regular officer or employee or eligible pensioner may elect to drop Dental or Vision coverage for one or more dependents within the plan year due to same circumstances as noted in Section 4.07(e).
 - j. The employee's election of a Dental and/or Vision plan is binding for the plan year. The employee who elects to enroll in dental and/or vision coverage on his/her EMPLOYMENT COVERAGE DATE may not change such coverage until the next open enrollment period unless the employee meets the requirements of Eligibility and Enrollment Rule 3.06.
 - k. An employee on approved leave of absence without pay may waive participation in the Dental and/or Vision Plan. Employee must notify his/her Benefit Representative or Human Resources Office of request as waive must be designated in the appropriate enrollment system. When employee returns to work, participation must be reinstated in the appropriate enrollment system to be effective the first of the month following employee's return to work.
- 40.
- l. An employee on approved leave of absence without pay may continue to participate in the Dental and/or Vision Plan by making full payment of premium by end of each month or coverage will be terminated. Employee must make payment to Benefit Representative or Human Resources Office for further processing.

Revised May 2003
 Revised September 22, 2008
 Revised May 29, 2009
 Revised August 2011
 Revised January 1, 2012
 Revised March 1, 2013

**STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM
ELIGIBILITY TABLE**

<u>Employee Start Date</u>	<u>Coverage Start Date</u> (Employee pays the full cost)	<u>Eligible for State Share</u>
January 2 nd through February 1 st	February 1 st	May 1 st
February 2 nd through March 1 st	March 1 st	June 1 st
March 2 nd through April 1 st	April 1 st	July 1 st
April 2 nd through May 1 st	May 1 st	August 1 st
May 2 nd through June 1 st	June 1 st	September 1 st
June 2 nd through July 1 st	July 1 st	October 1 st
July 2 nd through August 1 st	August 1 st	November 1 st
August 2 nd through September 1 st	September 1 st	December 1 st
September 2 nd through October 1 st	October 1 st	January 1 st
October 2 nd through November 1 st	November 1 st	February 1 st
November 2 nd through December 1 st	December 1 st	March 1 st
December 2 nd through January 1 st	January 1 st	April 1 st

Appendix "A"

Appendix G – List of Reports

Name	Direction	Frequency	Target Date
Participant Enrollments – via fax	Vendor to SBO	Daily/Varies	Daily/Varies
Participant Update – via fax	Vendor to SBO	Daily/Varies	Daily/Varies
Participant Status – via fax	Vendor to SBO	Daily/Varies	Daily/Varies
Termination of COBRA – via fax	Vendor to SBO	Daily/Varies	Daily/Varies
Proof of Compliance with federal COBRA and HIPAA Regulations	Vendor to SBO	Quarterly	15 days after the end of each quarter
List of Benefit Representatives that have access to the on-line portal	Vendor to SBO	Quarterly	10 days after the end of each quarter
Report of qualifying events submitted by Dept ID	Vendor to SBO	Monthly	10 days after the end of each month
COBRA Participant Update – Payment and Recon in Excel format - <i>Hardcopy</i>	<ul style="list-style-type: none"> • Vendor to Financial Ops (Accounting) • Financial Ops (Accounting) sends to SBO 	Monthly	Monthly (the 10 th of the for prior month)

Appendix H – Account Management Team Survey

Account Management Team Survey

Sample

Account Management Team Survey

For Reporting Period: FY ___ Quarter : ___
 Completed by: SBO Vendor Management Team

The Vendor Management Team of the Statewide Benefits Office is using this tool to evaluate the Account Management Team in serving as a provider of medical services to the employees and pensioners of the State of Delaware.

Knowledge: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	
1. Understands your benefits plan	<input type="checkbox"/>	For any "1" or "2" responses, please provide specific comments in the area below				
2. Understands your business needs. Meets with you to establish needs and service expectations.	<input type="checkbox"/>	_____				
3. Understands your service expectations. Develops a business plan that incorporates the agreed upon needs and expectations.	<input type="checkbox"/>	_____				
4. Displays knowledge regarding COBRA and HIPAA administration products and services	<input type="checkbox"/>	_____				
5. Clearly explains your report results	<input type="checkbox"/>	_____				
					Average Rating	_____

Professionalism: Indicate the extent to which you agree that your Account Management Team:

Strongly Agree 5 Agree 4 Somewhat Agree 3 Disagree 2 Strongly Disagree 1 For any "1" or "2" responses, please provide specific comments in the area below

- 6. Actively listens to and acknowledges your issues and concerns 5 4 3 2 1
- 7. Provides appropriate verbal communication 5 4 3 2 1
- 8. Provides appropriate written communication 5 4 3 2 1
- 9. Works with you to develop a positive working relationship 5 4 3 2 1

Average Rating _____

Proactive Management: Indicate the extent to which you agree that your Account Management Team:

Strongly Agree 5 Agree 4 Somewhat Agree 3 Disagree 2 Strongly Disagree 1 For any "1" or "2" responses, please provide specific comments in the area below

- 10. Actively monitors your account and interacts with you in a frequency that meets your needs 5 4 3 2 1
- 11. Communicates potential problems/issues 5 4 3 2 1
- 12. Provides viable alternative solutions that meet your business needs 5 4 3 2 1
- 13. Manages and understands system requirements and their effect on your business 5 4 3 2 1
- 14. Sets realistic expectations regarding turn-around time 5 4 3 2 1

Average Rating _____

Accessibility: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
15. Available to you on a timely basis	<input type="checkbox"/>	_____				
16. Allocates appropriate time when meeting with you	<input type="checkbox"/>	_____				
17. Demonstrates flexibility with regard to schedule changes	<input type="checkbox"/>	_____				
18. Provides/communicates alternate contacts in the event of their absence	<input type="checkbox"/>	_____				
19. Advises you of schedule limitations upon contact for meetings, conference calls, projects etc.	<input type="checkbox"/>	_____				
						Average Rating _____

Responsiveness: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
20. Responds to your inquiries in a timely manner	<input type="checkbox"/>	_____				
21. Provides thorough responses to your inquiries	<input type="checkbox"/>	_____				
22. Follows-through regarding outstanding problems/issues/items	<input type="checkbox"/>	_____				
23. Solicits the assistance of product experts when needed	<input type="checkbox"/>	_____				
						Average Rating _____
						Overall Average Rating _____

Please include any other comments or suggested action steps:

Appendix I – Technical Standards and Security Requirements Forms

See the separate pages that follow. Please print and include your response as required on each form. The electronic submission will require the form to be scanned into a pdf format.

State of Delaware
DEPARTMENT OF TECHNOLOGY AND INFORMATION
William Penn Building
801 Silver Lake Boulevard
Dover, Delaware 19904

Contractor Confidentiality (Non-Disclosure) and Integrity of Data Agreement

The Department of Technology and Information is responsible for safeguarding the confidentiality and integrity of data in State computer files regardless of the source of those data or medium on which they are stored; e.g., electronic data, computer output microfilm (COM), tape, or disk. Computer programs developed to process State Agency data will not be modified without the knowledge and written authorization of the Department of Technology and Information. All data generated from the original source data, shall be the property of the State of Delaware. The control of the disclosure of those data shall be retained by the State of Delaware and the Department of Technology and Information.

I/we, as an employee(s) of _____ or officer of my firm, when performing work for the Department of Technology and Information, understand that I/we act as an extension of DTI and therefore I/we are responsible for safeguarding the States' data and computer files as indicated above. I/we will not use, disclose, or modify State data or State computer files without the written knowledge and written authorization of DTI. Furthermore, I/we understand that I/we are to take all necessary precautions to prevent unauthorized use, disclosure, or modification of State computer files, and I/we should alert my immediate supervisor of any situation which might result in, or create the appearance of, unauthorized use, disclosure or modification of State data.

Penalty for unauthorized use, unauthorized modification of data files, or disclosure of any confidential information may mean the loss of my position and benefits, and prosecution under applicable State or Federal law.

This statement applies to the undersigned Contractor and to any others working under the Contractor's direction.

I, the Undersigned, hereby affirm that I have read DTI's Policy on Confidentiality (Non-Disclosure) and Integrity of Data and understood the terms of the above Confidentiality (Non-Disclosure) and Integrity of Data Agreement, and that I/we agree to abide by the terms above.

Contractor or Employee Signature: _____

Date: _____

Contractor Name: _____

**Terms and Conditions for Cloud Providers
As of May 17, 2011**

No.	Doc	Item	Acknow- ledgement
1	T&C	<p><u>Ownership of Information</u></p> <p>The State of Delaware shall own all right, title and interest in its data that is related to the services provided by this contract.</p>	
2	T&C	<p><u>Privacy of Information</u></p> <p>Protection of personal privacy must be an integral part of the business activities of the Service Provider to ensure that there is no inappropriate use of State of Delaware information at any time. To this end, the Service Provider shall comply with the following conditions: Personal information obtained by the Service Provider will become and remain property of the State of Delaware. At no time will any information, belonging to or intended for the State of Delaware, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware. The Service Provider may not use any personal information collected in connection with the service issued from this proposal for any purpose other than fulfilling the service.</p>	
3	T&C	<p>When requested by the State of Delaware, the provider must destroy all requested data in all of its forms, disk, CD / DVD, tape, paper, for examples. Data shall be destroyed according to National Institute of Standards and Technology (NIST) approved methods and certificates of destruction must be provided to the State of Delaware.</p>	
4	T&C	<p>The Service Provider shall not store or transfer State of Delaware data outside of the United States.</p>	
5	T&C	<p>The Service Provider must inform the State of Delaware of any security breach or detection of any suspicious intrusion that is or has occurred that jeopardizes the State of Delaware data or processes. This notice must be given to the State of Delaware within 24 hours of its discovery. Full disclosure of the assets that might have been jeopardized must be made. In addition, the Service Provider must inform the State of Delaware of the actions it is taking or will take to reduce the risk of further loss to the State. If the breach requires public notification, all communication shall be coordinated with the State of Delaware.</p>	
6	T&C	<p>The Service Provider must encrypt all non-public data in transit to the cloud. In addition, the Service Provider will comply with the ISO/IEC 27001 standard for information security management systems, providing evidence of their certification or pursuit of certification.</p>	
7	T&C	<p>The Service Provider shall disclose to the State of Delaware a description of their roles and responsibilities related to electronic discovery, litigation holds, discovery searches, and expert testimonies. The provider shall disclose its process for responding to subpoenas, service of process, and other legal requests.</p>	
8	T&C	<p>In the event of termination of the contract, the Service Provider shall implement an orderly return of State of Delaware assets and the</p>	

		<p>subsequent secure disposal of State of Delaware assets.</p> <p>Suspension of services: During any period of suspension, the Service Provider will not take any action to intentionally erase any State of Delaware Data.</p> <p>Termination of any services or agreement in entirety: In the event of termination of any services or agreement in entirety, the Service Provider will not take any action to intentionally erase any State of Delaware Data for a period of 90 days after the effective date of the termination. After such 90 day period, the Service Provider shall have no obligation to maintain or provide any State of Delaware Data and shall thereafter, unless legally prohibited, delete all State of Delaware Data in its systems or otherwise in its possession or under its control.</p> <p>Post-Termination Assistance: The State of Delaware shall be entitled to any post-termination assistance generally made available with respect to the Services unless a unique data retrieval arrangement has been established as part of the Service Level Agreement.</p>	
9	T&C	<p>The Service Provider shall:</p> <ol style="list-style-type: none"> 1. Ensure that State information is protected with reasonable security measures, 2. Promote and maintain among the Service Provider's employees and agents an awareness of the security needs of the State's information, 3. Safeguard the confidentiality, integrity, and availability of State information, 4. Ensure that appropriate security measures are put in place to protect the Service Provider's internal systems from intrusions and other attacks. 	
10	T&C	The Service Provider shall not utilize any staff (including sub-contractors) to fulfill the obligations of the contract who has been convicted of a felony or class A misdemeanor.	
11	T&C	The Service Provider will make the State of Delaware's data and processes available to third parties only with the express written permission of the State.	
12	T&C	The Service Provider will not access State of Delaware User accounts, or State of Delaware Data, except (i) in the course of data center operations, (ii) response to service or technical issues or (iii) at State of Delaware's written request.	
		(Statement of Work) SOW	
1	SOW	The Service Provider must allow the State of Delaware access to system logs, latency statistics, etc. that affect its data and or processes.	
2	SOW	The Service Provider must allow the State of Delaware to audit conformance to the contract terms and test for vulnerabilities. The State of Delaware may perform this audit or contract with a third party at its discretion.	

3	SOW	Advance notice (to be determined at contract time) must be given to the State of Delaware of any major upgrades or system changes that the Service Provider will be performing. The State of Delaware reserves the right to defer these changes if desired.	
4	SOW	The Service Provider shall disclose its security processes and technical limitations to the State of Delaware such that adequate protection and flexibility can be attained between the State of Delaware's and the Service Provider. An example might be virus checking and port sniffing – the State of Delaware and the Service Provider must understand each other's roles and responsibilities.	
5	SOW	The Service Provider will cover the costs of response and recovery from a data breach. The State will expect to recover all breach costs from the provider.	
6	SOW	The State of Delaware will provide requirements to Service Provider for encryption of the data at rest	
7	SOW	The Service Provider shall have robust compartmentalization of job duties, perform background checks, require/enforce non-disclosure agreements, and limit staff knowledge of customer data to that which is absolutely needed to perform job duties.	
8	SOW	The Service Provider will provide documentation of internal and external security controls, and their compliance level to industry standards.	
9	SOW	The State of Delaware and the provider shall identify a collaborative governance structure as part of the design and development of service delivery and service agreements.	
10	SOW	The State of Delaware must have the ability to import or export data in piecemeal or in its entirety at its discretion without interference from the Service Provider.	
11	SOW	The Service Provider will be responsible for the acquisition and operation of all hardware, software and network support related to the services being provided. The technical and professional activities required for establishing, managing, and maintaining the environment are the responsibilities of the Service Provider. The environment and/or applications must be available on a 24 hours per day, 365 days per year basis, providing around the clock service to customers as defined in this RFP.	
12	SOW	The web portal hosting site environment shall include redundant power, fire suppression, and 24 hours per day, 365 days per year on-site security. The hosting environment shall include redundant Internet connectivity, redundant firewalls, Virtual Private Network (VPN) services, secured remote access methods, fault tolerant internal network with gigabit Ethernet backbone, clustered central file and database servers, load balanced, application, and web servers, hardware, accelerator, three tier development environment, nightly backups, and 24x365 monitoring of all services and servers.	
13	SOW	The Service Provider shall identify all of its strategic business partners who will be involved in any application development and/or operations.	
14	SOW	The State shall have the right at any time to require that the Service Provider remove from interaction with State any Service Provider	

		representative who the State believes is detrimental to its working relationship with the Service Provider. The State will provide the Service Provider with notice of its determination, and the reasons it requests the removal. If the State signifies that a potential security violation exists with respect to the request, the Service Provider shall immediately remove such individual. The Service Provider shall not assign the person to any aspect of the contract or future work orders without the State's consent.	
15	SOW	The Service Provider will ensure the State of Delaware's Recovery Time Objectives (RTOs) is met.	
16	SOW	The Service Provider will provide evidence that their Business Continuity Program is certified and mapped to the international BS 259999 standard.	
17	SOW	The Service Provider shall ensure that State of Delaware backed-up data is not commingled with other cloud service customer data.	
18	SOW	SLA/SOW - Return of Customer Data/Unique Post Termination: The Service Provider shall make available to the State all Customer Data in a state defined format based on vendor and state platforms including: Database, O/S and physical media, along with attachments in their native format.	
19	SOW	Service Providers shall comply with and adhere to the State IT Security Policy and Standards. These policies may be revised from time to time and the Master Contractor shall comply with all such revisions. Updated and revised versions of the State IT Policy and Standards are available at: www.DTI.Delaware.gov	
20	SOW	The Master Contractor may deliver two copies of each software source code and software source code documentation to a State-approved escrow agent with the State's prior approval. The Master Contractor shall cause the escrow agent to place the software source code in the escrow agent's vaulted location, in Delaware, and that is acceptable to the State. Two copies of the source code shall be stored on compact discs or other media designated by the State in a format acceptable to the State, and shall be easily readable and understandable by functional analysts and technical personnel with the skill set for that type of component, subcomponent, or software code.	

This document is also available at the following URL:
<http://dti.delaware.gov/pdfs/pp/RFPRequirementsforSubmissionofaDataDictionaryorDataModel.pdf>

Requirements for Submission of a Data Dictionary or Data Model

The State of Delaware Data Governance Council was established in January 2012 to put a greater focus on the management and governance of data within the state. The state recognizes that data is an enterprise asset that can be leveraged and managed to allow the state government to operate more efficiently and effectively. In order to achieve this, a clear understanding must be obtained of all of the data owned by the state. Therefore, a data dictionary or data model must be submitted for all applications developed, procured, or utilized by the state.

At a minimum, a data dictionary OR a conceptual data model for state-owned business data must be submitted for the project approval process. The data dictionary or conceptual data model does not have to be submitted with a vendor response to an RFP, but must be submitted once the design of the solution is complete or prior to implementation of the solution. The submitted data dictionary or conceptual data model must adhere to the below requirements.

The data dictionary or data model must include at least the following items:

- **Entity names and descriptions**
- **Entity relationships and descriptions**
- **Attribute names, descriptions, data type, and length**
- **Primary identifier for each entity**

The data dictionary must be submitted in Excel or in a .csv file. The directions for how to format the Excel workbook is explained in the first section of the [Data Model Samples document](#). If a data model is submitted, it must be in either Sybase PowerDesigner or CA ERwin format.

To protect the proprietary information of vendor solutions the information submitted only needs to contain the core objects that house state-owned business data. Examples of core state-owned business data are citizen, address, company, etc. The submitted data dictionary or conceptual data model does not need to include objects for the data that is not owned by the state. Examples of non-state data are the objects that exist to maintain the database or control the inner workings of the application. To further protect the proprietary information about the database, the data dictionary or conceptual data model is not expected to have the actual physical object names.

The data models/dictionaries are stored in a secure repository where only the agency who is the steward of the data, the DTI Data Management Team, and the Data Governance Council can access the information for purposes of data governance. The data models/dictionaries will only be shared with others if approved by the data steward.

Following is more information regarding the preparation of a data dictionary or a data model for submission.

Data Dictionary Overview

A data dictionary contains information about the components of a data repository. The components are the tables, attributes, and their relationships. The details of each include:

- Descriptions for tables (also known as entities), attributes (also known as columns), and relationships.
- The attributes that make up a table.
- The format and length of attributes.
- Indicates if the attribute is a key identifier to the table.

- The type of relationship between the tables.

The data dictionary can be submitted as an Excel workbook or in multiple .csv files. The .csv files will need to be individual files where the following directions indicate a worksheet within an Excel workbook. The .csv files need to be comma delimited with text in quotes.

For examples, please see the [Data Model Samples - Section A](#).

Data Modeling Overview

A database is a repository of information, a house of data. The data model is to the database what blue prints are to a house. The data architect performs similar functions as the building architect working with clients to define needs and usage. Data models are key for understanding the data a business uses, how it is organized, how it is governed, how the data can be shared, and how the data is housed.

A data model is more than just a diagram portraying tables and columns. The data model:

- Defines the tables in the database.
- How the tables will be connected (relationships).
- What data elements (columns) are in each table.
- The format and size of each attribute.
- The key attribute (usually the unique identifier) for each table. The columns are also known as attributes because they are describing something about the table.
- There are definitions for the model, tables, attributes, and relationships.

All of this information is pertinent to understanding the data and is required in the data model. Additional information that is helpful but not necessary is the data classification, the data steward name (this could be an individual or group), and rules that govern the sharing of the data.

Data models range from small simplistic views of a business to extensive in depth physical implementations. There are three types of data models each building from the other. The first is the conceptual model which organizes the way a business uses its data. Next is the logical model which expands on the conceptual to begin modifying the structure to the requirements of an application. Both the conceptual and logical models are technology independent. The third model is the physical model which is the actual implementation of the data objects designed for performance and based upon a specific technology.

Below are further explanations for each type of data model and some of the types of changes that occur between the models. Though it is typical to start with the conceptual and work through to the physical, you can start with any of the model types and then create the other types of models.

Conceptual Data Model

The Conceptual Data Model describes data requirements from a business point of view without the burden of technical details. Models at this level are about understanding the data requirements of the business.

The conceptual model is started by documenting the main entities or subject areas. Then identify how they relate based upon business rules and processes. You add the attributes which sometimes causes changes in the relationships or the defining of more entities. Lastly you indicate the identifying attribute(s) which creates the uniqueness of a record within an entity. As you create the model you should be documenting the definitions of the tables, relationships, and attributes. This is the early stages so you may not know all of what is to be captured. This is a starting point to know what base attributes are needed.

Conceptual models are independent of technology. They can be used where understanding the data used by a business is needed. They do not need to be drawn just for relational databases. They can be built for non-relational systems like ADABAS and Lotus Notes to better understand what data the business uses and how it uses it.

Documenting the subject areas, their relationships, the data elements, and key identifiers are beneficial even at the RFP stage. The conceptual data model can be used to evaluate if a vendor's product can meet your business needs for data or help determine if you need to change how you use your data.

For a sample conceptual model, please see the [Data Model Samples - Section B](#).

Logical Data Model

The Logical Data Model refines the conceptual model by modifying the entities, their attributes and their relationships in consideration of an application design. These models are technology independent.

The logical model builds on the conceptual model. Primary and foreign keys are generated for each table. The primary key guarantees the uniqueness of a record. The foreign key creates the relationship between two tables. The conceptual tables are normalized to:

- Eliminate redundancies in the database so that data is captured only once.
- A single compound attribute (such as name) will be expanded to individual columns (such as first name, middle name, last name).
- Verify that every attribute in a record has a direct relation to the primary key for that table and not to another table.

For a sample logical model, please see the [Data Model Samples - Section C](#).

Physical Data Model

The Physical Data Model represents the detailed specification of what is physically implemented using specific technology. Physical design considerations include performance, size and growth, availability, recovery from failure, and use of specific technology features.

The physical data model is tied to technology. When it is generated you select the type of database. The code generated is specific to the database type.

The physical data model includes objects to manage the data or improve database performance. This may include user views, alternate table indexes, table partitioning, business rules applied to attributes, triggers, stored procedures, and security.

For a sample logical model, please see the [Data Model Samples - Section D](#).