
FEHB Program Carrier Letter

Community-Rated Carriers

U.S. Office of Personnel Management
Office of Insurance Programs

Letter No. 1999-038 B

Date: August 18, 1999

Fee-for-service [n/a] Experience-rated HMO [n/a] Community-rated [32]

SUBJECT: Amendments to the Standard Contracts for Community-Rated Carriers

Please review the enclosed Parts I through IV of the Standard Contract for community-rated carriers for Contract Year 2000. New language is in **boldface** and language to be deleted is in ~~strikeout~~. We are sending you a full contract this year that will incorporate in one document all contract changes made through December 31, 1999. You should limit your review to the changes only. Please keep in mind that the FEHBAR clauses went through the regulatory process before being incorporated into the contract. Therefore, recommended changes to FEHBAR clauses will be considered for the regulatory process and the 2001 contract. So that your comments can be considered, we must receive them no later than September 3, 1999.

Section 1.21, Year 2000 Compliance, now includes medical equipment in the list of items that must be Year 2000 compliant, as well as more specific language with regard to the technology you use to perform date/time processing involving dates later than December 31, 1999. The clause now refers to hardware, software, and firmware containing embedded chip technology. The clause also prescribes OPM's remedy in the event you are unable to provide benefits and services to enrollees as a result of non-compliant information technology. A system failure caused by the failure of hardware, software, or firmware containing embedded chip technology that results in your inability to deliver required benefits and services to FEHB enrollees is a significant event under Section 1.10, and we will take appropriate action as authorized under that clause.

Two new Sections, 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, and 1.24, Transitional Care, implement the continuity of care provisions of the Patients' Bill of Rights. Section 1.23 requires you to notify FEHB Program enrollees at least 90 days in advance when you terminate a specialty provider contract, unless you terminate the provider for cause. The requirement to notify enrollees also applies in the event you terminate all or a part of your FEHB

contract, including service area reductions. Your prompt notice will ensure that the notification period and the transitional care period run concurrently.

Section 1.24 sets out your responsibilities when an enrollee qualifies for transitional care because you are terminating all or a part of your FEHB contract or their specialty provider contract, or you are enrolling a new member who had to change carriers because the individual's former carrier left the FEHB Program. The clause covers your responsibilities when your enrollees remain in your plan after a provider change. The clause also requires you to pay for or provide the services required at no additional cost to enrollees during the transition period. In addition, it requires you to ensure the providers promptly transfer all medical records to the designated new provider; provide any necessary assistance to enrollees in obtaining or amending medical records; and provide you with the information you need for quality assurance purposes.

New Section 2.14, Continuing Requirements After Termination of the Carrier, states that when a carrier's contract is terminated, it continues to be responsible for the obligations that it agreed to under the contract. Such obligations include offering conversion contracts to enrollees during the 31-day extension of coverage so that they may convert to a private policy with the carrier, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying disputed claims incurred under the contract.

We have revised Sections 3.2, Accounting and Price Adjustment, and 3.3, Rate Reduction for Defective Pricing or Defective Cost or Pricing Data, to include guidance for carriers designated to participate in a DoD Demonstration Project authorized by Public Law 105-261. The law will allow certain Medicare and other eligible DoD beneficiaries to enroll in health benefit plans in certain geographic areas under the FEHB Program. On July 6, we published an interim regulation that amends the Federal Employees Health Benefits Acquisition Regulation (FEHBAR) to implement the law. The regulation includes the contract clauses we are proposing to amend, and you will have an opportunity to comment on them during the public comment period. We have also updated the clauses to incorporate Plain language® concepts.

If you are a carrier participating in the DoD/FEHBP Demonstration Project, your contract amendment also includes a separate clause entitled Participation in the DoD Demonstration Project.® The clause will be placed in Part IV of the contract. The clause requires you to participate in the DoD Demonstration Project and sets out reporting requirements.

We also have updated the introductory language and paragraph (a)5. of Appendix D-a, FEHB Supplemental Literature Guidelines, and have included website material as supplemental marketing literature.

When we send you the final contract, we will update Federal Acquisition Regulation clauses in Part V of the contract that have been revised during the past year so that the most recent version will appear in the contract. All new and revised clauses in Parts I through IV will show the date AJAN 2000." Revised FAR clauses in Part V will show the date of the FAR revision. You will receive the final contract for signature at the same time we execute your year 2000 rates and benefits.

Please forward your comments to Mary Ann Mercer at OPM or fax them to (202) 606-0633. I look forward to working with you during contract year 2000.

Sincerely,

Frank D. Titus
Assistant Director
for Insurance Programs

Enclosure

**FEDERAL EMPLOYEES
HEALTH BENEFITS PROGRAM**

STANDARD CONTRACT

FOR

***COMMUNITY-RATED
HEALTH MAINTENANCE ORGANIZATION CARRIERS***

2000

(INSERT SIGNATURE PAGE OF CONTRACT)

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 1997)

For purpose of this contract, the following definitions apply:

- FEHBP: Federal Employees Health Benefits Program.
- Enrollee: The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.
- Member: The Enrollee and/or an eligible dependent for benefit purposes, and sometimes referred to as subscriber.
- Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.
- Regulations: (1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) chapters 1 and 16 of title 48, Code of Federal Regulations.
- Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.
- Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.
- Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

SECTION 1.2
ENTIRE CONTRACT (JAN 1996)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. All modifications to the contract must be made in writing by the duly authorized Contracting Officer.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this policy shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this policy or be used in the prosecution of or defense of a claim under this policy unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the change will be made effective for the contract period subsequent to the period in which the change is promulgated and, if the change is promulgated in November or December, the change will not be effective until the second contract year following the year in which the change is promulgated; unless (i) The Carrier agrees to an earlier date or (ii) the change is ordered by the Contracting Officer pursuant to the *Changes--Negotiated Benefits Contracts* clause of the contract.

SECTION 1.5 RECORDS AND INFORMATION TO BE FURNISHED BY OPM (JAN 1997)

(a) The OPM shall maintain or cause to be maintained records from which may be determined the names and social security numbers of all Enrollees. Such information shall be furnished to the Carrier by the OPM, or other agencies of the Federal Government, at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The OPM shall direct the agencies to provide

ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4 INCORPORATION OF LAWS AND REGULATIONS (JAN 1996)

the Carrier, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government.

(c) Neither clerical error (whether by the OPM, by any other Government agency, or by the Carrier) in keeping any records pertaining to coverage under this contract, nor delays in making entries thereon, nor failure to make or account for any deduction of enrollment charges, shall invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. If any relevant facts pertaining to any individual to whom coverage under this contract relates shall be found to have been misstated, and if such misstatement affects the existence or the amount or extent of coverage, the true facts shall be used in determining whether coverage is in force under the terms of this contract.

SECTION 1.6 CONFIDENTIALITY OF RECORDS (JAN 1991) (FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the *Federal Register* as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

- (1) As may be reasonably necessary for the administration of this contract;
- (2) As authorized by the patient or his or her guardian;
- (3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;
- (4) As necessary to audit the contract;
- (c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 1999)

- (a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Section 1308 and Chapter 89 of title 5, United States Code.
- (b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.
- (c) The Carrier shall furnish the routine reports in the required number of copies to the addresses specified in Appendix C, *Contract Administration Data*.
- (d) The Carrier shall notify the OPM Contract Representative immediately upon a change in the name or address of the Carrier's contract administrator(s).

SECTION 1.8
NOTICE (JAN 1991)

Where the contract requires that notice be given to the other party, such notice shall be given in writing to the address specified in Appendix C, *Contract Administration Data*.

SECTION 1.9

- (5) As necessary to carry out the coordination of benefit provisions of this contract; and
 - (6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.
- FEHB QUALITY ASSURANCE (JAN 1999)

(a) The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the program must include procedures to address:

(1) Accuracy of Payments.

(i) Processing Accuracy - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(ii) COB Processing - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(2) Timeliness of Payments to Members or Providers

(i) Average Processing Time (All FEHB Claims) - the average number of working days from the date an FEHB claim is received to the date it is adjudicated (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD:

(A) An average of 60 percent of FEHB claims received over the given time period are adjudicated within 20 working days (28 calendar days).

(B) An average of 80 percent of FEHB claims received over the given time period are adjudicated within 30 working days (42 calendar days).

(C) An average of 95 percent of FEHB claims received over the given time period are adjudicated within 60 working days (84 calendar days).

(3) Quality of Services and Responsiveness to

Members

(i) Member Inquiries - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage for the given time period.

REQUIRED STANDARD:

(A) An average of 60 percent of FEHB member written inquiries are responded to within 10 working days (14 calendar days).

(B) An average of 90 percent of FEHB member written inquiries are responded to within 30 working days (42 calendar days).

(ii) Telephone Access - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. *Except that*, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(A) Telephone Waiting Time - the number of seconds elapsed before a member's telephone call is connected to a Carrier representative.

REQUIRED STANDARD: On average, no more than 1.5 minutes elapse before a member's telephone call is connected to a Carrier representative.

(B) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: On average, callers receive a busy signal no more than 10 percent of the time.

(C) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, no more than 8 percent of calls are abandoned.

(4) Responsiveness to FEHB Member Requests for Reconsideration.

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given

(NOTE: For the purpose of this standard (7), a simplified classification system is used in which all appointments are classified as either emergency, urgent or routine. Emergency appointments must be seen immediately to prevent health deterioration.

time period, within 30 days after receipt by the Carrier, the Carrier must affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(5) Quality Assurance Plan - the Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance and abuse prevention standards.

(6) Physician Credentialing - the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.

(A) Verification of medical school graduation records.

(B) Routine check with local and/or state medical societies and/or boards.

(C) Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.

(D) Routine check of the National Practitioner Data Bank.

(7) Appointments - All Health Maintenance Organization carriers must meet the following standards for the given time period. *Except that*, if this information is not routinely collected, report results from periodic surveys.

REQUIRED STANDARD:

(i) Urgent appointments are available, on average, within 24 hours of an authorized request for one.

(ii) Routine appointments are available, on average, within 1 month of an authorized request for one.

(iii) Average office waiting times - on average, members who arrive on time for a scheduled appointment wait no more than 30 minutes before they are seen by the provider of the medical service.

Urgent appointments are those for the sudden, acute onset of symptoms that must be seen within 1 (one) day to prevent health deterioration. All other appointments are considered routine.)

(8) Assessing Quality of Health Care. The Carrier

shall collect data on the measures endorsed by the Foundation for Accountability (FACCT), as requested by the OPM for services rendered through the Carrier's Preferred Provider Organization and/or Point of Service networks. Further, the Carrier shall provide statistical reports in accordance with FACCT guidelines when requested by OPM. The Carrier may be asked to collect data on one or more measures in a specified geographic locality. In addition, the Carrier shall report on measures developed by the National Committee for Quality Assurance as directed by OPM.

(b) The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.

(c) The Carrier shall keep complete records of its quality assurance procedures and fraud program and the results of their implementation and make them available to the Government as determined by OPM. If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.

(d) The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order.

(e) Assessing Member Services. In addition to any other means of surveying Plan members that the Carrier may develop, the carrier shall participate in either a National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) consumer survey or an FEHB-specific

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10) Any change in its charter, constitution, or by-laws which affects any provision of this contract or the

consumer survey, to provide feedback to enrollees on enrollee experience with the various FEHB plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.

SECTION 1.10

NOTICE OF SIGNIFICANT EVENTS (JAN 1997) (FEHBAR 1652.222-70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) working days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15% or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

Carrier's participation in the Federal Employees Health Benefits Program;

(11) Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12) Any fraud, embezzlement or misappropriation of FEHB funds; or

(13) Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the

American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by he Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval*.

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall insert this clause in any subcontract or subcontract modification if both the amount of the subcontract or modification charged to the FEHBP (or, in the case of a community-rated

(b) The Carrier shall insert this clause in all subcontracts for underwriting and administrative services and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.12

CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or

carrier, applicable to the FEHBP) exceeds \$100,000 and the amount of the subcontract or modification to be charged to the FEHBP (or, in the case of a community-rated carrier, applicable to the FEHBP) exceeds 25 percent of the total cost of the subcontract or modification. If the Carrier is an HMO, it shall also insert this clause in all provider agreements over \$25,000. If the Carrier is not an HMO, it shall also insert this clause in the contract with its underwriter, if any. The Carrier shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.11

FEHB INSPECTION (JAN 1991) (FEHBAR 1652.246-70)

(a) The Government or its agent has the right to inspect and evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unduly delay the work.

If the Government or its agent performs inspection or evaluation on the premises of the Carrier or a subcontractor, the Carrier shall furnish and require the subcontractor to furnish all reasonable facilities and assistance for the safe and convenient performance of these duties.

implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15,

Renewal and Withdrawal of Approval.

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS
(JAN 1999)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. OPM in its sole discretion, may order the Carrier to print and distribute the agreed upon brochure text in a format and quantity approved by OPM, including an electronic brochure version for OPM's World Wide Web Site. This formatted document is referred to as the FEHB brochure. The

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR
ADVERTISING (JAN 1991)(FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material, including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the *FEHB Supplemental Literature Guidelines* which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.702, as the primary guide in preparing material; further guidance is provided in the *NAIC Rules Governing Advertising of Accident and Sickness Insurance With Interpretive Guidelines*. Guidelines are periodically

Carrier shall distribute the FEHB brochure to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version of the approved language. The Carrier may print additional FEHB brochures for distribution or its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1625.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to protect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense and in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all enrollees of the Plan(s) that had been the subject of the original material.

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval*.

(e) Prior to taking action as described in

paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
[RESERVED]

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent to the performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S
CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the Carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
CERTIFICATION UNDER P.L. 104-191 (HEALTH
INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996) (JAN 1998)

non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

The Carrier shall issue a certification of coverage for enrollees in accordance with the regulations issued by the Health Care Financing Administration.

SECTION 1.20
PATIENT BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities (APatient Bill of Rights@) in accordance with OPM guidance.

(b) During the Carrier-s provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patient Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patient Bill of Rights in accordance with OPM guidance.

SECTION 1.21
YEAR 2000 COMPLIANCE (JAN ~~1999~~ 2000)

(a) The Carrier shall ensure that the hardware, software, firmware, **and medical equipment containing embedded chip technology** it uses in the performance of its FEHB Program contract will accurately process date/time data (including, but not limited to, calculating, comparing and sequencing) involving dates later than December 31, 1999, including leap year calculations. ~~On May 31, 1999, the Carrier shall either notify the Contracting Officer~~

~~that the system will be compliant or provide the Contracting Officer with a contingency plan that will detail how the system will remain operational after December 31, 1999.~~

(b) When acquiring information technology that will be required to perform date/time processing involving dates later than December 31, 1999, the Carrier shall ensure that solicitations and contracts:

~~–(c) Not later than May 31, 1999, the Carrier shall submit a copy of its company purchase policy that the hardware, software, and firmware it either contracts for or purchases is Year 2000 compliant.~~

~~–(d) (c) A Year 2000 compliant@ means that the information technology accurately processes date/time data (including, but not limited to, calculating, comparing, and sequencing) involving dates later than December 31, 1999, including leap year calculations, to the extent that other information technology used in combination with the information technology being acquired, properly exchanges date/time data with it.~~

(d) A system failure caused by the failure of hardware, software, firmware, or medical equipment containing embedded chip technology that results in the Carrier's inability to deliver benefits and services to FEHB Program enrollees is a significant event under Section 1.10 of this contract, Notice of Significant Events, and must be reported promptly to OPM.

SECTION 1.22 HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations. A Guaranteed availability@ means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act @the Act@) to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Act), with respect to such coverage.

~~(1) require the information technology to be Year 2000 compliant ; or (2) require that non-compliant information technology be upgraded to be Year 2000 compliant prior to the earlier of (i) the earliest date on which the information technology may be required to perform date/time processing involving dates later than December 31, 1999, or (ii) December 31, 1999.~~

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of this contract, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.23 NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2000)

(a) Enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its enrollees in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the enrollee's specialty provider contract, for reasons other than cause in order to allow sufficient time for the enrollees to arrange for continued care after the 90-day period. The Carrier shall send the notice in time to ensure it is received by the enrollees no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and transitional care period run concurrently.

TRANSITIONAL CARE (JAN 2000)

SECTION 1.24

(a) **Transitional care** is specialized care provided for up to 90 days or through the postpartum period to an enrollee undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when his or her carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the enrollee receives the notice required under Section 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) Beginning January 1, 2000, the Carrier shall ensure the following:

(1) *If it terminates its FEHBP contract or a specialty provider contract other than for cause, it allows enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period;*

(2) *If it enrolls a new member who involuntarily changed carriers because the enrollee's former carrier was no longer available in the FEHB Program, it provides for the transitional care under the same terms and conditions the enrollee had under the prior carrier; and,*

(3) *For the Carrier's non-transitional care enrollees who remain in the plan after a provider change, the enrollee is subject to the same benefit provisions as all other members. There will be no vesting of benefits;*

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to enrollees;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient;

(3) provide assistance to enrollees who want to obtain records from the specialty provider and/or request that the provider amend or allow them to

append a record they believe is inaccurate, irrelevant, or incomplete; and,

(4) require the specialty provider to give all necessary information to the Carrier for quality assurance purposes.

PART II - BENEFITS

SECTION 2.1 ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2 BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1996)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The

Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members are required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any covered medical service or supply.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

- (1) identify enrollment in a plan,
- (2) verify eligibility for payment of a claim for health benefits, and
- (3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(3) shall

fully discharge the Carrier to the extent of such payment.

(g) Overpayments. If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates

the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

SECTION 2.4 TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5 SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation

is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Model Guidelines implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will continue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent

SECTION 2.6

COORDINATION OF BENEFITS (JAN 1991) (FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Model Guidelines for Coordination of Benefits (COB) as specified by OPM. *that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]*

SECTION 2.7

DEBARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8

FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(CR-2000)

6/29/99 2:42 PM

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial.

If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

- (i) Affirm the denial in writing to the covered individual;
- (ii) Pay the bill or provide the service; or

was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

- (i) Specifically identify the information needed;
- (ii) State the reason the information is required to make a decision on the claim;
- (iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and
- (iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

- (1) The specific and detailed reasons for the denial;
- (2) The covered individual's right to request a review by OPM; and
- (3) The requirement that requests for OPM review must be received within 90 days after the date

of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under ' 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9 PROTECTION OF MEMBERS AGAINST PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Carrier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10 INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11 CLAIMS PROCESSING (JAN 1998)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A of this contract, then the Carrier shall limit its payment to an amount that supplements the

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) By the year 2000, the majority of provider claims should be submitted electronically;

(2) All physicians shall be notified that future claims must be submitted electronically or on the Health Care Financing Administration 1500 form;

(3) The Carrier shall not use any unique physician claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the HCFA 1500 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12 CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.13 BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 1998)

benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, and the balance between the Medicare approved amount and the Medicare limiting charge

made by non-participating providers. This provision does not apply to debarred providers (see Section 2.7).

**SECTION 2.14
CONTINUING REQUIREMENTS AFTER
TERMINATION OF THE CARRIER (JAN 2000)**

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination.

(b) Contract requirements that extend beyond the date of the Carrier's termination include, but are not limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1

PAYMENTS (JAN 1999) (FEHBAR 1652.232-70)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM, amounts assessed under FEHBAR 1609.7101-2, and amounts for obligations due pursuant to paragraph (b), plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a).

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be due and payable not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special nonrecurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision 1.15, Renewal and Withdrawal of Approval, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the reserves held by the Carrier are insufficient for that purpose.

[NOTE: The adjustment for error or fraud referenced in paragraph (a) and the necessary and proper charges against this contract if the contract is terminated or not renewed, referenced in subsection

(d), shall be limited to the subscription rate and any contingency reserve payment otherwise provided for in this contract and shall not include claim charges or other expenses attributable to individual Members. Further, FEHBAR 1652.216-70, Accounting and Price Adjustment, applies if any adjustment to the contract price is determined.]

SECTION 3.2

ACCOUNTING AND PRICE ADJUSTMENT (JAN 1998 2000) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. ~~The accounting shall be in the form prescribed by OPM.~~ **The Carrier shall follow the OPM prescribed accounting format.**

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR ' 1602.170-13.

(3) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates ~~are found~~ to be lower than the equivalent rates for the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) **The Government shall not allow or consider and the Carrier shall not make any** ~~No~~ upward adjustment in the rate established for this contract ~~will be allowed or considered by the Government or will be made by the Carrier~~ in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108). Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

SECTION 3.3
RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN-1998 2000) (FEHBAR 1652.215-70)

(a) If **the Carrier increased** any rate established in connection with this contract ~~was increased~~ because

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, **the Contracting Officer shall determine and allow an appropriate offset** ~~an offset in an amount determined appropriate by the~~

~~it~~ (1) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.804-70); (2) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) ~~the Carrier~~ developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR '1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) ~~the Carrier~~ submitted or, or kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current--then, ~~the rate shall be reduced~~ **Carrier shall reduce the rate** in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense: (i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

~~Contracting Officer~~ based upon the facts ~~shall be allowed~~ against the amount of a contract price reduction if--

(A) The Carrier certifies to the Contracting Officer

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that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date. (ii) ~~An offset shall not be allowed~~

The Contracting Officer shall not allow an offset if-- (A) ~~The understated data was known by the Carrier~~ **Carrier knew the data to be** understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves ~~that~~ the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid--

(1) ~~Simple interest on the amount of the overpayment from the date the overpayment was paid from the FEHB Fund to the Carrier~~ **Government paid the Carrier the overpayment from the FEHB Fund** until the date the **Carrier liquidates the** overcharge is ~~liquidated~~.

In calculating the amount of interest due, **the Carrier shall use** the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the **Carrier retained the** overcharge ~~was retained by the Carrier shall be used~~; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

(d) Exception for the DoD Demonstration Project. Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier-s demonstration project premium rates. The Carrier-s rates shall not be adjusted for equivalency with SSSG rating

SECTION 3.6 DISCREPANCIES BETWEEN ENROLLMENT AND PAYMENTS TO CARRIER (JAN 1999)

(a) The OPM and the Carrier recognize that the portion of subscription payments under Section 3.1(a) forwarded by OPM to the Carrier for Enrollees may not be consistent with the Carrier's reconciliation of enrollment under Section 1.5. Therefore, the OPM and the Carrier agree:

methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

SECTION 3.4 CONTRACTOR RECORDS RETENTION (JAN 1999) (FEHBAR 1652.204-70)

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)) *Audit and Records - Negotiation* the Carrier shall retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of 5 years after the end of the contract term to which the records relate, except that individual enrollee and/or patient claim records shall be maintained for 3 years after the end of the contract term to which the claim records relate.

SECTION 3.5 APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.

(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

(1) That any individual discrepancies discovered in the course of reconciliation, in which the agency certifying officer and the Carrier agree as to the enrollment status of the individual, shall be corrected by the applicable agency to reflect the valid enrollment(s). If the reconciliation indicates that the subscription payments were not made or were made in error, appropriate adjustments shall be made by the agency to the Fund pursuant to law. Any adjustment in the subscription charges received by the

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Fund from the agency as a result of a reconciliation shall be forwarded by OPM under Section 3.1(a); and

(2) That the rates in Appendix B include an adjustment to the subscription charges equal to one percent in full resolution of all discrepancies not corrected under Section 3.6(b)(1).

(b) In consideration of the adjustments in Section 3.6(a)(1) and (2), the Carrier accepts the adjustment to the subscription charges in full resolution of all obligations of the Government in connection with the subscription payments as described in this section 3.6, and waives any rights it may have to claims for subscription payments under Section 3.1(a).

(c) The OPM and the Carrier shall review the reconciliation process and this provision for Contract Year 2001.

SECTION 3.7

SURVEY CHARGES (JAN 1999)

(a) If the Carrier contracts with a National Committee for Quality Assurance (NCQA) certified vendor to conduct the annual consumer assessment survey, paragraph (b) does not apply.

(b) If the Carrier participates in an FEHB-specific annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of conducting the survey. The Carrier shall pay a separate fee for each plan option and /or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the survey contractor within 60 days of the billing date, OPM shall withhold the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-70, Payments to community-rated contracts, and forward payment to the survey contractor.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1 ALTERATIONS IN CONTRACT (JAN 1998) (FAR 52.252.4)

Portions of this contract are altered as follows:

(a) Sections 5.30, 5.31, 5.32. Cost Accounting Standards, part 30 of the FAR, has not yet been implemented for the FEHBP community rated contracts. Sections 5.30, 5.31 and 5.32 are not applicable to this contract.

(b) Section 3.2. As required by Public Law 101-508, ' 8909 of title 5, U.S.C., and Section 3.2(b) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(c) PARTICIPATION IN /FEHBP DEMONSTRATION PROJECT (JAN 2000)

(a) The Carrier shall participate in the DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108 (ADoD Demonstration Project®) under the terms and conditions specified by OPM.

(b) In setting the premium rate, the Carrier shall comply with the requirements in Section 3.2, Accounting and Price Adjustment (FEHBAR 1652.216-70), and 3.3, Rate Reduction for Defective Pricing or Defective Cost or Pricing Data (FEHBAR 1652.215-70).

(c) In the event that the Carrier experiences costs far in excess of the premiums for the DoD enrollment group, OPM will work with the Carrier to make an equitable adjustment.

(d) The Carrier shall compile, maintain, and, when requested by OPM, report data on the plans experience to produce reports containing the following information and analysis:

(1) The number of eligible beneficiaries who elect to participate in the demonstration project.

(2) The number of eligible beneficiaries who elected to participate in the demonstration project and did not have Medicare Part B coverage before electing to participate.

(3) The costs of health benefits charges and the costs (direct and indirect) of administering the benefits and services provided to eligible beneficiaries who elect to participate in the demonstration project as compared to similarly situated enrollees in the FEHB Program.

(4) Prescription drug costs for demonstration project beneficiaries.

**Proposed Year 2000 Amendments to the Standard Contract for
Community-Rated Carriers (DoD Demonstration Project)**

1. Redate Section 1.21, YEAR 2000 COMPLIANCE, as JAN 2000 and update and revise the clause as follows:

SECTION 1.21

YEAR 2000 COMPLIANCE (JAN 1999 2000)

(a) The Carrier shall ensure that the hardware, software, firmware, **and medical equipment containing embedded chip technology** it uses in the performance of its FEHB Program contract will accurately process date/time data (including, but not limited to, calculating, comparing and sequencing) involving dates later than December 31, 1999, including leap year calculations. ~~On May 31, 1999, the Carrier shall either notify the Contracting Officer that the system will be compliant or provide the Contracting Officer with a contingency plan that will detail how the system will remain operational after December 31, 1999.~~

(b) When acquiring information technology that will be required to perform date/time processing involving dates later than December 31, 1999, the Carrier shall ensure that solicitations and contracts: ~~(1) require the information technology to be Year 2000 compliant ; or (2) require that non-compliant information technology be upgraded to be Year 2000 compliant prior to the earlier of (i) the earliest date on which the information technology may be required to perform date/time processing involving dates later than December 31, 1999, or (ii) December 31, 1999.~~

~~(c) Not later than May 31, 1999, the Carrier shall submit a copy of its company purchase policy that the hardware, software, and firmware it either contracts for or purchases is Year 2000 compliant.~~

~~(d) (c) A Year 2000 compliant@ means that the information technology accurately processes date/time data (including, but not limited to, calculating, comparing, and sequencing) involving dates later than December 31, 1999, including leap year calculations, to the extent that other information technology used in combination with the information technology being acquired, properly exchanges date/time data with it.~~

(d) A system failure caused by the failure of hardware, software, firmware, or medical equipment containing embedded chip technology that results in the Carrier's inability to deliver benefits and services to FEHB Program enrollees is a significant event under Section 1.10 of this contract, Notice of Significant Events, and must be reported promptly to OPM.

2. Add new Sections 1.23, NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT, and 1.24, TRANSITIONAL CARE, to implement the continuity of care provisions of the Patient Bill of Rights, as follows:

SECTION 1.23

NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2000)

(a) Enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its enrollees in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the enrollees' specialty provider contract, for reasons other than cause in order to allow sufficient time for the enrollees to arrange for continued care after the 90-day period. The Carrier shall send the notice in time to ensure it is received by the enrollees no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

SECTION 1.24

TRANSITIONAL CARE (JAN 2000)

(a) **Transitional care** is specialized care provided for up to 90 days or through the postpartum period to an enrollee undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when his or her carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the enrollee receives the notice required under Section 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) Beginning January 1, 2000, the Carrier shall ensure the following:

(1) *If it terminates a specialty provider contract other than for cause, it allows enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, under the same terms and conditions that existed at the beginning of the transitional care period; and*

(2) *If it enrolls a new member who involuntarily changed carriers because the enrollee's former carrier was no longer available in the FEHB Program, it provides for the transitional care under the same terms and conditions the enrollee had under the prior carrier.*

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to enrollees;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient;

(3) provide assistance to enrollees who want to obtain records from the specialty provider and/or request that the provider amend or allow them to append a record they believe is inaccurate, irrelevant, or incomplete; and,

(4) require the specialty provider to give all necessary information to the Carrier for quality assurance purposes.

3. Add a new clause 2.14, CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER, to reinforce certain existing contractual requirements as follows:

SECTION 2.14

CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2000)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination.

(b) Contract requirements that extend beyond the date of the Carrier's termination include, but are not limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date.

4. Redate Section 3.2, ACCOUNTING AND PRICE ADJUSTMENT, as JAN 2000; add a new paragraph (c) to implement the DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108; and make clarifying changes as follows:

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SECTION 3.2

ACCOUNTING AND PRICE ADJUSTMENT (JAN 1998 2000) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. ~~The accounting shall be in the form prescribed by OPM.~~ **The Carrier shall follow the OPM prescribed accounting format.**

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR 1602.170-13.

(3) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates ~~are found~~ to be lower than the equivalent rates for the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) **The Government shall not allow or consider and the Carrier shall not make any** ~~No~~ upward adjustment in the rate established for this contract ~~will be allowed or considered by the Government or will be made by the Carrier~~ in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108). Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

5. Redate Section 3.3, RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (FEHBAR 1652.215-70), as JAN 2000; add a new paragraph (d) to implement the DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108; and make clarifying changes as follows:

SECTION 3.3

RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN 1998 2000) (FEHBAR 1652.215-70)

(a) If **the Carrier increased** any rate established in connection with this contract ~~was increased~~ because **it** (1) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.804-70); (2) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) ~~the Carrier~~ developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR ' 1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) ~~the Carrier~~ submitted or, or kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current--then, ~~the rate shall be reduced~~ **Carrier shall reduce the rate** in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense: (i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, **the Contracting Officer shall determine and allow an appropriate offset** ~~an offset in an amount determined appropriate by the Contracting Officer~~ based upon the facts ~~shall be allowed~~ against the amount of a contract price reduction if--

(A) The Carrier certifies to the Contracting Officer that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date.

(ii) ~~An offset shall not be allowed~~ **The Contracting Officer shall not allow an offset** if-- (A) ~~The understated data was known by the Carrier~~ **Carrier knew the data to be** understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves ~~that~~ the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid--

(1) Simple interest on the amount of the overpayment from the date ~~the overpayment was paid from the FEHB Fund to the Carrier~~ **Government paid the Carrier the overpayment from the FEHB Fund** until the date the **Carrier liquidates the overcharge is liquidated**. In calculating the amount of interest due, **the Carrier shall use** the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the **Carrier retained the overcharge** ~~was retained by the Carrier shall be used~~; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

(d) Exception for the DoD Demonstration Project. Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

6. Add a new clause under Section 4.1, entitled PARTICIPATION IN THE DoD DEMONSTRATION PROJECT, to implement the joint DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108, as follows:

**SECTION 4.1
PARTICIPATION IN /FEHBP
DEMONSTRATION PROJECT
(JAN 2000)**

(a) The Carrier shall participate in the DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108 (ADoD Demonstration Project®) under the terms and conditions specified by OPM.

(b) In setting the premium rate, the Carrier shall comply with the requirements in Section 3.2, Accounting and Price Adjustment (FEHBAR 1652.216-70), and 3.3, Rate Reduction for Defective Pricing or Defective Cost or Pricing Data (FEHBAR 1652.215-70).

(c) In the event the Carrier experiences costs far in excess of the premiums for the DoD enrollment group, OPM will work with the Carrier to make an equitable adjustment.

(d) The Carrier shall compile, maintain, and, when requested by OPM, report data on the plan's experience to produce reports containing the following information and analysis:

(1) The number of eligible beneficiaries who elect to participate in the demonstration project.

(2) The number of eligible beneficiaries who elected to participate in the demonstration project and did not have Medicare Part B coverage before electing to participate.

(3) The costs of health benefits charges and the costs (direct and indirect) of administering the benefits and services provided to eligible beneficiaries who elect to participate in the demonstration project as compared to similarly situated enrollees in the FEHB Program.

(4) Prescription drug costs for demonstration project beneficiaries.

7. Update the introductory paragraph and paragraph (a)5. of Appendix D-a to include website material under supplemental literature, as follows:

APPENDIX D-a
FEHB SUPPLEMENTAL LITERATURE GUIDELINES

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, **including website material**, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Guidelines for additional guidance when needed.)

a) 5. Under the FEHBP, the FEHB brochure is ~~based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions~~

the official statement of benefits. Include the following statement (**website material should include the statement as a preface**) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary [or brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ([insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure.

**FEDERAL EMPLOYEES
HEALTH BENEFITS PROGRAM**

STANDARD CONTRACT

FOR

***COMMUNITY-RATED
HEALTH MAINTENANCE ORGANIZATION CARRIERS***

2000

(INSERT SIGNATURE PAGE OF CONTRACT)

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 1997)

For purpose of this contract, the following definitions apply:

- FEHBP: Federal Employees Health Benefits Program.
- Enrollee: The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.
- Member: The Enrollee and/or an eligible dependent for benefit purposes, and sometimes referred to as subscriber.
- Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.
- Regulations: (1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) chapters 1 and 16 of title 48, Code of Federal Regulations.
- Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.
- Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.
- Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for
 - (a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

SECTION 1.2
ENTIRE CONTRACT (JAN 1996)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. All modifications to the contract must be made in writing by the duly authorized Contracting Officer.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this policy shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this policy or be used in the prosecution of or defense of a claim under this policy unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 1996)

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the change will be made effective for the contract period subsequent to the period in which the change is promulgated and, if the change is promulgated in November or December, the change will not be effective until the second contract year following the year in which the change is

promulgated; unless (i) The Carrier agrees to an earlier date or (ii) the change is ordered by the Contracting Officer pursuant to the *Changes--Negotiated Benefits Contracts* clause of the contract.

SECTION 1.5 RECORDS AND INFORMATION TO BE FURNISHED BY OPM (JAN 1997)

(a) The OPM shall maintain or cause to be maintained records from which may be determined the names and social security numbers of all Enrollees. Such information shall be furnished to the Carrier by the OPM, or other agencies of the Federal Government, at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The OPM shall direct the agencies to provide the Carrier, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government.

(c) Neither clerical error (whether by the OPM, by any other Government agency, or by the Carrier) in keeping any records pertaining to coverage under this contract, nor delays in making entries thereon, nor failure to make or account for any deduction of enrollment charges, shall invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. If any relevant facts pertaining to any individual to whom coverage under this contract relates shall be found to have been misstated, and if such misstatement affects the existence or the amount or extent of coverage, the true

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN 1999)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Section 1308 and Chapter 89 of title 5, United States Code.

facts shall be used in determining whether coverage is in force under the terms of this contract.

SECTION 1.6 CONFIDENTIALITY OF RECORDS (JAN 1991) (FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the *Federal Register* as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies to the addresses specified in Appendix C, *Contract Administration Data*.

(d) The Carrier shall notify the OPM Contract Representative immediately upon a change in the

name or address of the Carrier's contract administrator(s).

SECTION 1.8 NOTICE (JAN 1991)

Where the contract requires that notice be given to the other party, such notice shall be given in writing to the address specified in Appendix C, *Contract Administration Data*.

SECTION 1.9 FEHB QUALITY ASSURANCE (JAN 1999)

(a) The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the program must include procedures to address:

(1) Accuracy of Payments.

(i) Processing Accuracy - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(ii) COB Processing - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(i) Telephone Access - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. *Except that*, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(A) Telephone Waiting Time - the number of seconds elapsed before a member's telephone call is connected to a Carrier representative.

REQUIRED STANDARD: On average, no more than 1.5 minutes elapse before a member's telephone call is connected to a Carrier representative.

(B) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the

(2) Timeliness of Payments to Members or Providers

(i) Average Processing Time (All FEHB Claims) - the average number of working days from the date an FEHB claim is received to the date it is adjudicated (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD:

(A) An average of 60 percent of FEHB claims received over the given time period are adjudicated within 20 working days (28 calendar days).

(B) An average of 80 percent of FEHB claims received over the given time period are adjudicated within 30 working days (42 calendar days).

(C) An average of 95 percent of FEHB claims received over the given time period are adjudicated within 60 working days (84 calendar days).

(3) Quality of Services and Responsiveness to Members

(i) Member Inquiries - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage for the given time period.

REQUIRED STANDARD:

(A) An average of 60 percent of FEHB member written inquiries are responded to within 10 working days (14 calendar days).

(B) An average of 90 percent of FEHB member written inquiries are responded to within 30 working days (42 calendar days).

Carrier.

REQUIRED STANDARD: On average, callers receive a busy signal no more than 10 percent of the time.

(C) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, no more than 8 percent of calls are abandoned.

(4) Responsiveness to FEHB Member Requests for Reconsideration.

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given

time period, within 30 days after receipt by the Carrier, the Carrier must affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(5) Quality Assurance Plan - the Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance and abuse prevention standards.

(6) Physician Credentialing - the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.

(A) Verification of medical school graduation records.

(B) Routine check with local and/or state medical societies and/or boards.

(C) Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.

(D) Routine check of the National Practitioner

(8) Assessing Quality of Health Care. The Carrier shall collect data on the measures endorsed by the Foundation for Accountability (FACCT), as requested by the OPM for services rendered through the Carrier's Preferred Provider Organization and/or Point of Service networks. Further, the Carrier shall provide statistical reports in accordance with FACCT guidelines when requested by OPM. The Carrier may be asked to collect data on one or more measures in a specified geographic locality. In addition, the Carrier shall report on measures developed by the National Committee for Quality Assurance as directed by OPM.

(b) The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.

(c) The Carrier shall keep complete records of its quality assurance procedures and fraud program and the results of their implementation and make them

Data Bank.

(7) Appointments - All Health Maintenance Organization carriers must meet the following standards for the given time period. *Except that*, if this information is not routinely collected, report results from periodic surveys.

REQUIRED STANDARD:

(i) Urgent appointments are available, on average, within 24 hours of an authorized request for one.

(ii) Routine appointments are available, on average, within 1 month of an authorized request for one.

(iii) Average office waiting times - on average, members who arrive on time for a scheduled appointment wait no more than 30 minutes before they are seen by the provider of the medical service.

(NOTE: For the purpose of this standard (7), a simplified classification system is used in which all appointments are classified as either emergency, urgent or routine. Emergency appointments must be seen immediately to prevent health deterioration. Urgent appointments are those for the sudden, acute onset of symptoms that must be seen within 1 (one) day to prevent health deterioration. All other appointments are considered routine.)

available to the Government as determined by OPM.

If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.

(d) The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order.

(e) Assessing Member Services. In addition to any other means of surveying Plan members that the Carrier may develop, the carrier shall participate in either a National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) consumer survey or an FEHB-specific consumer survey, to provide feedback to enrollees on enrollee experience with the various FEHB plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS (JAN 1997)
(FEHBAR 1652.222-70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) working days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

- (1) Disposal of major assets;
- (2) Loss of 15% or more of the Carrier's overall membership;
- (3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;
- (4) Addition or termination of provider agreements;
- (5) Any changes in underwriters, reinsurers or
- (13) Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

- (1) Directing the Carrier to take corrective action;
- (2) Suspending new enrollments under this contract;
- (3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;
- (4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;
- (5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or
- (6) Terminating this contract pursuant to Section

participating plans;

(6) The imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10) Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11) Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12) Any fraud, embezzlement or misappropriation of FEHB funds; or

1.15, *Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall insert this clause in any subcontract or subcontract modification if both the amount of the subcontract or modification charged to the FEHBP (or, in the case of a community-rated carrier, applicable to the FEHBP) exceeds \$100,000 and the amount of the subcontract or modification to be charged to the FEHBP (or, in the case of a community-rated carrier, applicable to the FEHBP) exceeds 25 percent of the total cost of the subcontract or modification. If the Carrier is an HMO, it shall also insert this clause in all provider agreements over \$25,000. If the Carrier is not an HMO, it shall also insert this clause in the contract with its underwriter, if any. The Carrier shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.11
FEHB INSPECTION (JAN 1991) (FEHBAR
1652.246-70)

(a) The Government or its agent has the right to inspect and evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unduly delay the work.

If the Government or its agent performs inspection or evaluation on the premises of the Carrier or a subcontractor, the Carrier shall furnish and require the subcontractor to furnish all reasonable facilities and assistance for the safe and convenient performance of these duties.

(b) The Carrier shall insert this clause in all subcontracts for underwriting and administrative services and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.12 CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval*.

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13 INFORMATION AND MARKETING MATERIALS (JAN 1999)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. OPM in its sole discretion, may order the Carrier to print and distribute the agreed upon brochure text in a format and quantity approved by OPM, including an electronic brochure version for OPM's World Wide Web Site. This formatted

contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version of the approved language. The Carrier may print additional FEHB brochures for distribution or its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1625.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no

expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR
ADVERTISING (JAN 1991)(FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material, including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the *FEHB Supplemental Literature Guidelines* which are developed by OPM and should be used, along with the

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all enrollees of the Plan(s) that had been the subject of the original material.

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval*.

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not

additional guidelines set forth in FEHBAR 1603.702, as the primary guide in preparing material; further guidance is provided in the *NAIC Rules Governing Advertising of Accident and Sickness Insurance With Interpretive Guidelines*. Guidelines are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to protect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense and in the same manner and media as the original material was made; and less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
[RESERVED]

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent to the

performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S
CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the Carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
CERTIFICATION UNDER P.L. 104-191 (HEALTH

(b) During the Carrier's provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patient Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patient Bill of Rights in accordance with OPM guidance.

SECTION 1.21
YEAR 2000 COMPLIANCE (JAN 1999 2000)

(a) The Carrier shall ensure that the hardware, software, firmware, **and medical equipment containing embedded chip technology** it uses in the performance of its FEHB Program contract will accurately process date/time data (including, but not limited to, calculating, comparing and sequencing) involving dates later than December 31, 1999, including leap year calculations. ~~On May 31, 1999, the Carrier shall either notify the Contracting Officer that the system will be compliant or provide the Contracting Officer with a contingency plan that will detail how the system will remain operational after December 31, 1999.~~

(b) When acquiring information technology that will be required to perform date/time processing involving dates later than December 31, 1999, the Carrier shall ensure that solicitations and contracts: ~~(1) require the information technology to be Year 2000 compliant ; or (2) require that non-compliant information technology be upgraded to be Year 2000 compliant prior to the earlier of (i) the earliest date on~~

INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996) (JAN 1998)

The Carrier shall issue a certification of coverage for enrollees in accordance with the regulations issued by the Health Care Financing Administration.

SECTION 1.20
PATIENT BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities (APatient Bill of Rights@) in accordance with OPM guidance. ~~which the information technology may be required to perform date/time processing involving dates later than December 31, 1999, or (ii) December 31, 1999.~~

~~(e) Not later than May 31, 1999, the Carrier shall submit a copy of its company purchase policy that the hardware, software, and firmware it either contracts for or purchases is Year 2000 compliant.~~

~~(d) (c) AYear 2000 compliant@ means that the information technology accurately processes date/time data (including, but not limited to, calculating, comparing, and sequencing) involving dates later than December 31, 1999, including leap year calculations, to the extent that other information technology used in combination with the information technology being acquired, properly exchanges date/time data with it.~~

(d) A system failure caused by the failure of hardware, software, firmware, or medical equipment containing embedded chip technology that results in the Carrier's inability to deliver benefits and services to FEHB Program enrollees is a significant event under Section 1.10 of this contract, Notice of Significant Events, and must be reported promptly to OPM.

SECTION 1.22
HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996

(HIPAA) and implementing regulations. ^AGuaranteed availability[@] means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act ^Athe Act[@]) to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Act), with respect to such coverage.

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of

(a) Enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its enrollees in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the enrollee's specialty provider contract, for reasons other than cause in order to allow sufficient time for the enrollees to arrange for continued care after the 90-day period. The Carrier shall send the notice in time to ensure it is received by the enrollees no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and transitional care period run concurrently.

SECTION 1.24 TRANSITIONAL CARE (JAN 2000)

(a) ^ATransitional care[@] is specialized care provided for up to 90 days or through the postpartum period to an enrollee undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when his or her carrier (1) terminates all or part of its FEHBP

this contract, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.23 NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2000)

contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the enrollee receives the notice required under Section 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) Beginning January 1, 2000, the Carrier shall ensure the following:

(1) *If it terminates its FEHBP contract or a specialty provider contract other than for cause, it allows enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period;*

(2) *If it enrolls a new member who involuntarily changed carriers because the enrollee's former carrier was no longer available in the FEHB Program, it provides for the transitional care under the same terms and conditions the enrollee had under the prior carrier; and,*

(3) *For the Carrier's non-transitional care enrollees who remain in the plan after a provider change, the enrollee is subject to the same benefit provisions as all other members. There will be no vesting of benefits;*

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to enrollees;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient;

(3) provide assistance to enrollees who want to obtain records from the specialty provider and/or request that the provider amend or allow them to append a record they believe is inaccurate, irrelevant, or incomplete; and,

(4) require the specialty provider to give all necessary information to the Carrier for quality assurance purposes.

PART II - BENEFITS

SECTION 2.1 ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2 BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise

(a) By enrolling or accepting services under this contract, Members are obligated to all terms,

contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3 PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1996)

conditions, and provisions of this contract. The Carrier may request Members to complete reasonable

forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members are required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when claim filing is required, the Carrier may

Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,
(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any covered medical service or supply.

reimburse that person for any covered medical service or supply.

(4) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(3) shall fully discharge the Carrier to the extent of such payment.

(g) Overpayments. If the Carrier or OPM determines that a Member's claim has been paid in

error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:

(7) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

SECTION 2.4 TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation

is prohibited, but in which the Carrier subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

SECTION 2.6 COORDINATION OF BENEFITS (JAN 1991) (FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Model Guidelines for Coordination of Benefits (COB) as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider

accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Model Guidelines implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will continue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]

SECTION 2.7 DEBARMENT AND OTHER SANCTIONS (JAN 1999)

during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8 FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the

denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under ' 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9 PROTECTION OF MEMBERS AGAINST PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Carrier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10 INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11 SECTION 2.13 BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 1998)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, and the balance between the Medicare approved amount and the Medicare limiting charge made by nonparticipating providers. This provision does not apply to debarred providers (see Section 2.7).

CLAIMS PROCESSING (JAN 1998)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) By the year 2000, the majority of provider claims should be submitted electronically;

(2) All physicians shall be notified that future claims must be submitted electronically or on the Health Care Financing Administration 1500 form;

(3) The Carrier shall not use any unique physician claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the HCFA 1500 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12 CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.14

CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2000)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination.

(b) Contract requirements that extend beyond the date of the Carrier's termination include, but are not limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date.

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS (JAN 1999) (FEHBAR 1652.232-70)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM, amounts assessed under FEHBAR 1609.7101-2, and amounts for obligations due pursuant to paragraph (b), plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a).

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be due and payable not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special nonrecurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision 1.15, Renewal and Withdrawal of Approval, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the reserves held by the Carrier are insufficient for that purpose.

[NOTE: The adjustment for error or fraud referenced in paragraph (a) and the necessary and proper charges against this contract if the contract is terminated or not renewed, referenced in subsection (d), shall be limited to the

subscription rate and any contingency reserve payment otherwise provided for in this contract and shall not include claim charges or other expenses attributable to individual Members. Further, FEHBAR 1652.216-70, Accounting and Price Adjustment, applies if any adjustment to the contract price is determined.]

SECTION 3.2
ACCOUNTING AND PRICE ADJUSTMENT (JAN 1998 2000) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. ~~The accounting shall be in the form prescribed by OPM.~~ **The Carrier shall follow the OPM prescribed accounting format.**

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR ' 1602.170-13.

(3) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates ~~are found~~ to be lower than the equivalent rates for the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) **The Government shall not allow or consider and the Carrier shall not make any** ~~No~~ upward adjustment in the rate established for this contract ~~will be allowed or considered by the Government or will be made by the Carrier~~ in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108). Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

SECTION 3.3

RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN-1998 2000) (FEHBAR 1652.215-70)

(a) If **the Carrier increased** any rate established in connection with this contract ~~was increased~~ because it (1)

(A) The Carrier certifies to the Contracting Officer that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were

~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.804-70); (2) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) ~~the Carrier~~ developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR '1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) ~~the Carrier~~ submitted or, kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current--then, ~~the rate shall be reduced~~ **Carrier shall reduce the rate** in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense: (i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, **the Contracting Officer shall determine and allow an appropriate offset** ~~an offset in an amount determined appropriate by the Contracting Officer~~ based upon the facts ~~shall be allowed~~ against the amount of a contract price reduction if--

available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date. (ii) ~~An offset shall not be allowed~~ **The Contracting Officer shall not**

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allow an offset if-- (A) ~~The understated data was known by the Carrier~~ **Carrier knew the data to be** understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves ~~that~~ the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid--

(1) ~~Simple interest on the amount of the overpayment from the date the overpayment was paid from the FEHB Fund to the Carrier~~ **Government paid the Carrier the overpayment from the FEHB Fund** until the date the **Carrier liquidates the** overcharge is ~~liquidated~~. In calculating the amount of interest due, **the Carrier shall use** the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the **Carrier retained the** overcharge ~~was retained by the Carrier shall be used~~; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

(d) Exception for the DoD Demonstration Project. Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

SECTION 3.4 CONTRACTOR RECORDS RETENTION (JAN 1999) (FEHBAR 1652.204-70)

(1) That any individual discrepancies discovered in the course of reconciliation, in which the agency certifying officer and the Carrier agree as to the enrollment status of the individual, shall be corrected by the applicable agency to reflect the valid enrollment(s). If the reconciliation indicates that the subscription payments were not made or were made in error, appropriate adjustments shall be made by the

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)) *Audit and Records - Negotiation* the Carrier shall retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of 5 years after the end of the contract term to which the records relate, except that individual enrollee and/or patient claim records shall be maintained for 3 years after the end of the contract term to which the claim records relate.

SECTION 3.5 APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.

(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

SECTION 3.6 DISCREPANCIES BETWEEN ENROLLMENT AND PAYMENTS TO CARRIER (JAN 1999)

(a) The OPM and the Carrier recognize that the portion of subscription payments under Section 3.1(a) forwarded by OPM to the Carrier for Enrollees may not be consistent with the Carrier's reconciliation of enrollment under Section 1.5. Therefore, the OPM and the Carrier agree:

agency to the Fund pursuant to law. Any adjustment in the subscription charges received by the Fund from the agency as a result of a reconciliation shall be forwarded by OPM under Section 3.1(a); and

(2) That the rates in Appendix B include an adjustment to the subscription charges equal to one percent in full resolution of all discrepancies not corrected under Section 3.6(b)(1).

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(b) In consideration of the adjustments in Section 3.6(a)(1) and (2), the Carrier accepts the adjustment to the subscription charges in full resolution of all obligations of the Government in connection with the subscription payments as described in this section 3.6, and waives any rights it may have to claims for subscription payments under Section 3.1(a).

(c) The OPM and the Carrier shall review the reconciliation process and this provision for Contract Year 2001.

SECTION 3.7 SURVEY CHARGES (JAN 1999)

(a) If the Carrier contracts with a National Committee for Quality Assurance (NCQA) certified vendor to conduct the annual consumer assessment survey, paragraph (b) does not apply.

(b) If the Carrier participates in an FEHB-specific annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of conducting the survey. The Carrier shall pay a separate fee for each plan option and /or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the survey contractor within 60 days of the billing date, OPM shall withhold the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-70, Payments to community-rated contracts, and forward payment to the survey contractor.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1 ALTERATIONS IN CONTRACT (JAN 1998) (FAR 52.252.4)

Portions of this contract are altered as follows:

(a) Sections 5.30, 5.31, 5.32. Cost Accounting Standards, part 30 of the FAR, has not yet been implemented for the FEHBP community rated contracts. Sections 5.30, 5.31 and 5.32 are not applicable to this contract.

(b) Section 3.2. As required by Public Law 101-508, ' 8909 of title 5, U.S.C., and Section 3.2(b) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(CR-2000)

Proposed Year 2000 Amendments to the Standard Contract for Community-Rated Carriers

1. Redate Section 1.21, YEAR 2000 COMPLIANCE, as JAN 2000 and update and revise the clause as follows:

SECTION 1.21 YEAR 2000 COMPLIANCE (JAN 1999 2000)

(a) The Carrier shall ensure that the hardware, software, firmware, **and medical equipment containing embedded chip technology** it uses in the performance of its FEHB Program contract will accurately process date/time data (including, but not limited to, calculating, comparing and sequencing) involving dates later than December 31, 1999, including leap year calculations. ~~On May 31, 1999, the Carrier shall either notify the Contracting Officer that the system will be compliant or provide the Contracting Officer with a contingency plan that will detail how the system will remain operational after December 31, 1999.~~

(b) When acquiring information technology that will be required to perform date/time processing involving dates later than December 31, 1999, the Carrier shall ensure that solicitations and contracts:—(1) require the information technology to be Year 2000 compliant ; or (2) require that non-compliant information technology be upgraded to be Year 2000 compliant prior to the earlier of (i) the earliest date on which the information technology may be required to perform date/time processing involving dates later than December 31, 1999, or (ii) December 31, 1999.

~~(c) Not later than May 31, 1999, the Carrier shall submit a copy of its company purchase policy that the hardware, software, and firmware it either contracts for or purchases is Year 2000 compliant.~~

~~(d) (c) A Year 2000 compliant@ means that the information technology accurately processes date/time data (including, but not limited to, calculating, comparing, and sequencing) involving dates later than December 31, 1999, including leap year calculations, to the extent that other information technology used in combination with the information technology being acquired, properly exchanges date/time data with it.~~

(d) A system failure caused by the failure of hardware, software, firmware, or medical equipment containing embedded chip technology that results in the Carrier's inability to deliver benefits and services to FEHB Program enrollees is a significant event under

Section 1.10 of this contract, Notice of Significant Events, and must be reported promptly to OPM.

2. Add new Sections 1.23, NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT, and 1.24, TRANSITIONAL CARE, to implement the continuity of care provisions of the Patient Bill of Rights, as follows:

SECTION 1.23 NOTICE TO ENROLLEES ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2000)

(a) Enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its enrollees in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the enrollees' specialty provider contract, for reasons other than cause in order to allow sufficient time for the enrollees to arrange for continued care after the 90-day period. The Carrier shall send the notice in time to ensure it is received by the enrollees no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and transitional care period run concurrently.

SECTION 1.24 TRANSITIONAL CARE (JAN 2000)

(a) ~~A Transitional care@ is specialized care provided for up to 90 days or through the postpartum period to an enrollee undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when his or her carrier (1) terminates all or part of its FEHBP contract, or (2) terminates the enrollee's specialty provider contract~~

for reasons other than cause. The 90-day period begins the earlier of the date the enrollee receives the notice required under Section 1.23, Notice to Enrollees on Termination of FEHBP or Provider Contract, or the date the Carrier-s or the provider-s contract ends.

(b) Beginning January 1, 2000, the Carrier shall ensure the following:

(1) *If it terminates a specialty provider contract other than for cause, it allows enrollees who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, under the same terms and conditions that existed at the beginning of the transitional care period; and*

(2) *If it enrolls a new member who involuntarily changed carriers because the enrollee-s former carrier was no longer available in the FEHB Program, it provides for the transitional care under the same terms and conditions the enrollee had under the prior carrier.*

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to enrollees;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient;

(3) provide assistance to enrollees who want to obtain records from the specialty provider and/or request that the provider amend or allow them to append a record they believe is inaccurate, irrelevant, or incomplete; and,

(4) require the specialty provider to give all necessary information to the Carrier for quality assurance purposes.

3. Add a new Section 2.14, CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER, to reinforce certain contractual requirements as follows:

SECTION 2.14 CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2000)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination.

(b) Contract requirements that extend beyond the date of the Carrier-s termination include, but are not

limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date.

4. Redate Section 3.2, ACCOUNTING AND PRICE ADJUSTMENT, as JAN 2000; add a new paragraph (c) to implement the DoD/FEHBP Demonstration Project authorized by 10 U.S.C. 1108; and make clarifying changes as follows:

SECTION 3.2 ACCOUNTING AND PRICE ADJUSTMENT (JAN ~~1998~~ 2000) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. ~~The accounting shall be in the form prescribed by OPM.~~ **The Carrier shall follow the OPM prescribed accounting format.**

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR ' 1602.170-13.

(3) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates ~~are found~~ to be lower than the equivalent rates for

the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, **the Carrier or OPM find** the subscription rates to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) **The Government shall not allow or consider and the Carrier shall not make any** ~~No~~ upward adjustment in the rate established for this contract ~~will be allowed or considered by the Government or will be made by the Carrier~~ in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

(c) Exception for the 3-Year DoD Demonstration Project (10 U.S.C. 1108). Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carriers demonstration project premium rates. The Carriers rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

5. Redate Section 3.3, RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (FEHBAR 1652.215-70), as JAN 2000; add a new paragraph (d) to implement the DoD/FEHBP Demonstration Project authorized by Public Law 105-261; and make clarifying changes as follows:

SECTION 3.3
RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN-1998 2000) (FEHBAR 1652.215-70)

(a) If **the Carrier increased** any rate established in connection with this contract ~~was increased~~ because **it** (1) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.804-70); (2) ~~the Carrier~~ submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) ~~the Carrier~~ developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR ' 1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) ~~the Carrier~~ submitted or, or kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current--then, ~~the rate shall be reduced~~ **Carrier shall reduce the rate** in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense: (i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, **the Contracting Officer shall determine and allow an appropriate offset** ~~an offset in an amount determined appropriate by the Contracting Officer~~ based upon the facts ~~shall be allowed~~ against the amount of a contract price reduction if--

(A) The Carrier certifies to the Contracting Officer that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date. (ii) ~~An offset shall not be allowed~~ **The Contracting Officer shall not allow an offset** if-- (A) ~~The understated data was known by the Carrier~~ **Carrier knew the data to be** understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves ~~that~~ the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid--

(1) Simple interest on the amount of the overpayment from the date ~~the overpayment was paid from the FEHB Fund to the Carrier~~ **Government paid the Carrier the overpayment from the FEHB Fund** until the date the **Carrier liquidates the overcharge is liquidated**. In calculating the amount of interest due, **the Carrier shall use** the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the **Carrier retained the overcharge** ~~was retained by the Carrier shall be used~~; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

(d) Exception for the DoD Demonstration Project. Similarly sized subscriber group (SSSG) rating methodologies shall not be used to determine the reasonableness of the Carrier's demonstration project premium rates. The Carrier's rates shall not be adjusted for equivalency with SSSG rating methodologies. The Carrier shall benchmark premiums against adjusted community rates if available, Medigap offerings, or other similar products.

(End of Clause)

6. Update the introductory paragraph and paragraph (a)5. of Appendix D-a to include website material under supplemental literature, as follows:

APPENDIX D-a
FEHB SUPPLEMENTAL LITERATURE GUIDELINES

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, **including website material**, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Guidelines for additional guidance when needed.)

a) 5. Under the FEHBP, the FEHB brochure is ~~based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions~~ **the official statement of benefits**. Include the following statement (**website material should include the statement as a preface**) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary [or brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ([insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."